

Theoretical Perspectives on Community Engagement in HIV Prevention and Programming among the Basotho Tribe

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ABSTRACT Community level HIV prevention proposes that attempts to change the norms, attitudes, collective self-efficacy and risk behaviour practices in populations vulnerable to AIDS are essential for various reasons. People contract HIV as a result of sexual and drug abuse activities that take place in their day-to-day lives in the community. Changing communities to make them safer is a logical direction for HIV prevention; hence community level and population-focused interventions have the potential to be cost effective by virtue of their scope. Therefore, the aim of this article is to investigate, through a literature study, the background of community engagement in issues of health and well-being among the Basotho in the era of HIV and AIDS. This will be preceded by a discussion of the various community engagement theories and frameworks in the context of HIV and AIDS prevention, care and support, and impact mitigation. A subsequent section will focus on the psychological theory of Behaviourism in relation to cultural movements and gender dynamics. The research paper will conclude with a comparison of the community engagement and Behaviourist theories and their suitability to the HIV and AIDS response among the Basotho tribe.

INTRODUCTION

Since the outbreak of the HIV and AIDS pandemic, community engagement has been playing a vital role in the response to HIV and AIDS in generating individual and social change as volunteers and activists led the first educational, prevention and care activities and created community based organisations in the most affected areas (Ramirez-Valles 2002). The same phenomenon has occurred in Lesotho and other parts of Southern Africa, hence the rigorous community activity evident in the national response to HIV and AIDS today, though volunteerism is strongly relied upon. This paper articulates community engagement in HIV programming in Lesotho. Basotho have always been a close-knit community who supported each other in their everyday lives and responded to challenges from national, community and individual levels. This is evident in the joint activities that were performed by communities during the ploughing, hoeing or harvesting seasons during which they would support each other by means of joint working groups called *mat-*

sema (singular *letsema*, meaning cooperative working). Similar interventions are still taking place during times of sickness and bereavement although there is an evident decline in some of these practices as the effect of globalisation and family disintegration become more prevalent within these communities. The International Council of AIDS Service Organisations (ICASO) (2007) reiterates the fact that most communities share values, beliefs and norms on sexuality that create vulnerability to HIV transmission such as widowhood-related rituals, female genital mutilation and early marriage. Many of these practices have never been questioned and their association with HIV is not well understood, hence the need for HIV programmes to draw the links between local traditions and HIV transmission, both at the national policy and community intervention levels. ICASO further emphasises the fact that there is a need at community level to strengthen community-based participatory strategies that allow for raising awareness, analysis and questioning of underlying factors that predispose communities, particularly women, to HIV.

LESOTHO IN CONTEXT

Lesotho is a homogenous nation, regarding the ethnic make-up of its population, as well as religion and culture. Stoddard (2000) argued that

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Lesotho's strong cultural identity does not translate into a strong national identity, since its location deep in the heart of South Africa has historically forced the small country into dependence on its much larger neighbour. Sesotho is the primary language spoken by the majority of inhabitants of Lesotho, as well as in parts of South Africa. Historically, Sesotho was one of the first African languages to develop a written form, and it has an extensive literature. English is the second official language, dating back to 1868 when Lesotho was placed under British rule for protection against South African aggression. Zulu and Xhosa are spoken by a small minority. Traditional authority is the basis of village government. The system of chieftaincy follows the progression of paramount chief (the king), senior chiefs, sub-chiefs, headmen and sub-headmen. Their primary role is the authority to distribute the land of the nation to the people. Many political affiliations are passed down through the chain, with entire villages voting in accord during an election. The domestic family unit consists of any number of the extended family. Often second or third cousins become 'brothers' or 'sisters'. Grandmothers become official mothers, though some other challenging gender dynamics indicate that through tribal custom, widows become a wife of the brother or other male member of her deceased husband's family (Stoddard 2000). The Sesotho saying 'it takes a village to raise a child' is a well-known and accurate description of African and Basotho practices as it means that every village woman is eligible to correct and even reprimand an erring child, to rescue one in difficulty and to encourage all. This cements a conception that community engagement among the Basotho is entrenched in their culture and considered 'normal'; hence the importance of engaging communities in all HIV and AIDS and other development programmes.

Baxter (2008) indicates that every family in Lesotho has lost loved ones to AIDS-related illnesses as it is estimated that about a third of Basotho are living with HIV and AIDS; hence the need for community engagement in prevention, care and support strategies. He states that the number of homeless children, children orphaned by AIDS or those who have become homeless as a result of alcoholism, family disintegration or abandonment, defies estimation. In every town and village there are homeless

children, and in the city and towns, begging children haunt every street and alley – some homeless, others living in makeshift shelters with relatives or friends. Little girls are taken in as sex workers by pimps and crime rings (Baxter 2008; Mugenyi 2008). Some remain in Lesotho, but there is a much larger market for sex workers in the neighbouring South Africa, where they work until they are thrown out and left to die, often riddled with disease, before they are twenty years old (Epstein 2002; Lamptey 2002). The World Health Organisation (WHO) and other development and civil society partners work with the Ministry of Health and Social Welfare in Lesotho to build on the national and indigenous support systems by promoting community home-based care (CHBC). CHBC is defined by the WHO as care provided to the terminally or chronically ill in the comfort of their homes or their familiar communities. Typically, CHBC substitutes or complements long-term institutional care. Care in the home is provided primarily by family members and community volunteers, and in the specific case of HIV and AIDS, support is even provided by people living with HIV and AIDS. Community volunteers, who are mainly community health workers (CHW), and support group members engage in a variety of activities including door-to-door sensitisation on HIV and AIDS and related issues, basic nursing care, palliative care, anti-retroviral therapy (ART) literacy and preparedness performed by community volunteers and people living with HIV and AIDS (PLWHA), treatment support and adherence (Baxter 2008).

UNITED NATIONS DEVELOPMENT PROGRAMME (UNDP) COMMUNITY CAPACITY ENHANCEMENT FRAMEWORK

This framework translates the principle of community participation into development practice by creating opportunities for people to understand, discuss, decide and act on issues that affect their lives (UNDP 2005) as outlined in the framework below:

Community Capacity Enhancement Framework

The framework and methodology as outlined by UNDP (2005) are based on the principle that

'the emergence of the AIDS pandemic has simultaneously affected communities at many levels: sickness and death is combined with deepening poverty and widespread orphaning. The challenge was initially perceived as a health problem requiring a public health approach. But health services, and communities for that matter, were ill prepared to deal with a problem that encompasses the complex issues of sex, terminal illness and death – all three raised to astonishing levels by HIV/AIDS. Innovative ways of working with communities to generate an effective and structured response had to be put in place'. In response to HIV and AIDS, the methodology works to strengthen the capacity of individuals and communities to respond to HIV and AIDS and, more importantly, to understand how their relationships, attitudes and practices influence the spread of HIV and AIDS within their communities. The methodology assists communities in comprehending the basic translation of the complex science and epidemiology of HIV and AIDS. This will encourage them to reflect on how HIV is spread and how it evolves within the body and, therefore, help them to identify which of their behaviours and socio-cultural practices need to be changed, modified or abandoned if they were to take responsibility for controlling the pandemic. This awareness was brought about through a process called 'Community Conversations' which are a series of facilitated dialogues within a community. The difference between this facilitated dialogue and the conventional communication or mass media approaches, such as the old Basotho meetings called *lipitso* and others such as pamphlet distributions and health talks that do not involve the community, is that the latter often leave communities with unclear prescriptive messages which they may not necessarily relate to within their context.

On the other hand, community conversations provide a platform for people to consider all the repercussions of a situation, namely the way in which their individual values and behaviours, and those of their family and neighbours, affect people's lives. The community conversations create space for mutual learning, as well as new perspectives in reshaping relationships in line with transformed values. These conversations are inclusive processes for enhancing the capacity of all groups in the community, including people living with HIV. It is through these

conversations that power relations within the community are shifted, that ownership and responsibility to change are strengthened and that local capacities and resources are mobilised by the community (Craig-Unkefer and Kaiser 2003; Sansosti and Powell-Smith 2008; Hester 2009; Ingersoll 2010). Furthermore, these conversations and social communication provide a key opportunity for local authorities to listen to and comprehend the challenges, concerns and decisions of communities in order to feed them into planning and implementation processes at district and national levels. In this way, democratisation and good governance are being facilitated, while, at the same time, social networks and coalitions between civil society organisations among themselves and with the communities that they serve are strengthened and reinforced. It can be argued that the methodology applies and resonates to various levels of society as the facilitated dialogues or conversations promote policy dialogue, mutual learning, enabling environment, HIV and AIDS competencies and strengthen leadership capacities from the personal to organisational and through to local levels (UNDP 2005; Sims and Sinclair 2008; Casenhiser et al. 2011). This methodology brings together men and women of different generations and gives them an opportunity to present different perspectives to be taken into account when decisions are made, thereby increasing their HIV and AIDS competence. Therefore, in relation to the title, the authors view this methodology as assisting communities in demystifying some of the gender dynamics and cultural myths and movements that have not allowed men and women in the past to jointly discuss issues that affect them. The conceptual framework of this methodology is based on the recognition and acknowledgement that communities have the capacity to prevent HIV, care for the infected and empower the affected, have the power to decide whether and when to change harmful attitudes, behaviours and practices, as well as to instil and sustain hope of overcoming the ramifications of the pandemic on their livelihoods. The methodology translates the principle of participation into development practice by creating opportunities for people to understand, discuss, decide and act on issues that affect their lives. Therefore, from this framework, it becomes imperative that local communities' responses to HIV and AIDS and other social

challenges, which are in most instances not part of the global and national plans, should be based on the realities of the existing cultural movement, social and gender dynamics, and complemented by the concerns of the local communities.

PROTECTIVE EFFECTS OF COMMUNITY ENGAGEMENT FOR HIV RISK BEHAVIOUR

The model presents a conceptual framework for the protective effects of community engagement in HIV and AIDS-related groups and organisations for HIV sexual risk behaviour among a specific population group of gay and bisexual men. It does, however, provide a comprehensive framework for HIV programming in the context of gender and culture as it guides prevention programmes based on the active and direct engagement of communities. Ramirez-Valles (2002:2) argues that the conceptual framework advances the understanding of HIV sexual risk behaviour by integrating both its socio-structural risk and protective factors as a result of contributing to health education. This contribution is made by specifying how interventions based on collective action for social change, for example, regarding community engagement, may be effective in generating healthy behaviours at individual and community levels.

Conceptual Framework for the Protective Effects of Community Engagement for HIV Risk Behaviour

The authors are of the opinion that most responses to HIV and AIDS, including the response in Lesotho, have failed for many years to integrate the socio-economic risk and protective factors into health and HIV information, education and communication (IEC) programs and their relation to community engagement. Since the advent of HIV in Lesotho, the national response has been driven by strategies and programmes targeting people regarding their HIV status and not necessarily focusing on the key populations at risk, the communities they reside in, as well as the socio-economic situation of the various population groups and the engagement of communities in the national response. For instance, the Lesotho National AIDS Strategic Plan 2006-2011 makes reference to vulnerable groups (women, girls, sex workers,

migrant populations, people with disabilities and herd boys) and highlights the need to cater for these populations regarding service provision and non-discrimination without necessarily linking these to the community and social aspects of the pandemic. As an affirmation of the above mentioned challenges and gaps, the Human Sciences Research Council (HSRC) carried out an audit of HIV and AIDS policies in six Southern African countries, including Lesotho, in 2005. One of the key findings from the audit was that there is poor or very limited community engagement in programmes that continues to undermine the many efforts to respond to the HIV pandemic. The recommendation was that communities should be more involved since traditional and religious leaders can improve community participation in all HIV and AIDS initiatives. In this way, awareness of the pandemic at community level can be increased, which reinforces the fact that greater leadership commitment from government can also help to uproot stigma and silence and promote open HIV status disclosure for the greater engagement and empowerment of people living with HIV and AIDS (GIEPA).

The framework of the protective effects of community engagement for HIV risk behaviour argues that community engagement moderates the association between socio-structural risk factors such as poverty, homophobia, racism and sexual risk behaviour. The framework posits also that community engagement in HIV and AIDS reduces sexual risk behaviour via its effects on four mediating factors (that is, peer norms, self-efficacy, positive self-identity and alienation). Furthermore, it proposes five socio-cultural barriers to and facilitators of community engagement in HIV and AIDS as motives for participation, poverty, acculturation, stigma and perceived opportunities. Finally, the framework addresses burnout as one potential negative consequence of community engagement in HIV and AIDS-related organisations and groups. The above arguments will be analysed further in the context of Lesotho and in relation to the country's response to HIV and AIDS

SOCIO-CULTURAL BARRIERS TO AND FACILITATORS OF COMMUNITY ENGAGEMENT IN HIV AND AIDS

Ramirez-Valles (2002) states that, among others, there are five key socio-cultural issues

that can be viewed either as barriers to or as facilitators of community engagement. These include motives for participation, poverty, acculturation, stigma and perceived opportunities. The section below will further explore these issues in relation to the topic.

Motives for Participation

Ramirez-Valles (2002) defines motives in this context as psychosocial and cultural factors that partly determine levels of community engagement. The levels and types of community engagement may depend on the levels of motivation and the types of motives individuals have for participation. He goes on to highlight the fact that research on participation in community-based, neighbourhood and AIDS service organisations has identified categories of motives for engagement such as concern for one's community, moral values, understanding others, coping with one's troubles and helping others (Snyder and Omoto 1992; Bebbington and Gatter 1994; Smith 1994; Gabard 1995; Hodgkinson 1995; Omoto and Snyder 1995; Stewart and Weinstein 1997). Ramirez-Valles (2002) concludes that the types of motives did not differ greatly across these studies but the types of motives identified as most salient were different. For instance, some researchers found overall motivation positively associated with length of time as an HIV and AIDS volunteer, but self-orientated motives (for example, personal development) were better predictors of the length of service than community-orientated motives such as community engagement.

Poverty

Although the relationship between poverty and HIV transmission is not very simple and straightforward as believed by some scholars and communities, it remains a fact, which cannot be easily disputed, that many of the factors predisposing a large number of Africans to increased risk of HIV infection – particularly women and girls – are aggravated by poverty (Poku 2002; Whiteside 2004; Commission on HIV/AIDS and Governance in Africa [CHGA] 2008). Ramirez-Valles (2002:13) indicates that previous studies, however, have not explained why some individuals initiate and maintain safer sex behaviours despite facing poverty, homopho-

bia in the case of homosexuals including lesbians and gay men, racism and other challenges. This highlights the need for further research in this area.

Acculturation

Compared with women, men in Lesotho have always been less involved in health- and HIV and AIDS-related community work (Newman et al. 2009:11) which is evident from the vast majority of community health workers, caregivers and support group members still being women. CHGA (2008:12) states also that, in order to cope with HIV and AIDS, women face more harm from stigmatisation and discrimination than men, exacerbating obstacles to access testing, treatment and care. The struggle for gender equality begins in the family, the primary site for stigmatisation, discrimination and violence against women. These struggles extend to the workplace and communities, therefore, making it more difficult for women to demand equal treatment and care. This is confirmed by Mosetse (2006:64) as she indicates that patriarchy is another element that greatly contributes to gender inequality, especially in the context of Lesotho. She illustrates some examples of domains in which women experience patriarchy, namely the social, sexual, religious, political, traditional and family domains. This means that boys and girls are socialised differently within the family, men and women are expected to behave in certain ways (manly or womanly), some religious practices often restrict women to subordinate positions, and job allocation differs on the basis of one's sex. For instance, during events in the community, women are expected to cook and not to participate in the event as fully as men. This is illustrated in times of death or bereavement: Women (especially the spouse and close female relatives of the deceased) are expected to sit inside the house and not to be seen outside the house until the actual funeral has taken place. Women are further not expected to take any active part in the funeral proceedings. All the male relatives within the family play active roles, even in instances where they did not even know the deceased. For instance, if the deceased had been ill before passing on, a male relative will be given the usually 'prestigious' role of *mooki* – literally translated as 'Nurse' – to give testimony of the cause of

death, rather than the closest person to the deceased who clearly knows and has been there for the deceased during his/her illness and lifetime. In most cases, this person would be a woman.

Stigmatisation

For nearly two decades, as countries all over the world have struggled to respond to the HIV and AIDS pandemic issues of stigmatisation, discrimination and denial have been poorly understood and often marginalised within national and international programmes and responses (Aggleton and Parker 2003; Snyder et al. 1999). The same applies to Lesotho (National AIDS Commission 2006). The authors indicate that, as early as 1987, Jonathan Mann, the founding Director of the World Health Organisation's former Global Programme on AIDS, addressed the United Nations General Assembly, distinguishing between three phases of the AIDS pandemic in any community. The first phase is the pandemic of HIV infection – a pandemic that typically enters every community silently and unnoticed, and often develops over many years without being widely perceived or understood. The second phase is the pandemic of AIDS itself – the syndrome of infectious diseases that can occur due to HIV infection, but typically only after a delay of a number of years. Finally, he described the third phase, potentially the most explosive – the pandemic of social, cultural, economic and political responses to AIDS, which is characterised by, among others, exceptionally high levels of stigmatisation, discrimination and, at times, collective denial that, according to Mann, 'are as central to the global AIDS challenge as the disease itself'. The authors of this paper concede that Lesotho and the rest of the world are in this final phase of the pandemic and, therefore, community engagement has become more important than ever in curbing the spread of HIV and mitigating its impact through addressing social challenges like stigmatisation and discrimination of people living with HIV and AIDS, their families and caregivers. This is further emphasised by Kelly (1999) and Aggleton and Parker (2003) who assert that, if models of community mobilisation, advocacy and social change provide one important basis for developing responses aimed at overcoming HIV and AIDS-related stigma-

tisation and discrimination, they must be conceived as part of a multidimensional approach and in conjunction with the structural or environmental interventions aimed at transforming the context in which both individuals and communities operate as they respond to HIV and AIDS.

Perceived Opportunities

Studies on national and local civil and social service organisations indicate that participation may be largely determined by individuals' perceptions of opportunities to participate (Snow et al. 1980; Williams and Ortega 1986; Smith 1994; Catalano et al. 1996 in Ramirez-Valles 2002). These authors are of the opinion that individuals are likely to become involved in community programmes if they know of the existence of organisations and opportunities to do so, and if they perceive these organisations and opportunities as accessible and acceptable. There is, however, a need to examine whether perceived opportunities to participate in HIV and AIDS-related activities and programmes is positively associated with actual community engagement.

Potential Negative Consequences of Community Engagement in HIV and AIDS-related Organisations and Groups

Though community engagement is essential for effective HIV prevention and programming, there are a number of challenges that should be taken into consideration during the planning stages. Firstly, this includes burnout and the abuse of volunteers by organisations and entities. It has been noted that community engagement in HIV and AIDS may cause stress and burnout as activists, community health workers, caregivers and volunteers usually experience physical and emotional fatigue. Secondly, in Lesotho, community health workers do not receive any form of remuneration although they are key health personnel within all communities across the country. They are the first point of call when there is an emergency, death or birth within the community, as well as when organisations go into communities to implement projects, which, most of the time, have not been designed with any community engagement. Therefore, the health workers, who perform

community mobilisation, HIV counselling, delivery of babies and bereavement counselling and support, are abused.

Bronfenbrenner's Ecological Model

The Ecological Model that describes behaviour as shaped at multiple levels and by varied forces. This model, as outlined by Bronfenbrenner (2000), is adopted in this paper as it suggests that an individual develops within a context or ecology.

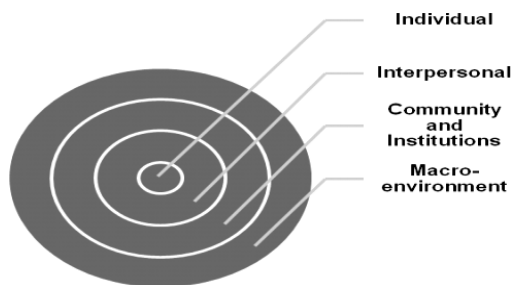


Fig. 1. Spheres of the Ecological Model: micro-, meso- and macro-levels

Huitt (2003) defines and illustrates these three levels as follows: The micro-system with the most immediate and earliest influence is the family, along with local neighbourhood or community and community institutions such as the school, religious institutions and peer groups, as well as the specific culture with which the family identifies. The meso-system comprises the intermediate level of influences such as social institutions involved in activities, for example, transportation, entertainment, news organisations and similar influences. The influence of meso-systems and institutions interacts with and is filtered through the micro-system institutions. The macro-system comprises the most removed influences such as international regional and/or global changes or even more abstract aspects of culture. For instance, the movement from the agricultural and industrial economies to an information age and global economy is having widespread influence on the way in which societies, communities and families operate. Finally, the model states that, while the focus sometimes tends to be on the influence of the family or school on human development, other important influences should be taken into account, for example, the Sesotho

saying mentioned above, a notion in direct correspondence with the Basotho culture (Fig.1).

Behaviourism

Behaviourism, as described by the online Wikipedia Dictionary (2009), is 'an approach to psychology focusing on behaviour, denying any independent significance for mind and assuming that behaviour is determined by the environment'. In light of this, the study will focus on the social psychology component of Behaviourism. According to Wikipedia (2009), social psychology focuses on the behaviour of individuals in a social context, as group behaviour may show characteristics that are greater than the sum of individuals which comprise the group. Catania and Harnad (1998:11) argue that human behaviour is the joint product of contingencies of survival responsible for natural selection, contingencies of reinforcement responsible for the repertoires of individuals, and the special contingencies maintained by an evolved social environment. According to Domjan (2003), B.F. Skinner analysed a form of behaviour that would be representative of all naturally occurring ongoing activity. He recognised that, before behaviour can be analysed empirically, a measurable unit of behaviour must be defined; and causal behaviour suggests that ongoing behaviour is continuous as one activity leads to another. Skinner, therefore, proposed the concept of the operant as a way of dividing behaviour into meaningful measurable units; with an operant response being defined with regard to the effect the response has on the environment. Nye (1992: 48) highlights that Skinner, in his strong advocacy for the importance and advantages of an objective behavioural approach, share similar thoughts with other psychologists such as Watson. Skinner was very clear that modern Radical Behaviourism does consider feelings, thoughts and other inner events, though not as causes of behaviour; it acknowledges the importance of genetic endowment in determining aspects of behaviour and takes topics such as self-knowledge and creativity into consideration. It should be noted also that, while acknowledging humans as feeling and thinking organisms, Skinner did not search within the human psyche (soul and mind) for any causes of behaviour, hence his Behaviourism was deservedly termed 'radical', as his approach

also applied the same type of analysis to covert (within the person – feelings, thoughts and others) and overt (publicly observable) behaviours. Regarding HIV, culture and gender, Skinner's theory, therefore, indicates that thoughts and feelings are overtly translated into the behaviours that people display.

Some social campaigns in the response to HIV and AIDS are based on and focus on people's feelings, as people's beliefs and culture greatly influence the way they act and behave. For example, in Sesotho culture, men are not expected to publicly display their affection and emotions, while women are allowed to, leading to men not taking an active part in social care and support activities, including caring for the sick. Another example is that of societal expectations for women to be silent and not to engage in public affairs, either at a community gathering (*pitso*) or in national activities like running for public office or political representation. It is becoming evident now that, following the Beijing Declaration and Platform for Action formulated during the Fourth World Conference on Women on 15 September 1995, women have been expected to take an active part in these areas and activities as they were thought to have been empowered by this transformative event. Since social and physical conditions of our environments are critically important in determining our behaviours, Skinner stressed the importance of discovering functional relations (informally expressed 'cause-and-effect' connections) between environmental conditions and behaviours. This is in line with other radical Behaviourists who have described in considerable detail the various observable factors that affect learning, thereby buttressing their arguments that human behaviour is controlled in many ways by circumstances that can be specified and manipulated objectively (Nye 1992:49). Catania and Harnad (1998:5) define Operant Behaviourism (or Radical Behaviourism) as the variety of Behaviourism that particularly indicates that behaviour itself is a fundamental subject matter and not an indirect means of studying something else like cognition, or mind or brain. What we call behaviour is, therefore, a set of functions furthering the interchange between organisms and the environment. These authors define Behaviourism as a philosophy of science concerned with the subject matter and methods of psychology, and not as the scientific

study of behaviour. According to this definition, Behaviourism takes seeing as an act, thinking as an act, and the quest for truth as an act of finding or constructing. Behaviour seems to be directed towards future consequences, but only because it is a product of past consequences.

One can assume that communities behave the way they do, based mainly on past consequences and in an effort to positively address future consequences. Some of the cultural practices and dynamics that are observed and practiced in Lesotho in this era may have originated because of some good or bad consequences that faced Basotho. For instance, the culture of mourning indicates that, when a wife loses a husband due to death, the wife should wear black clothes for a year to display her mourning. There are some rules and regulations a Mosotho woman must adhere to during this mourning period, including not arriving home after sunset, not raising her voice, only washing the particular attire after dark. It is, therefore, necessary to explore some of the particular reasons why some of these practices were introduced and enforced, including:

1. Was it because once a man died, the woman or her family hastily found her another husband and collected more herd of cattle in terms of *lobola* or the bride price?
2. Was it because women became more promiscuous and had multiple sexual partners after the death of a spouse to such an extent that her engagement in any sexual activity during the mourning period had to be restricted?

CONCLUSION

Considering the current HIV and AIDS situation in Lesotho, the researchers argue that, although some public health and other practitioners have reservations about the originality and contextual relevance regarding some national and regional campaigns to curb the spread of HIV through multiple and concurrent partnerships among men and women in Southern Africa, these campaigns are essentially being implemented in the same spirit as emphasised by Skinner and others, namely that current behaviour is a product of past consequences. In conclusion, all the theories and frameworks mentioned in this article are in total agreement that community-level HIV prevention interven-

tions that prove successful cannot be imposed on a population but should rather grow from and be owned by the population segments one hopes to reach. This, therefore, highlights the need for more social and cultural analyses of the HIV pandemic in Lesotho. In addition, the theories and frameworks further embrace pre-prescripts and elements of ethnographic studies. Ethnographic studies aimed to learn and understand cultural phenomena which reflect the knowledge and system of meanings guiding the life of a cultural group. As mentioned, social communication and conversation with communities are important in the endeavours geared at addressing the HIV pandemic. It is in such conversations that an opportunity for communicative learning arises. Such communicative learning would be characterized by learning that includes understanding values, concepts, and others' points of view. In addition, the learning that occurs is likely to result in transformations in the conditions of life of community members. This approach affirms the view that the best source of information about the issues would be community members themselves. These community members, due to their permanent residence status, may move beyond merely providing information and become agents of change.

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