

HIV/AIDS IN RURAL BOTSWANA:
POVERTY, GENDER INEQUALITY, MARGINALIZATION AND STIGMA

by

Seiko Watanabe

B.A. Keio University, Japan, 1972

Diploma Occupational Therapy, Fuchu School of Rehabilitation, Japan, 1980

PROJECT SUBMITTED IN PARTIAL FULLFILMENT OF
THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF ARTS
in
INTERNATIONAL STUDIES

THE UNIVERSITY OF NORTHERN BRITISH COLUMBIA

July 2005

© Seiko Watanabe, 2005

**UNIVERSITY of NORTHERN
BRITISH COLUMBIA
LIBRARY
Prince George, B.C.**

Abstract

HIV/AIDS in Africa has strong connections to development, poverty and gender inequality. Botswana continues to face one of the highest HIV/AIDS prevalence rates in the world. The common approaches to dealing with HIV prevalence based on medical and behaviour models have not been effective in curtailing this epidemic. Particularly in rural areas, people avoid facing the reality of HIV/AIDS due to fear and stigma.

In this project, the linkage between HIV/AIDS and relevant social, economic and cultural factors is explored in rural areas of northern Botswana, where marginalized minority groups, particularly the San, live in extreme poverty. Data were collected through semi-structured interviews and focus group discussions between March and October 2004. The analysis indicates that poverty, gender inequality, traditional beliefs related to illness and healing, marginalization, and stigma interact and create the key barriers to current HIV prevention strategies. Recommendations based on my seven months of fieldwork suggest that HIV/AIDS prevention programmes must address poverty eradication, gender equality, cultural sensitivity, marginalization and stigma reduction at all levels. Economic-social rights and non-mainstream cultures of marginalized people must be respected and incorporated into policy decisions so that the communities gain ownership of prevention strategies against devastating HIV/AIDS problems.

Table of Contents

| | | |
|-------------------|---|-----|
| Abstract | | ii |
| Table of Contents | | iii |
| List of Tables | | v |
| List of Acronyms | | vi |
| Acknowledgment | | vii |
| Chapter One | Introduction | 1 |
| Chapter Two | Analytical Framework of HIV/AIDS Pandemic Sub-Saharan Africa | |
| | 2.0 Introduction | 10 |
| | 2.1 Analytical Framework | 13 |
| | 2.2 Current Policies and Strategies of the Botswana Government | 25 |
| | 2.3 Summary | 28 |
| Chapter Three | Methods | |
| | 3.0 Introduction | 30 |
| | 3.1 Methodology and Ethics | 31 |
| | 3.2 Qualitative Methods | 35 |
| | 3.3 Research Location | 42 |
| | 3.4 Opportunities and Constraints | 49 |
| | 3.5 Summary | 51 |
| Chapter Four | Results and Discussions | |
| | 4.0 Introduction | 52 |
| | 4.1 Knowledge of and Attitudes toward HIV/AIDS | 53 |
| | 4.2 Factors Perceived as Contributing to HIV/AIDS | 61 |
| | 4.3 Discussion | 74 |
| | 4.4 Conclusion | 79 |
| Chapter Five | Conclusions and Recommendations | |
| | 5.0 Conclusion | 81 |
| | 5.1 Recommendations | 86 |
| | 5.2 Direction for Further Research | 89 |
| Bibliography | | 92 |

| | | |
|------------|--|-----|
| Appendix | | |
| A – 1 | Map of Botswana | 99 |
| A – 2 | Map of TOCaDI catchment | 100 |
| A – 3 | Map of Okavango Panhandle | 101 |
| Appendix B | Letter of Support from TOCaDI, Member of the Kuru Family of Organizations | 102 |
| Appendix C | Interview Questionnaires | 104 |

List of Tables

| | | |
|---------|--|----|
| Table 1 | Number of staff interviewed by ethnicity and gender | 37 |
| Table 2 | Number of the participants by area and ethnic background | 39 |

List of Acronyms

| | |
|--------|---|
| AIDS | Acquired Immune Deficiency Syndrome |
| ARV | Anti-Retroviral |
| CBO | Community-based Organization |
| CDF | Community Development Facilitator |
| DHT | District Health Team |
| GOB | Government of Botswana |
| HIV | Human Immunodeficiency Virus |
| MLGLH | Ministry of Local Government, Lands and Housing |
| MoH | Ministry of Health |
| MTPII | Second Medium Term Plan |
| NACA | National AIDS Coordinating Agency |
| NGO | Non-Governmental Organization |
| PMTCT | Prevention of Mother-to-Child Transmission |
| RADP | Remote Area Development Program |
| STD | Sexually Transmitted Disease |
| TOCaDI | Trust for Okavango Cultural and Development Initiatives |
| UNAIDS | The Joint United Nations Programme on HIV/AIDS |
| UNDP | United Nations Development Programme |
| WHO | World Health Organization |
| WUSC | World University Service of Canada |

Acknowledgement

I thank TOCaDI and Kuru Family of Organizations for allowing me to conduct my MA research and for all the support they have given to me, especially, Karine Rousset and Willemien LeRoux for their informative discussions.

My sincere appreciation goes to TOCaDI staff especially the following members of the HIV/AIDS Task Force, Gaetlogelwe Mapa, Nxisae Nxae, Dahm Illae, Semango(Susan) Andreas, Splash Moranga, Joyce Tsaae Xwaa, Poneso Mwamo, Supa Kanyetu, and David Naude, for their understanding, support and teaching during my fieldwork. I also thank Moranga Tanago, Nloaxom Extension Team Leader, for his patience and openness. I am grateful to the people of the villages I visited for sharing their views and engaging in dialogue with me, especially Ronny Mahindi, from Shaikarawe, for his support for HIV/AIDS work.

Also, I thank Dr. Fiona MacPhail, my academic supervisor, for her support and guidance, especially during my fieldwork in Botswana. Finally, my special appreciation goes to George Harding, my partner and a fellow volunteer at the rural communities in Botswana, for his support throughout my fieldwork and writing of this project.

Chapter One

Introduction

1.0 The Problem

I entered the small grass-thatched hut where a young woman was lying down on a straw mat placed on the sand. It was late summer in 2004 in a rural village in northern Botswana. I was visiting an Acquired Immune-Deficiency Syndrome (AIDS) patient with a home-based care worker (her formal title is family welfare educator). She was immobile and had a pressure sore. She was cold because of her incontinence. I saw no family member looking after her. A volunteer home-based caregiver would come once or twice a week and buy some food for her, but she has not been washed for sometime. She needed another blanket and a mattress to lie on but had no money, however, there was no government funding. Before coming to this hut, we visited another young woman, a 19 -year-old mother of twins. The young mother also had AIDS. While their grandmother cuddled the babies, the young mother sat quietly on the sand. She had nothing to eat because the system had failed to register her in the destitute program. Her gaze was on me, then it wandered off in despair. Both women are eligible for the Anti-Retroviral (ARV) therapy that the Government of Botswana (GOB) provides to people living with Human Immuno-deficiency Virus (HIV) or AIDS without cost if their CD4 counts are 200 or below.¹ However, these women have not had a chance to travel 400

¹ CD4 count is the number of CD4 T-cell per cubicle millimetre of blood. The CD4 count is a test to determine the stage of HIV infection. The GOB provides free ARV to persons whose CD4 count is below 200 or with a symptom of AIDS.

kilometres to the nearest ARV clinic for a blood test and treatment. With no money and no transportation, the twins may soon join the statistics of the increasing number of AIDS orphans. Moreover, the women's illness is hidden from the community.

The AIDS epidemic update by the Joint United Nations Programme on HIV/AIDS (UNAIDS) reported, in December 2002, that a total of ^{39.5}42 million people worldwide were living with HIV/AIDS, with 29.4 million, or 69% in Sub-Saharan Africa (UNAIDS/WHO, 2002, p. 2). In the year 2002, 3.5 million people were newly infected in the same region. Botswana has one of the highest HIV/AIDS prevalence rates in the world (UNAIDS/WHO, 2002, p. 5; GOB/NACA 2003a, p. 13)². The GOB, with joint funding from the UNAIDS and the Bill and Melinda Gates Foundation, has developed an extensive network of researchers as well as strategies to curtail the prevalence. It established voluntary counselling and testing centres in major cities such as Gaborone, Francistown and Maun, and provides free ARV therapy to people who meet the criteria. However, it appears to have made little difference in the nation when it comes to reducing the prevalence rate during the past decade (GOB, 2002; GOB/NACA, 2003a)³.

Most people in Botswana still do not know their HIV status, and only a small percentage of those living with HIV are receiving ARV therapy (GOB/NACA, 2003a, p. 11). Apparently, the policies and strategies have not reached the most vulnerable population in the remote area of the north Okavango District where I was posted to

² In the 2002 UNAIDS statistics, Botswana is listed with the highest prevalence rate at 35.4% followed by Lesotho 31%, Zimbabwe 33.7% and Swaziland 33.4% (UNAIDS/WHO, 2002, p. 2 - 4). National AIDS Coordinating Agency listed the rate at 37.4% in its 2003 Report (p. 13).

³ The prevalence rates among attendees of the Prevention of Mother-to-Child Transmission and the Voluntary Testing Program increased among all ages between 2000 and 2002 (GOB/NACA, 2003a).

work as a HIV/AIDS consultant for a local non-governmental organization (NGO), Trust for Okavango Cultural and Development Initiatives (TOCaDI). After I arrived, I became increasingly aware of the impact of HIV/AIDS in this rural community. The staff are often sick themselves, or they miss work due to illnesses or funerals of their family members. The astonishing reality was that most staff and residents in the communities did not know their HIV status, therefore, many deaths were assumed to be due to AIDS related illnesses considering their young ages.

Poverty is visible in these rural communities. During my fieldwork, villagers told me that they had nothing to eat when a 'healthy diet' was recommended to strengthen their immune system. People are afraid of knowing their status when the remedy seems so unattainable for them. They do not want to acknowledge HIV/AIDS, a new disease, when their lives are already threatened by the high prevalence of tuberculosis and malaria. AIDS is just another deadly illness added to their difficult lives. Particularly in the area where I worked, there is a concentrated population of minority groups, and people are already exhausted from poverty and seem to have very little ability to cope with HIV/AIDS. There is a need to change the implementation of the strategies to combat the HIV/AIDS pandemic. Understanding the reasons why the current strategies are not effective will help to develop more practical and realistic ones that will meet the unique needs of the communities.

1.1 Nature of HIV/AIDS

HIV is a retrovirus and is transmitted through blood, semen, vaginal secretions, and breast milk. The virus must enter into the blood stream in order to

infect the person. The virus penetrates into the immune system, mutates, and destroys T-cells⁴, weakening the body's immune system. Over a period of time, the immune system declines further to such a degree that it is no longer able to resist infections that are, in normal circumstances, often curable (hence called opportunistic infections). This stage is called AIDS and the individual's body becomes overtly weak. The individual further debilitates and will die of these diseases (UNAIDS/WHO, 2002; Willis, 2002).

HIV infection is unique because the person may remain asymptomatic for many years after infection while being capable of infecting others. The long course of this disease also makes understanding of HIV/AIDS difficult. Since HIV attacks the immune system, not particular organs, the infection rates and the progress of illness depend on the existing status of the individual's immune system when the virus and opportunistic infections are contracted. If the immune system is already weakened by other infections such as tuberculosis and malaria, poor health condition or malnutrition, the individual is highly vulnerable to HIV infection and developing AIDS (Stillwaggon, 2002, p. 5).

1.2 The Pandemic of HIV/AIDS in Sub-Saharan Africa

Unlike in European and North-American countries, in Africa more women are infected than men (UNAIDS 1999, as cited in Willis, 2002, p. 46 - 52). In Sub-Saharan Africa, the majority of HIV transmissions occur through heterosexual intercourse (Howson, Harrison, Horta & Law, 1996; Cohen & Trussell, 1996; Webb,

⁴ Usually called T-cell, the T-lymphocyte cell in the body is directly affected by the HIV virus.

1997; Susser & Stein, 2000; Jackson, 2002; GOB/MoH, 2002) and mother-to-child transmission (Jackson, 2002; Stillwaggon, 2002, p. 3). The highest HIV prevalence is seen among young women between 20 and 34 years while men have the highest infection rate in the older age group (35 to 49 years) (Howson, et al., 1996; GOB/NACA, 2003b, p. 36 - 39). In Sub-Saharan Africa, other sexually transmitted diseases (STDs) are prevalent and strongly coupled to HIV infection, thus STDs are considered a co-factor of HIV transmission (Howson, et al., 1996; Stillwaggon, 2002, p. 8 - 9). Howson et al. (2002) pointed out that women with STDs will not seek out medical care until the diseases progress to the advanced stages due to stigma, leaving women highly susceptible to HIV infection (p. 242). When this biological vulnerability combines with gender inequality in sexual relationships, women are highly vulnerable to HIV infection.

1.3 HIV/AIDS in Socio - Economic Context

In a sense, the HIV transmission is based on individual's behaviour and is thus preventable if the human behaviours that cause virus transmission are eliminated. Using this simplistic logic, behaviour change approaches were emphasized in the early research and still tend to be the focus of many policies and strategies (Cohen & Trussell, 1996; Packard & Esptein, 1991; Simbayi, 1999). This emphasis on individual behaviour change seems to be the underlying principle of current policies and strategies of the Botswana Government (GOB/MoH, 2002; GOB, 2002). However, this common behaviour modification approach called ABC (Abstain, Be faithful and Condomize) fails to take into account the reality of women's

lives (Ackermann & de Klerk, 2002). AIDS is stated as a “disease of poverty in the African context” (Stillwaggon, 2002, p.18). Poverty predisposes women to be extremely vulnerable to HIV infection.

Socio-economic and cultural factors shape individuals’ behaviour and have an impact on individuals’ decision-making. Increasingly, anthropologists are recognizing the culture-based approach to HIV/AIDS prevention and care as critical (Airhihenbuwa & Webster, 2004; Susser & Stein, 2000; Buseh, Glass, & McElmurry, 2002). Stigma is one of the primary barriers for people seeking voluntary testing and counselling, however, the factors creating stigma require further study (Schoepf, 2001; Castro & Farmer, 2005). In the Botswana government policies, socio-economic and cultural factors are listed as the determinants of the HIV/AIDS pandemic. However, there seem to be large gaps between the policies and implementation strategies in that the actual strategies do not include required structural changes to poverty and gender inequalities (Abt Associates South Africa Inc., 2000; GOB, 2002; GOB/MoH, 2003). Understanding the linkage between local socio-cultural process and global inequalities of class, gender and ethnicity is similarly important in gaining a new perspective on the events in local communities (Webb, 1997; Schoepf, 2001). As Webb (1997) proposed, the crucial question is “how important are the different determinants in the specific context?”, rather than ‘what are the determinants of the individual behaviours?’ (p. 34).

1.4 Research Objectives and My Position

My primary interest is in the welfare of the rural population in the remote areas of northern Botswana, more specifically, the marginalized minority groups who live there. It appears that this population is left out of Botswana government policy and strategies on HIV/AIDS. This exclusion is particularly true for the San people, who tend to live with other minority groups, such as Herero, Wayeyi and Hambukushu, in the same villages. Marginalization, gender inequality, poverty, traditional beliefs and stigma seem to be the key factors that create barriers to HIV/AIDS prevention. How these factors intertwine and affect people's behaviour toward HIV/AIDS need to be investigated in the rural context. My research objectives for this project are:

- 1) To understand the knowledge of, and attitudes about, HIV/AIDS held commonly by the local residents; and,
- 2) To gain insight into how poverty, gender inequality, traditional views of illness and healing, marginalization and stigma intertwine and create the key barriers for HIV/AIDS prevention.

I use these insights to develop recommendations for policy changes by government and the effective role TOCaDI can play for its staff and communities in HIV prevention. TOCaDI has an important role as it is the only NGO in the area that operates with a particular focus on development issues of minority groups.

I chose a qualitative research design in order to gain insight into the life of the local people, their knowledge and attitudes toward the problem of HIV/AIDS. During this fieldwork carried out between March and October 2004, I held a position as a

volunteer HIV/AIDS project advisor, funded by the World University Service of Canada (WUSC), a Canadian development NGO that had a one - year contract with TOCaDI. Although, the central interest of the organization is income generation, TOCaDI is aware of the impact of HIV/AIDS on its work and recognizes the need to address HIV/AIDS issues in its programs. Within its mandate and with limited financial and human resources, an assessment of whether TOCaDI is providing adequate attention to this matter is needed. Currently, the management strategy of TOCaDI is to encourage behavioural change at an individual staff level.

My primary role for TOCaDI was to assist the organization to gain a deeper understanding of the impact of HIV/AIDS so that it would be able to mainstream HIV/AIDS into their policy and day-to-day programs. TOCaDI has three main extension teams that conduct fieldwork in collaboration with community-based organizations (CBOs) in each area. The HIV/AIDS project was independent of the extension team structure but covered all the extension areas. My contribution is first to provide insight into HIV/AIDS and the minority groups in the north Okavango area: their knowledge level, attitudes and perceptions. There is little research done on HIV/AIDS impact on minority groups, the San, Hambukushu and Wayeyi in this area. Second, I provide perspectives on the impact of socio-economic and cultural factors on HIV/AIDS prevalence and behaviours of residents in the areas.

I lived in the TOCaDI compound in Shakawe, Botswana from November 2003 to November 2004. From this base, I travelled to the villages with community development facilitators (CDF) of the extension teams to conduct my fieldwork. These trips included a number of day trips and also four camping trips.

1.5 Conclusion

My research objectives are explained in conjunction with the background issues relevant to the HIV/AIDS problems in rural Botswana. This research project is divided into five chapters. Chapter Two provides an historical and analytical framework for understanding current issues in researching HIV/AIDS in Sub-Saharan Africa. Chapter Three presents research methods used in the study period. Ethical issues related to conducting fieldwork in a developing country are also discussed in this chapter, and a description of the research location is given. Chapter Four presents research findings and discusses the issues identified as important based on my research, particularly economic, social and cultural factors contributing to barriers to HIV/AIDS prevention. Chapter Five provides a summary and recommendations for the future.

Chapter Two

Analytical Framework of HIV/AIDS Pandemic in Sub-Saharan Africa

2.0 Introduction

AIDS has brought the complexity of the structural problems of our society to the surface. The medical challenges of HIV/AIDS including its fast mutating nature require continuous epidemiological, pathological and pharmacological research. However, the HIV/AIDS pandemic is no longer a mere medical issue but clearly a development issue. It is best regarded as a “disease of development and underdevelopment” (Symonds & Schoepf, 1999, p. 190).

Since first discovered in 1982, AIDS has made its greatest impact in the developing countries, where inadequate health and social infrastructures are further weakened by prolonged economic crisis. The 1997 Human Development Report (UNDP, 1997) stated, “of the 23 million people with HIV/AIDS, 94% are in the developing world, with most in Sub-Saharan Africa” (p. 67). Eight years ago, the United Nations Development Programme (UNDP, 1997) reported that “the incidence of HIV infection in poorer countries (750 per 100,000 people) is more than ten times than in industrial countries, and the spread is faster” (p. 67).

In the earlier stage of the pandemic, much attention was given to medical factors of HIV/AIDS and human behaviour that caused the virus transmission, particularly sexual behaviour, and thus a behaviour modification approach was emphasized (Cohen & Trussell, 1996). However, economic status, cultural beliefs and societal norms shape behaviours and decisions that an individual makes around

HIV/AIDS. Economic and social conditions, such as poverty and malnutrition, together with poor infrastructure increase the vulnerability of people to HIV infection and its consequences (Piot & Pinstrip-Anderson, 2002, p. 3 - 4; Stillwaggon, 2002, p. 1 - 2). Poor nations lose people in their prime resulting in a decline in the nation's productivity.

In the early stage of research on HIV/AIDS in Sub-Saharan Africa, the primary focus was given to African sexuality and promiscuity in an approach described as "infused with racial stereotypes" (Packard & Epstein, 1991, p. 349). Packard and Epstein (1991) blamed this narrow-minded view on the common cultural assumptions of the "peculiarities of African behaviours" on the part of western researchers, that have shaped the direction of the initial AIDS research (p. 346).

The HIV/AIDS pandemic in Africa has its roots in social and cultural dynamics that are highly complex. Sub-Saharan Africa is geographically, demographically, socially and culturally heterogeneous. Therefore, the epidemic of HIV/AIDS and the extent and the spread of HIV infection are diverse while some overall characteristics and trends can be seen (Cohen & Trussell, 1996). AIDS-related stigma is a major barrier to voluntary testing and counselling, and prevents people from facing the reality of HIV/AIDS prevalence in Sub-Saharan Africa (Aggleton & Parker, 2002, p. 6; Castro & Farmer, 2005, p. 53). There is an urgent need to understand the dynamics of stigma. The ways in which cultures are overlooked and misrepresented with stereotypes based on racist assumptions of "African Sexuality" have contributed to stigmatization (Aggleton & Parker, 2002, p. 9; Treichler, 1991, p. 381 - 385).

Poverty has a strong association with gender inequality. While prevalence rates are increasing among poor nations in the Third World, the epidemic trends have also changed in developed countries. For example, HIV prevalence is higher among African-American and Latin-American women who are disproportionately poor in the United States (Simmons, Farmer and Schoepf, 1997, p. 62; UNDP, 1997, p. 67). Here, the dynamics of relationships between poverty, gender, marginalization and HIV prevalence are evident.

The AIDS epidemic is rooted in the vulnerability of people. It has exposed prevailing gender inequality and also other structured inequalities based on race and class (Castro & Farmer, 2005, p. 56). The failure to see how socio-economic and cultural factors are intertwined with HIV/AIDS results in the failure to understand the implications of those structural inequalities in local events. Without addressing the socio-economic and cultural structures, the behaviour modification based approach has little effect in actually changing people's behaviour.

The AIDS strategies of the Botswana government reflect the same problem. The current policy and strategies heavily focus on individuals' behaviour change and are not designed to implement infrastructure that will empower women and the poor. What does this gap mean to local residents in the north Okavango in curtailing the HIV/AIDS pandemic?

In this chapter, first, I provide the analytical framework for understanding the HIV/AIDS prevalence in Sub-Saharan Africa that has guided my research. I also summarize the Botswana Government's current policy and strategies on HIV/AIDS.

2.1 Analytical Framework

The analytical framework I use in this research is the interrelationships among HIV/AIDS, poverty, gender inequality, culture, marginalization and stigma. AIDS is a disease that has profound social effects with its impacts differing from one society to another. AIDS is regarded as a disaster that requires full consideration of the vulnerability of the population at risk (Barnett & Blaikie, 1992, p. 8). The socio-economic impacts that predispose vulnerable people to HIV/AIDS include famine, migration and sexual exploitation of women as result of social unset and warfare, among others (Howson et al., 1996, p. 26). In the rural area of Botswana where I studied, people are free from warfare and famine. However, poverty and gender inequality appear to have severe, chronic effects on people's life. In addition, traditional beliefs of illness and healing emerge as a strong influence on people's life. The population in the area consists of marginalized minorities who are exposed to stigma.

2.1.1 Poverty and HIV/AIDS

a. Definition of Poverty

Poverty itself is multi-dimensional and means more than income poverty. It is a matter of the quality of people's lives and is defined by many variables. The human poverty index (HPI) used by UNDP measures different features of deprivations in the quality of life (UNDP, 1997, p. 18). While the human development index (HDI) measures achievement including income perspectives, the HPI measures deprivations in three critical dimensions of human development: survival, knowledge

and the decent standard of living (UNDP, 1997, p. 17 - 21). Sub-Saharan Africa suffers from chronic poverty. Of the world's population living in absolute poverty, defined as income of 1 US dollar a day or less, 30% live in Sub-Saharan Africa (UNDP, 2004, p. 130). The 2004 Human Development Report (HDR) listed all Sub-Saharan African countries, except Mauritius and Cape Verde, with an HPI index of more than 30% (UNDP, 2004, p. 247) (higher rates indicate higher deprivation). According to the HPI index, the quality of life for the people of Botswana declined since 1996: HPI for Botswana was 22.9% in 1996 (UNDP, 1997, p. 21) increasing to 43.5% in 2004 (UNDP, 2004, p. 247).

Saitoti (2002) listed certain characteristics that all developing countries usually exhibit, which either cause poverty or are themselves a manifestation of absolute poverty. The characteristics include extremely low or negative rates of growth in GDP and per capita income; highly skewed income distribution in which very few rich people control a large share of income while the rest control a negligible share; inability of many people to meet basic necessities of life such as food, clothing, shelter and access to education, health care and clean water, which translate into high mortality rates; and high levels of unemployment or underemployment (Saitoti, 2000, p. 69). These indicators are important in discussing poverty. The problem of poverty is intricately intertwined with the problem of HIV/AIDS in Africa, therefore, the two problems must be dealt with simultaneously (Saitoti, 2002; Schwab, 2001; De Waal, 2003; Symonds & Schoepf, 1999). Saitoti (2002) argued, "we cannot win the war against poverty unless we win the war against AIDS. On the other hand, we are unlikely to make much headway in

our war against HIV/AIDS unless we put in place credible policies to fight poverty”(p. 67). Poverty makes people vulnerable to HIV infection and, in turn, HIV/AIDS aggravates poverty when people are already poor.

b. Impact of HIV/AIDS on Poverty in Sub-Saharan Africa

A common assumption is that an HIV prevalence rate of 10% implies a reduction in economic growth of 0.4% (De Waal, 2003, p. 7); when HIV prevalence reaches 15%, a country can expect an annual drop in GDP of more than 1% (Piot & Pinstrip-Anderson, 2002, p. 6). De Waal (2003) presents a much more complex picture of the economic implications of HIV/AIDS including a reduction in the overall population and demographic changes that result in a decline in the labour force.

The pandemic of AIDS is contributing to the shortening of life expectancies in all Sub-Saharan African countries (UNDP, 2004). According to the 2004 Human Development Report (UNDP, 2004), due to the HIV/AIDS pandemic, the life expectancy at birth declined from 56 years in 1970 -75, to 41.4 years in 2002 in Botswana (p. 170). It is expected to decline below 39 years by 2010 (UNDP, 1998, p. 35). The child mortality rate doubled between 1990 and 2000 (UNDP, 2004, p. 132). Despite comparatively well-developed infrastructure including safe water, a public health care system, and a democratic government with one of the highest GDP per capita in Africa, Botswana fell to 128th place in HDI rank (UNDP, 2004, p. 141). Also, Botswana has one of the highest Gini coefficients in the world (0.63), which indicates a significantly high level of income inequality (UNDP, 2004, p. 190). In Botswana, an estimated 47% of the population live in income poverty (below \$2 a

day) (UNDP, 2004, p. 148) and are particularly hard hit by HIV/AIDS (Abt Associates South Africa Inc., 2000, p. 38). In rural Botswana, more than 55% of people live in poverty (GOB/MoH, 2002, p. 15).

The direct and indirect costs of AIDS-related expenses are exacerbating the conditions in which poor people live. AIDS-impooverished families can no longer pay school fees or uniforms for their children. When their parents die, many girls drop out school to look after their young siblings (Jackson, 2002, p. 257 - 263). Communities also lose teachers and other professional workers to AIDS (GOB, 2002, p.12 -14).

c. Poverty as Contributor to HIV/AIDS Prevalence

Poverty predisposes people to HIV infection. The majority of poor people are concentrated in rural areas in Africa (Saitoti, 2002, p. 74 - 76), where infrastructure is limited and employment opportunities are scarce. People migrate from rural villages to urban areas seeking employment. The high mobility of Africans has not only contributed to the spread of HIV/AIDS but also affected social disintegration and breakdown of the traditional family structure (Klein, Easton, & Parker, 2000, p. 23). Kaya (1999) pointed out that where labour migration, reinforced by poverty results in long absences from the origin areas, sex and alcohol become the only source of pleasure in the daily struggles of life (p. 39). This makes migrant workers vulnerable to HIV/AIDS and other sexually transmitted diseases (STDs) (Kaya, 1999). In Botswana, people are highly mobile resulting in frequent and long-established work-related separation of spouses or partners (Lesediti, 1999, p. 50 - 51).

The impact of HIV/AIDS on poverty shows the two-way relationship between poverty and illness (UNDP, 1997, p. 67). Poverty increases the risk of malaria, tuberculosis, and STDs: these illnesses are strongly tied to HIV infection in Africa (Jackson, 2002, p. 151; Howson et al., 1996, p. 246). Poverty makes it difficult for people to access to medical testing and treatment. In a study conducted in Botswana, poverty was listed as the primary barrier to seeking treatment, either because of the cost of medication or the cost of transportation, especially for people living in rural areas (Weiser et al., 2003, p. 283). The spread of AIDS has been exacerbated by low nutritional level and poor health conditions (Bujra & Baylies, 2000, p. 26). Stillwaggon (2002) also argued the strong connection between poverty and malnutrition and HIV/AIDS, while Piot and Pinstруп-Anderson (2002) pointed out the overlap of the maps of HIV prevalence and malnutrition. "When you ask people living with AIDS in rural communities in the developing world what their highest priority is, very often their answer is food" (Piot & Pinstруп-Anderson, 2002, p. 2). Poverty also relates to poor educational attainment, which leads to lack of accurate information on HIV/AIDS (Mwale & Burnard, 1992, p.12; Kaya, 1999, p. 38). The unemployment rate is high at 70.7% among young people 15 -24 years in Botswana (MoH, 2003, p. 10).

d. Poverty and Gender

Poverty has strong ties to gender inequality. Women are disproportionately poor and often disempowered and burdened by productive work, childbirth, and care of family members without having adequate access to land and better employment

opportunities (UNDP, 1997, p. 3). Poverty affects women differently from men. This will be further discussed in the next section.

2.1.2 Gender Inequality and HIV/AIDS

a. Vulnerability of Women

HIV prevalence is higher among women than among men in all Sub-Saharan Africa: among HIV-infected people, an average of 51 - 56% are women, 40 - 45% are men, and 2 - 6% are children (data extracted from UNAIDS 1999, cited in Willis, 2002, p. 46 - 52). Several factors make women more vulnerable to HIV infection. Farmer, Connors, Fox and Furin (1997) argued that the relationship between poverty, gender inequality, and biological vulnerability is the major risk factor contributing to the HIV/AIDS prevalence. Baylies (2000) noted the need to understand how gender relations create vulnerability in women and how the epidemic has impact on women in specific ways. Women's bodies are more susceptible to infection during sexual activity, however, when the physiological vulnerability is reinforced by the social vulnerability of women, their susceptibility to infection increases greatly (Howson et al., 1996, p. 247; Baylies, 2000; Ackermann & de Klerk, 2002). Klein et al. (2002) argued that poverty, a high level of migration due to employment, and gender inequalities are the key forces that affect HIV prevalence, and when they intertwine, lead to an epidemic.

b. Poverty and Gender Inequality

Poverty and gender inequalities are structured in Sub-Saharan African societies. Poverty forces women to turn to risky sexual activity for survival, increasing the chances of virus transmission. When women have to rely on men for basic needs, poverty and sexual exploitation force many women into circumstances where sex becomes a survival strategy (Simmons et al., 1997). Women in poor communities are especially vulnerable because in most Southern African cultures, they have little power to refuse sex, and if they insist on using condoms, they may face physical or economic retaliation (UNDP, 1997, p. 67). Research conducted in rural areas of Zambia, Uganda and South Africa reveals the common situation women in Sub-Saharan Africa face. In Zambia, women lack power in sexual decision-making including lack of control of their husbands' lives outside their marriage where extra-marital sexual relationships are common (Mwale & Burnard, 1992). The cases in Uganda show that extreme economic deprivation, lack of social status, and a patriarchal system that encourages polygamous relationships has predisposed women to high infection rates. Furthermore, poverty lures young women and girls into prostitution placing them at high risk of infection (Nyakabwa, 1997).

Ackermann and de Klerk (2002) pointed out that sex is a survival strategy (p. 168). Many young women exchange sex for money to buy basics such as food, soap, clothes and sometimes to pay for their education in South Africa. Poverty makes a wide age discrepancy in sexual relationships acceptable, often resulting in

exploitation of girls and early pregnancy with many young girls dropping out of school in Botswana (Lesetedi, 1999, p. 51).

c. Gender Inequality and Cultural Values

Traditional cultural values are strong determinants for decision-making. In Sub-Saharan Africa, traditional cultural values reinforce gender inequality and predispose women to vulnerability. Traditional cultural values dispose women to HIV/AIDS in Africa by structuring social, economic and political inequalities of women in the society and not allowing women to have a voice in decision-making (Buseh et al., 2002; Uwakwe, 1997). The multiple roles women play in a society as wives, mothers and health care providers are framed by cultural norms, which are central to the society and therefore difficult to change. Lesetedi (1999) argued that HIV/AIDS prevention programs often fail to recognize the difficulties facing women in light of traditional obligations and the modern context (p. 53). For example, the increasing responsibilities and burden to care for the sick fall on women when women continue to be regarded as socially inferior and are disadvantaged. Culture is dynamic with changes due to inner and outer forces such as economic demands, encounters with other cultures, and the pandemic of HIV/AIDS. Traditional culture values have affected the ways HIV/AIDS spreads. Conversely, the HIV/AIDS pandemic affects traditional cultural values. Cultural plurality exists when traditional beliefs and practices face the forces of new cultures and attempts to preserve power relationships (Baylies et al., 2000, p. 96).

In many African countries, multiple sexual partnerships and extra-marital sexual activities for men are widely accepted, especially in rural areas where cultural and economic pressures remain strong (Sikwibele et al., 2000; Buseh et al., 2002; Ackermann & de Klerk, 2002; Susser & Stein, 2000). However, traditional cultural reasoning behind polygamous sexual relationships may have changed. Ackermann and de Klerk (2002) argued that urbanization and modernization changed the organization of sexual partnerships resulting in an increase in mistresses and love affairs (p. 168). In Botswana, despite rapid economic improvement, persistent income inequality between men and women sustains women's submissive position in society (Lesetedi, 1999, p. 51).

In Sub-Saharan Africa, reproduction carries highly significant weight in cultural patterns regarding sexuality and needs to be considered when developing prevention programs (Buseh et al., 2002). In addition to the submissive position of women in society, there is a strong belief in fertility. It is almost imperative to have children, therefore, the cultural attitude toward fertility minimizes condom use (Susser & Stein, 2002; Lesetedi, 1999, p. 53). Baylies (2002) pointed out the particular vulnerability of young married women whose desire for children makes protection problematic as men tend to have more partners before or in the early years of marriage (p. 11).

Breast-feeding and home births are also the norms due to tradition and poverty. Women transmit the virus to their children and also can be infected by providing care for infected persons without knowing (Howson et al., 1996, p. 251). Most global AIDS prevention programs such as partner reduction, condom

promotion and STD treatment are inadequate to protect most of the women in the world, who are poor and lack the power to negotiate within their sexual relationships (Klein et al., 2002).

There are ambivalent and conflicted feelings towards sexuality (Blair et al., 1997). In traditional African culture, sexuality and sexual behaviour are forbidden subjects in many societies (Howson et al., 1996, p. 249; Okafor, 1997, p. 114), therefore, access to accurate information is extremely limited, especially for women in rural areas (Buseh et al., 2002). Despite the taboo about sexuality, multiple sexual partnerships are the norm in many societies. Mistrust between spouses and partners is common in sexual relationships leading to blaming of others, as well as doubts and misconceptions regarding condoms resulting in their rejection (Blair et al., 1997, p. 51; Klein et al., 2002).

2.1.3 Traditional Views of Health and HIV/AIDS

Traditional beliefs in illness and healing have a strong influence on people's understanding of HIV/AIDS and health-seeking behaviour. Although Botswana has a well-established public health care system compared to other Sub-Saharan African nations, many people continue to believe that traditional diseases need to be cured by traditional doctors (Abt Associates South Africa Inc., 2000). The traditional diseases in Botswana include Depathi, similar to Chira in Kenya (Blair et al., 1997, p. 54) (Depathi is further explained in Chapter Four). Others believe that AIDS is caused by spirits or supernatural forces (Kalichman & Simbayi, 2004, p. 578). Kalichman and Simbayi (2004) reported that beliefs in witchcraft as a cause of AIDS

and STDs are likely prevalent in rural areas of South Africa and Zambia (p. 576 - 578). These beliefs potentially reduce the effectiveness of the HIV/AIDS campaign. Mbilinyi & Kaihula (2000) argued that beliefs in traditional disease no longer seem to have an impact on sexual behaviour patterns (p. 85 – 86). However, it is used as a convenient explanation of death in that it does not carry stigma compared to admitting a family member died of AIDS. The question of whether AIDS is a new or old disease often arises (Baylies et al., 2000, p. 103). Missionaries and Christian churches also have a strong impact on views on HIV/AIDS and its prevention with their strong religious principles and doctrine relating to moral sexual and cultural behaviour that alter traditional authority systems (Mbilinyi & Kaihula, 2000). The South African government acknowledges the roles of traditional healers in health and organises them by establishing associations and train them on HIV/AIDS and other STDs (Green & Zokwe, 1996). However, such a movement is not strong or well-organized in Botswana (Abt Associates South Africa, Inc., 2002). Because traditional healing continues to have complex impact on people, in order to understand the ways that people perceive HIV/AIDS, it is crucial to understand the traditional concepts of healing and incorporate “indigenous knowledge systems” into prevention strategies (Tangwa, 2002, p. 228).

2.1.4 Marginalization and Stigma

Stigma is one of the most prominent barriers to the prevention of spread of HIV/AIDS. An ARV adherence study conducted in Botswana reports that 69% of patients kept their HIV status secret from their families and 94% from their

community, fearing they might lose their jobs (Weiser et al., 2003, p. 285). Stigma prevents people from facing the reality of HIV/AIDS. "When discussing behaviour change, respondents almost always talked about other people's behaviour and not their own, thus indirectly implying that they themselves were not at risk" (Blair et al., 1997, p. 51).

Aggleton and Parker (2002) defined stigmatization as a process of devaluation linked to power and domination throughout the society. HIV/AIDS-related stigma plays into, and reinforces social inequalities that are based on gender, race, class and ethnicity (p. 8 - 9). Communities of ethnic minorities are also marginalized and hit hard by the devastating illness (Aggleton & Parker, 2002). Marginalization has a strong connection with stigmatization as it leads to blaming: "people with HIV/AIDS from racial and ethnic minorities are often seen not as individuals living in the context of marginalization and inequality, but as the causes of their own misfortune" (Aggleton & Parker, 2002, p. 9). Aggleton and Parker (2002) pointed out that the racial assumptions of many early AIDS-related discourses were clear in statements of "African sexuality" (p. 9). Castro and Farmer (2005) also argued that "stigma and discrimination are part of complex systems of beliefs about illness and disease that are often grounded in social inequalities" (p. 54).

Gender inequality, poverty and some cultural beliefs intertwine and create stigma for people who are infected with HIV and are the most vulnerable. The consequences of stigmatization are severe. Women, especially, are typically blamed and endure the most serious consequences that may include violence,

divorce, and social ostracism (Howson et al., 1996). The complications of STDs, especially impaired fertility, are even more devastating. HIV infected women are at risk of abandonment by the very men who infected them (Howson et al., 1996).

Stigma rests in the core of society and disempowers people who are most vulnerable. Without understanding the dynamics of stigma and addressing factors behind the stigmatization, HIV/AIDS prevention campaigns have limited effect.

2. 2 Current Policies and Strategies of the Government of Botswana

Health care in Botswana has improved markedly over recent decades with good access to health services relative to other Sub-Saharan countries in general (Abt Associates South Africa Inc., 2000). The Botswana Government initially attempted to address the HIV/AIDS epidemic as largely a health issue by developing the Short and Medium Term Plans in 1987 and 1993, in the early stages of the pandemic (GOB, 2002). When it recognized the rapidly worsening situation of the pandemic, the Government formulated the National Policy on AIDS and developed the Second Medium Term Plan (MTPII) for 1997 - 2002 to set out a framework and strategies to integrate multi-sectoral responses (GOB, 2002)⁵. The National AIDS Policy was under review at the time of my research. The National Strategic Framework 2003 - 2009 was developed based on the assessment of the MTPII with a goal to prevent new HIV infection by year 2016. The National AIDS Coordinating Agency (NACA) is commissioned to co-ordinate national responses to HIV/AIDS

⁵ Confirmed AIDS deaths rose from 2.43% to 9% of total deaths in the 15 - 45 years age group between 1992 and 1997 (Abt Associates South Africa Inc. 2000).

prevalence at the policy level. The Government also funds and works with AIDS organizations in civil society such as Botswana Network for AIDS Service Organizations (BONASO), Botswana Network for People Living With HIV/AIDS (BONEPWA), and Botswana Network for Ethics and Law on HIV/AIDS (BONELA).

The GOB has two pillars in its public health system, the Ministry of Health (MoH) and the Ministry of Local Government, Lands and Housing (MLGLH). The Ministry of Health sets up overall health policies and strategies, and has direct authority over hospital services, while providing guidance and supervision to the districts, city and town councils and private services to ensure that they comply with its standards. The Primary Health Care, AIDS/STD Unit, Health Education & Communication Unit and Epidemiology & Disease Control Unit are important parts of the MoH structure addressing HIV/AIDS prevalence.

The MLGLH has jurisdiction over basic health services such as primary health care clinics, health posts and other community services within the health district. The Ministry is also responsible for social welfare services that deal with destitute and orphans programs. The district, city and town councils determine the organizational structure of the District Health Teams (DHT), plan, provide and evaluate the basic health services under the MoH policies (Abt Associates South Africa Inc., 2000). Botswana has 24 health districts and each district has a District Multi-Sectoral AIDS Coordinating Committee (DMSAC). This system aims to co-ordinate all efforts of various governmental departments, private sectors, NGOs, community-based organizations (CBO), the district council, the district health team, members of parliament, traditional authority (Kgotla - chieftain system), and groups of people

living with HIV/AIDS. DMSAC provides the DHT with consultation on HIV/AIDS and receives guidance. The multi-sectoral approach policies came from the recognition that "the results have tended to be narrow, health-focused responses, with Government as whole abdicating its responsibilities by placing AIDS within the ambit of the public health sector" (GOB/NACA, April 2002, p. 5).

Donors and international agencies have played a major role in developing the government health sector response to HIV/AIDS in Botswana. Donor funding has funded a substantial portion of developmental activities including research and evaluation. Donor funds accounted for about 60 % of funding for the AIDS/STD Unit in 1998/99 (Abt Associates South Africa Inc., 2002, p. 56). The major funders for AIDS activities include the European Union, World Bank, UNAIDS, UNDP, World Health Organization (WHO), Swedish International Development Agency (SIDA), Norwegian Agency for Development Corporation (NORAD), Bill and Melinda Gates Foundation, Botswana - Harvard Partnership, and Netherlands Development Organization (SNV). Currently Botswana has put enormous energy and resources into research including preparation for vaccines, epidemiology of TB and HIV, and preparation of microbicide trials in the country with the Botswana - Harvard Partnership.

The health sector has several focus areas including voluntary counselling and testing, home-based care, education and anti-retroviral drug therapy (ARV), all provided to citizens of Botswana free of charge. Voluntary counselling and testing for HIV is integrated into hospitals with free-standing testing and counselling centres being established in various parts of the country with support of development

partners. These services have taken a long time to reach the rural areas of north Okavango. Botswana also puts resources into the prevention of HIV transmission from a mother to a child through the Prevention of Mother-to-Child Transmission (PMTCT) program that promotes free AZT and Navirapine to all HIV positive pregnant women. When a child is born to an HIV positive mother, the child is given free infant formula and preventative drugs when it is appropriate. There is also a national Home Based Care Program for terminally ill patients including AIDS patients. Also, Health and HIV/AIDS Education Program is incorporated into the school curriculum at all levels including the primary school level. Attention has also been given to the reproductive health of youth – adolescents (GOB/MoH, 2002).

2.3. Summary

The analytical framework of HIV/AIDS prevalence and prevention has been discussed. These five factors of the framework are inter-related. Poverty makes people vulnerable to infection and accentuates gender inequality which predisposes women to infection. Traditional cultural values also reinforce women's inequality. Traditional concepts of illnesses and healing often work as deterrents to attainment of accurate knowledge and understanding of HIV/AIDS. Stigmatization disempowers people and creates barriers in facing the reality of HIV/AIDS. Marginalized people, the poor, women and ethnic minorities are vulnerable to stigmatization and discrimination.

A summary of the current Botswana health system, policy and strategies on HIV/AIDS was presented. The linkage between the analytical framework and local

events in the rural communities of northern Botswana will be discussed in Chapter Four.

Chapter Three

Methods

3.0 Introduction

For this study, qualitative methods of data collection were used. Qualitative research design is defined as “one in which the researcher plans to observe, discover, describe, compare and analyse the characteristics attributes, themes, and underlying dimensions of a particular unit” (Seaman, 1987, as quoted in Mwale, & Burnard, 1992, p. 20). Creswell (1998) defined qualitative research as an inquiry process of understanding that explores a social or human problem emphasizing a complex, holistic picture built on the study in a natural setting (p.15). I chose a qualitative research approach because I sought insight into the complex inter-relationships between the socio-economic and cultural factors and HIV/AIDS prevalence in the particular rural communities. My research question, what are the key barriers for people in rural communities to address the reality of HIV/AIDS prevalence, involves the following two aspects: 1) to understand the knowledge of, and attitudes about, HIV/AIDS held commonly by the local residents; and 2) to gain insight into how poverty, gender inequality, traditional views of illness and healing, marginalization and stigma intertwine and create the key barriers for HIV/AIDS prevention. The communities are unique because minority groups including a large number of San live there. As an HIV/AIDS advisor, my goal was to ensure the research conducted was useful to the communities and TOCaDI.

My qualitative data collection methods included semi-structured interviews, focus group discussions, and observations during community visits conducted over the period between March and October 2004. The information gathered through the study period was amalgamated into an end-of-contract report for TOCaDI. The characteristics of the study area are described in the end of this chapter to provide a picture of these communities.

3.1 Methodology and Ethics

Conducting field research in the Third World raises certain ethical issues related to power relationships between a researcher and people studied creating a dilemma, especially when the studied are poor and marginalized people. The diverse effects of gender, class, race and ethnicity need to be considered in defining the research agenda, the research process, and dealing of research outcomes (Wolf, 1996, p. 2 - 3). I had two major concerns conducting cross-cultural research: first of which was the accuracy and credibility of data collected. My second concern was the possibility of exploiting the local staff and villagers with my position during and after conducting my research. The first issue was about whether I could gain a sufficient level of trust and would be given access to information that is intimate and sensitive to them. Secondly, and more importantly, I needed to minimize damage or harm that I might cause by conducting my research in the communities.

I entered the field as a researcher and as a female, foreign worker hired by a local NGO, who is privileged with education, materials and opportunities. Upon arrival, I was given a prefabricated house that had tap water, hot shower, electricity

and a propane cooking stove, while most villagers had no electricity and had to haul water from a standpipe. Although I had to manage with much less, compared to what I had in Canada, it was obvious that I had a lot more than the average villager and local staff to make my life easier. What I did not have was the great network and support system that the local staff and villagers had among themselves especially in the time of need and during such occasions as funerals and illness. The better that I understood the magnitude of the poverty that the villagers faced, the clearer I realized the division that existed between them and myself. And, the undeniable fact was that, as an outsider, I would be able to leave when my contract finished.

Being an outsider also raised other issues. The Botswana Government has many foreigners working in the HIV/AIDS field and people are used to have foreigners 'helping' them. Before leaving Canada, I was told by a woman from Botswana of the perception held by Botswana people that they need foreigners to help them because foreigners are better than them. During my fieldwork, I received an impression that this perception was also common among the villagers and TOCaDI staff. This issue raised a concern that I also might be taking away ownership of the subject from the local people and making them dependent. If this were true, my presence would be harmful rather than helpful in the end. I made an effort to curtail this problem by developing leadership within the communities and the local staff of TOCaDI by sharing my knowledge and skills, while emphasizing reciprocal and mutual learning, and confidence building.

I was aware that being a female researcher in the patriarchal society would have some impact while conducting my research. I further did not assume that being a woman would warrant universal solidarity or trust from women as other strong factors such as race and class might affect our relationships. Breaking the norms by insisting on my own western cultural value of women's equality or simply confronting the exploitation the women face may have backfired (Berik, 1996, p. 65 - 68). I was often seen with my male partner, who was also a volunteer in the area, when conducting my fieldwork. Although I did not intentionally use this status, I felt I was respected because I was seen as a middle-aged married woman. Also, I realized that being an outsider and being explicit about my role allowed me some flexibility and I was allowed to openly talk about sex and sexuality.

During my fieldwork, I had a dual role, namely one as a project advisor hired by TOCaDI and another as a researcher. Although the residents in the area, particularly the San, have been research subjects for various topics, I felt my MA research would help develop an HIV/AIDS program. Therefore I shared my research objectives with TOCaDI staff and management and used my research results to institute HIV/AIDS initiatives to meet the specific needs of the local communities. Thus, I felt that there was little conflict between my roles as an advisor and a researcher.

I was aware that there was an obvious hierarchy and division between local staff and managers who were mainly non-local, and white. Because of my skin colour, the local staff regarded me as a manager at the beginning. However, as we worked together the division between local staff and myself somewhat weakened

although it never entirely diminished. I believe that local staff and I established a collaborative working relationship and trust.

I believe that a researcher has the foremost responsibility to approach subjects with political awareness and conscientiousness (Wolf, 1996). I avoided pretence and did not try to immerse in their culture but tried to learn and understand their culture and life with respect. I avoided making assumptions and tried to develop and maintain reciprocity by listening. I used a “speaker-centred approach” (Wolf, 1996, p. 25 - 26) in my focus group discussions by respecting the direction the speakers were taking whenever it was appropriate. I tried not to assume that my cultural values were superior to theirs because I was more educated and materially privileged. My whole experience brought me to the fundamental questions of what are the core values in life, what is culture, what does development mean, and who am I? I feel most privileged that I was given this opportunity to touch the lives of people in very rural and remote communities and learn about their lives.

My research proposal was discussed with the senior management team of TOCaDI and the Kuru Family of Organizations (an umbrella organization of TOCaDI) and received full support (Appendix B). Most of the residents in the areas of study are illiterate and are unfamiliar with the western concept of signing consent. I feared that asking them to sign a consent form might trigger adverse reactions and result in reservations in sharing honest thoughts. With a recommendation from a senior manager, I obtained permission from the Working Group for Indigenous Minorities in Southern Africa (WIMSA) to conduct my graduate research. WIMSA is an advocacy

organization that protects cultural and intellectual rights of the San. A few of the local staff of TOCaDI are members of the board.

I was introduced to the area extension teams and the communities as a HIV/AIDS advisor/consultant. I continually consulted with the staff, especially community development facilitators with whom I closely worked, on the issues of cultural sensitivity.

3.2 Qualitative Methods

3.2.1 Literature Review

Research conducted by ACORD (2003)⁶ on HIV/AIDS in a similar area in 2002 and an action research conducted on HIV/AIDS and !Khomani San in South Africa by the San Institute of Southern Africa (SASI) (2003) provided useful information in designing my research. Particular information on the traditional views of illness, death and healing, and gender was also obtained from literature. I was given full access to data collected by an oral history project in past years (Khwe Oral History/ Testimony Programme, 2003)⁷. These data were particularly useful in learning traditional values and ways of life in the San culture. I became aware that the beliefs in traditional healing are still strong among the San people.

⁶ ACORD is a British NGO that focused on HIV/AIDS research and education in some areas of the Okavango District between 2001 and 2003. It ended its operation in December 2003 due to funding cuts.

⁷ The oral history project started in 1998 by Kuru Family of Organizations and WIMSA led by Willemien Le Roux. Over the next four years, 18 trained interviewers took interviews of 300 San people. The interview results were compiled as a book "Voices of the San" by Willemien Le Roux & Alison White, and published in November 2004.

3.2.2 Qualitative Data Collection

a. Staff Interviews

Interviews with TOCaDI staff were conducted on two separate occasions. I conducted preliminary staff interviews at the early stage of the research with the primary focus on their knowledge levels, attitudes toward the disease and perceptions of the problems with respect to HIV/AIDS prevalence. The staff interviewed are mainly community development facilitators (CDF) from the three extension teams of TOCaDI. The CDFs, all from the local communities, are assigned to implement the TOCaDI program through CBOs, mostly community trusts, in their areas. I interviewed the same staff members later again to further understand their perception of economic and cultural-social issues related to HIV/AIDS after I had worked with them on HIV/AIDS and had developed a stronger rapport. All the CDFs speak English, therefore, the interviews were conducted in English without translation. Staff interviews took place in the TOCaDI compound in a secluded setting, often in my office or under trees, depending on their preferences. I explained the purpose of the interviews and assured them that information would be kept anonymous. The staff member signed his or her consent. The total number of the staff interviewed was 15, all of whom were interviewed twice. The age range was between 23 and 39 years old with most in their twenties. See Table 1 for details on interviewed staff by ethnicity and gender.

Table 1. Number of staff interviewed by ethnicity and gender:

| Area Ethnicity | N!oaxom/Shakawe Khwe & Hambukushu | Jakotsha Hambukushu & Wayeyi | Dobe Ju/'hoansi & Hambukushu | Total |
|-------------------|---|------------------------------------|------------------------------------|-------|
| Male | 6 | 3 | 1 | 10 |
| Female | 2 | 1 | 2 | 5 |
| Total | 8 | 4 | 3 | 15 |

b. Interviews of Villagers

Five villagers were interviewed. The interviewees were three young women, a male youth leader, and a male community leader. I also interviewed a traditional healer from the Khwe community on his view of HIV/AIDS. English was used for interviews except for the traditional healer, for whom staff translated between Khwedam and English. Interviews of villagers were held in their own villages. Village interviewees did not mind being interviewed in public. We were often surrounded by other villagers, who might not understand English. The traditional healer was willing to share his view on HIV/AIDS while surrounded by his family members.

In all interviews, except for the one with the traditional healer, an open-end questionnaire was used to elicit the interviewee's views as much as possible. The questionnaire was constructed with questions that specifically tie an individual's knowledge, perceptions and attitudes related to HIV/AIDS to socio-economic and his or her cultural backgrounds (Appendix C). The interview with the traditional healer focused on his beliefs on HIV/AIDS.

c. Focus Group Discussions

Focus group discussion is one of the common data collection methods for HIV/AIDS research in Africa (Uwakwe, 1997; Buseh et al., 2002; ACORD, 2003). I found focus group discussion useful because it provided deeper insight into the issues while opening a window into the common perceptions of the group. Participants usually appeared comfortable to express their opinions once discussion started. At the same time, I was aware that there were occasions when strong opinions overpowered the minor voices among the participants. For example, women often did not speak at meetings in the presence of men. Many youth did not speak freely at the meeting when elders were present. I made an effort to encourage all participants to speak by highlighting the uniqueness and importance of the topic.

All together, 34 focus group discussions were held in 20 villages and settlements between March and October 2004. See Table 2 for details of the participants by area, ethnic/ language background and gender.

There are eight different languages spoken in the catchment area of TOCaDI. Most villagers who participated in the focus group spoke Setswana, with a small number of the younger generation speaking English. However, some, especially older people, only spoke their mother tongue, therefore, translation was necessary. CDFs from the area translated between the local language or Setswana and English. The staff who translated interviews were proficient in translating between their mother tongue and English. The San language involves four different tongue-clicking sounds. Although there are several ways to express the pronunciation of the click sounds in writing, I use the symbols commonly used by authors and

researchers in the area: / dental click; ‡ alveolar-palatal click; ! palatal click; and // lateral click (Le Roux & White, 2004, p. ix)

Table 2. Number of the participants by area and ethnic background:

| Area | Villages | Language/ethnic background | Number of participants | | |
|---------------|----------------------------------|----------------------------|------------------------|--------|------|
| | | | Total | Female | Male |
| N!oaxom | Shaikarawe | Solely Khwe | 340 | 172 | 168 |
| | Kaputura | Solely Khwe | | | |
| | Gudigwa | Mostly Khwe | | | |
| | Tobere | Khwe and Hambukushu | | | |
| | Mogotlho | Hambukushu And Khwe | | | |
| | Ngarange | Khwe and Hambukushu | | | |
| Tsodilo Hills | Tsodilo Hills Basarwa village | Ju/'hoansi | 42 | 20 | 22 |
| | Tsodilo Hills Hambukushu village | Hambukushu | | | |
| Jakotsha | Etsha 6 | Hambukushu and Wayeyi | 221 | 128 | 93 |
| | Etsha 13 | Hambukushu and Wayeyi | | | |
| | Ikoga | Hambukushu | | | |
| | Etsha 1 | Hambukushu and Wayeyi | | | |
| | Jao | Wayeyi | | | |
| Dobe | Dobe | Ju/'hoansi and Herero | 125 | 74 | 51 |
| | Lobala | Ju/'hoansi | | | |
| | !ubi | Ju/'hoansi | | | |
| | Mahito | Ju/'hoansi | | | |
| | G!ohce | Ju/'hoansi | | | |
| | Bate | Ju/'hoansi | | | |
| | Magopa | Ju/'hoansi/Herero | | | |
| Total | | | 728 | 394 | 334 |

Focus group discussions took place in various settings that included trust board meetings, village meetings, two sessions of week -long workshops, and village meetings with and without a mini-workshop. I took every opportunity to be present at village meetings and to raise health and HIV/AIDS issues with the residents. Following the policy of the TOCaDI, effort was made to work through existing structures such as the Village Development Committee and the Boards of the Trusts. In some areas, a chief, or headman, called a kgotla (a traditional village meeting) to discuss HIV/AIDS issues when staff approached the village committee to arrange a meeting. Some meetings were attended mostly by men (e.g. trust board meeting), while others were attended mostly by women (a craft workshop, and payouts of thatching grass income). Age and gender specific discussion sessions were arranged during the HIV/AIDS workshops in an effort to obtain independent views of youth and women.

Focus groups took place in natural settings and the participation was usually spontaneous and the participants were not compensated. The two week-long workshops were organized to develop HIV/AIDS leadership in the communities. The participants were selected to those workshops and meals and transportation were provided.

The data were collected in the most cost-efficient and culturally sensitive manner. Although TOCaDI has a strong focus on San people, its work encompasses all minority groups in the area, therefore, my research did not exclude other minority groups. In consultation with CDFs, I decided not to divide the communities where more than one minority groups live together by calling only one

ethnic group for a meeting. Most communities have long been occupied by two or more minority groups and they have had to work out how to live together peacefully and collaboratively in small villages.

3.2.3 Recording Data

I took notes on the interviews and group discussions in English. The informants are identified only by gender, age group and ethnic background. The notes will be securely stored for future reference. I did not use an audio tape recorder for two reasons. First, I thought it might affect the interviewee's attitudes toward the interview considering the sensitivity of HIV/AIDS issues. Second, I realized that local staff were not readily available for transcribing the recorded data. During a group discussion, I took time to allow the staff to translate for me and asked questions until I understood the answers well.

3.2.4 Qualitative Data Analysis

Behavioural research based on the model referred to as KABP (knowledge, attitudes, beliefs and practices) survey was developed by the World Health Organization (WHO) and was central to HIV/AIDS research in 1990s (Simbayi, 1999; Cohen & Trussell, 1996). However, it soon became evident that the information was insufficient to produce risk-reducing behavioural change (Klein et al., 2002; Schoepf, 2001). Klein et al. (2002) argued that developing methodologies to evaluate structural and environmental interventions and documenting the effects of large-scale structural and environmental factors (e.g. poverty) on the highly localised

events (e.g. unprotected sex) are major challenges for HIV/AIDS research.

Research conducted in Zambia (Mwale & Burnard, 1992) and northern Botswana (ACORD, 2003) using the KABP model demonstrated difficulties linking the information collected through the survey to strategies that pragmatically address larger structural issues.

I adapted this classic research design and methods to frame my questionnaires but analysed my data by adding a further focus on the perceptions of culture and socio-economic issues. I divided the findings into two major categories: 1) knowledge and attitudes; and 2) perceived problems such as poverty, and cultural issues including traditional beliefs and gender, marginalization and stigma. I also compared the results from different ethnic minority groups to see if there are any significant differences in the knowledge level, attitudes and perceptions of socio-economic and cultural factors related to HIV/AIDS that may be contributing to barriers to behavioural changes.

3.3 Research Location

The physical environment of north Okavango District is described in order to provide a 'picture' of the study area. This is followed by a brief description of the history and composition of people in the area. The area is significant due to its ethnic diversity including a large population of San, also commonly called Bushmen⁸ in the

⁸ The San have been called by many names: in Botswana, they are called Basarwa. They are also commonly called "Bushmen". I use Khwe and Ju/'hoansi when referring to the particular group of San, except for when I am addressing the San as a whole.

western world. Since TOCaDI mainly focuses on the San, attention is directed to that group. Finally, health services available to area residents are summarised.

3.3.1 Geography of the Okavango District

Botswana is a land-locked country situated in the centre of Southern Africa. It shares borders with Namibia, Zimbabwe, Zambia and South Africa (Appendix A - 1). Dry riverbeds run through the Kalahari Desert, which covers 75% of Botswana and forms a sand-filled basin characterised by scrub-covered savannah. The entire Okavango District lies within the Kalahari Basin, a semi-arid expanse of wind-blown sand deposits and long sandy valleys that serve as sporadic water channels. The Okavango River flows from Angola through Namibia into northwest Botswana forming the Okavango Delta, 16,000 square kilometres of permanent and seasonal swamps (Greenway & Swaney, 2001, p. 18; Butchart, 2000, p. 8).

The area where I conducted my research falls within the Okavango District, the very north-western corner of Botswana bordered by Namibia and the edge of the Okavango Delta (Appendix A - 1). This area can be further divided into three areas in which TOCaDI field extension teams work through community-based organizations (Appendix A - 2, 3). The first area is called N!oaxom and covers the north, that is, Shakawe and the north-east side of the Okavango River. The area is also called the Okavango Panhandle. Here, the Okavango River is a permanent channel that meanders through papyrus-filled swamps between compacted sand and peat. The villages in which I conducted my research are Shaikarawe, Kaputura, Tobere, Ngarange, Mogothlo and Gudigwa. Only Shaikarawe and Kaputura are

solely occupied by the San group called Khwe. The second area is between Shakawe and Etsha 1. It is called Jskotsha after the community trust through which TOCaDI works. My research was conducted in Ikoga, Etsha 13, Etsha 6, Etsha 1, and Jao. The area is mostly occupied by Hambukushu and Wayeyi people.

The last one, Dobe, is dryland consisting of a deep sandy basin just east of the Namibian border. Away from the Okavango Delta, it is one of the most arid areas not subject to permanent or seasonal flooding. A few small villages and many tiny settlements are scattered in this infertile land. I conducted my research in Dobe, !ubi, Lobala, Mahito G!ohce, Magopa and Bate. Most of the settlements I visited were occupied by Ju/'hoansi, a San group, while some are occupied by Herero and Ju/'hoansi. A unique community of two villages occupied by Hambukushu and Ju/'hoansi is situated near historic Tsodilo Hills.

After the rainfall between November and March, the floodwaters move slowly through the network of channels to central Botswana flooding villages along the way. However, humidity is low during the rest of the year and drought appears to be a cyclical phenomenon (Butchart, 2000, p. 9).

3.3.2 Brief History and People of Okavango Delta

a. History

Historically, northern and north-western Botswana has always been cut off from the eastern parts of the country (Tlou & Campbell, 1997, p.132). Currently, five significant ethnic groups live in the area: the San, Hambukushu, Wayeyi, Herero and Tswana. The Tswana speaking people form the majority in Botswana and live in

more central locations such as Shakawe and Gumare. They hold most of the government administrative positions and professional jobs, such as teachers and nurses.

The San occupied most of Southern Africa for thousands of years, hunting and gathering (Tlou & Campbell, 1997). The San themselves are not an identifiable, homogeneous group but a collection of diverse groups of people with different languages who are identified by the commonality of hunting and gathering life style (Lee, 2003). The San are often associated with Khoe who lived in Southern Africa around the same time, however, they are distinguished by life style as the Khoe possessed livestock⁹. In Botswana, the San are officially called Basarwa. The San people who live in the Dobe area are called Ju/'hoansi, while the San who live in the north of the Okavango River call themselves Khwe (also divided into Bugakhwe and //Anikhwe according to different life styles and languages)¹⁰.

In the eighteenth century, as European white settlers expanded into northern part of Southern Africa, conflicts between those settlers and San people escalated to genocidal warfare and by the nineteenth century the San were almost exterminated in present-day South Africa (Lee, 2003; Morris, 1996; Penn, 1996). However, in Botswana, they continued to live in the Kalahari Desert with neighbouring Bantu-speaking people.

⁹ Tlou & Campbell (1997) argue that the San are as same as Khoe claiming both possessed cattle before Bantu-speakers arrived in the area. The questions of when and how the encounters between the San and other immigrants occurred have not been answered.

¹⁰ Other San groups live in the southern and western parts of Botswana.

The Wayeyi were the first Bantu-speaking people to move into the Ngamiland, which covers the Okavango Delta area, in the eighteenth to nineteenth centuries. They were agriculturists who also fished and hunted hippopotamuses (Tlou & Campbell, 1997). The San people lived peacefully with the Wayeyi people alongside the waterway. Khwe and Wayeyi had similar life styles and they intermarried (Taylor, 2000). The next group to move into the area, in the beginning of the nineteenth century, were Tswana (Bantu)-speaking Batawana people. Although the number was small, they were powerful and formed a central polity, leading to a rise of inequality among the population in the area (Taylor, 2000, p. 48 - 53; Tlou & Campbell, 1997, p.140 -141). In the mid-nineteenth century, another Bantu-speaking people, the Hambukushu, immigrated to the Okavango Delta from Angola fleeing warfare. Some historians argue that the Hamubukushu settled on the Okavango River by 1600 (Tlou & Campbell, 1997, p. 142). Between 1904 and 1907, the Ovaherero (Herero) people who were escaping massacre by Germans in what is now Namibia crossed the desert and sought refuge under the British Protectorate and settled in the area. The Ovarherero are pastoralists who own large herds of cattle, sheep and goats.

b. Marginalization of the San

The immigration of Bantu speaking people into the area had major impacts on the life of the San. Following the immigration of Bantu-speaking people to the area, the hierarchical relationships between the San people and other ethnic groups were

gradually formed: initially on an economic basis, and later these relationships determined access to the political structure (Taylor, 2000, p. 48 - 51).

The Bantu-speaking people are identified as herders and farmers. Due to the aridity of the land and lack of rainfall, boreholes are of central concern. The Bantu brought in cattle herding and farming into the areas and sought boreholes. Having a large number of cattle surrounding boreholes has had a significant impact on the environment and life style of the San people (Lee, 2003, p. 143 -145). San people started to work for the Herero as servants and herded their cattle while they continued their traditional life style of hunting and gathering. In the meantime, the quantity of wildlife in the area which the San relied on for their survival was reduced. The degraded environment meant that gathering and foraging has become difficult for the San. The GOB Tribal Grazing Land Policy (TGLP) introduced in 1975 as a land reform policy has made access to land by the San extremely difficult if not impossible (Smith et al., 2000, p. 89 - 90).

Also, Bantu-speaking people brought chiefdoms as a governance system that was different from the kinship-based system of the San. In 1966, the Botswana's independence brought a new era and a new situation for San people (Taylor, 2000, p. 40 - 51). The Botswana independent government, achieving a peaceful transfer of governance from the British colony administration, used the 'non-racial state' policy to establish the new nationhood, which denied the 'indigenous status' of San people (Saugestad, 2001, p. 68 - 76). The Bantu traditional chiefdom system was grafted onto the new independent state, and the process has created the situation in

which the San have no representation in the governing system (Taylor, 2000, p. 50; Saugestad, 2001, chap. 4; Chumbo & Mmaba, 2002, p. 18).

The Botswana political system, kgamelo, is based on chieftaincy with the kgotla as the centre of political power in a ward system that governs the local communities (Thapelo, 1997). Within the ward system, the San do not have political representation, placed at the bottom of the Botswana political hierarchy (Taylor, 2000; Chumba & Mmaba, 2002). As result, the San are “almost completely excluded from attaining formal position of authority and control over land” (Taylor, 2000, p. 51).

Saugestad (2001) argued that the Botswana government Remote Area Development Program (RADP) is a system that also has exacerbated the political marginalization of the San (p. 154 -169). The RADP is meant to achieve social justice for people in rural and remote areas through a fair distribution of benefits, by providing support to particular activities such as developing a community vegetable garden. Although the official target of the program is not specifically San, 70 - 80% of the recipients of the program are San (Saugestad, 2001, p. 127). The program does not consider the historical indigenous status or the unique economic and cultural practice of the San. By using the term ‘rural area dwellers’, the program failed to address the cultural identity issues with which the San struggle. Saugestad (2001) argued that the political debates around the time of the independence understated the actual extent of cultural and social diversity in Botswana and that the monocultural image of the country does not reflect the multicultural reality.

Currently, approximately 49,000 San people live in Botswana out of estimated 88,025 in Southern Africa (Smith et al., 2000, p. 65) with the majority living in remote areas and in extreme poverty. The majority of the San struggle to maintain their traditional way of life and culture outside the mainstream polity and culture. Wherever they are located, they face discrimination, human rights violations and marginalization (Pakleppa & Kwononokka, 2003; Felton & Becker, 2001; Suzman, 2001).

3.4 Opportunities and Constraints

a. Power Relationships

As described in Section 3.1, power relationships existed between TOCaDI local staff and myself. However, since I was specifically assigned as a HIV/AIDS advisor and was not attached to any particular extension team, most of staff did not regard me as their supervisor. Especially after working side by side on the HIV/AIDS issues, the staff appeared to be more open and comfortable to freely talk about their beliefs and opinions related to HIV/AIDS. For the communities studied, TOCaDI has never had any direct involvement in health issues, although it tried to establish a working relationship with an AIDS NGO, ACORD in the previous year. During the village meetings, some residents expressed their frustrations with chronic poverty and complained about the lack of support from the government and TOCaDI in the health area as they now realize that HIV prevalence is a serious matter. Once discussion started on the HIV/AIDS issue, the villagers did not appear constrained in speaking about their health concerns.

The San in the area, especially Ju/'hoansi have been heavily researched by a number of anthropologists and scholars (Lee, 2003; Smith et al., 2000; Marshall, 2000; Taylor, 2000). Researchers sometimes romanticised their traditional life style despite their extreme poverty (Taylor, 2000; Saugestad, 2001). I was aware and cautious that an interviewee tended to tell the interviewer what he/she thought the interviewer wanted to hear. I tried to be low-key by focusing on my work objectives on HIV/AIDS issues and avoided stereotyping local people. I built a collaborative working relationship with staff and villagers from all ethnic backgrounds by listening and acknowledging their concerns, offering the information and training on HIV/AIDS they requested, and incorporating their expressed needs into my HIV/AIDS work as an advisor. This included training of staff, workshops in the villages, assisting in the formation of youth groups in villages, promoting female leadership within TOCaDI and villages, and mentoring staff in the HIV/AIDS work.

b. The Accessibility

Accessibility to the villages and settlements was limited for several reasons. I needed at least one CDF to accompany me as a translator. CDFs were the most valuable source of information especially regarding cultural sensitivity issues. However, the CDFs were also engaged in other activities and often unavailable for me. Long distances and heavy sandy roads separate Shakawe from most of the villages and settlements. I needed to cancel scheduled meetings at times due to unavailability of a four-wheel drive vehicle.

c. Language Barrier

There was an obvious language barrier since I only speak English. Few researchers mention this constraint in their research (Mwale & Burnard, 1992, p. 24 - 25). However, I felt this issue is important because language also represents culture. Mwale and Burnard (1992) stated that using locally known assistants could reduce this difficulty (p. 25). I had to rely on staff for translation. To further my understanding and reduce limitation of translation, I learned the cultural backgrounds of each group by reading, attending meetings and consulting with the CDFs as much as I could.

3.5 Summary

The research methods undertaken for this project included semi-structured interviews and focus group discussions. Both methods were used in the most culturally sensitive way informed by my awareness of the power relationships between interviewees and myself. The historical and cultural uniqueness of the area, that I learned about through my fieldwork as well as literature review, are taken into account in the process of adapting the research design, fieldwork and analyses of the results.

Chapter Four

Results and Discussion

4.0 Introduction

Results from interviews and focus group discussions varied from village to village. There are also many commonalities in the perceptions of HIV/AIDS and behaviour patterns within the same ethnic group indicating that traditional beliefs are still strong. At the same time, the different responses in the discussions among the same ethnic group indicated that encounters with other cultural groups have affected each other in many ways. Botswana mainstream culture appeared to have had a strong impact on all groups.

The data collected were divided into two major categories for analysis. The first category is knowledge and attitudes with respect to HIV/AIDS held by local residents. The second category is the factors that are perceived by local residents as HIV/AIDS-related problems, namely, poverty, gender inequality, traditional beliefs of illness, marginalization and stigma. Each individual factor and their interactions serve as the analytical framework. In this project, I shed light on the commonalities and differences between women and men, generations, and different ethnic groups when possible. In discussion, the linkage between the HIV/AIDS and these particular economic, social and cultural factors is explored.

4.1 Knowledge of and Attitudes towards HIV/AIDS

4.1.1 Knowledge of HIV/AIDS

Data were collected on the knowledge level and significant content of the knowledge held by local residents so as to learn the accuracy and depth of their understanding of HIV/AIDS. Data on accessibility to the information were also collected to see if lack of access to information affects the knowledge held by the villagers.

a. Knowledge Level

At the time of the initial interviews, all staff had a basic knowledge of transmission, preventive measures, and availability of ARV therapy. However, they lacked comprehensive understanding and accurate knowledge of particular topics such as how mother-to-child transmissions occur and the eligibility criteria and procedures to receive ARV therapy. Most villagers also know that HIV is transmitted through unprotected sexual intercourse with an infected person, however, very few people indicate having knowledge of mother-to-child transmission.

Many people in the remote villages misunderstand and confuse HIV/AIDS with other diseases, especially tuberculosis and other STDs. In San villages in the Dobe and N!oaxom areas, people are more concerned about tuberculosis, malaria, and their health situation in general than about HIV/AIDS. Many people report, that although they saw people get sick and die, they could not tell whether the person died of AIDS or not because they do not know the symptoms of AIDS. There are

many misconceptions among the older Hambukushu and Khwe men about the infection: contraceptive pills and condoms are blamed for the spread of HIV directly (condoms are infected) and indirectly (condoms promote sex and promiscuity). One Khwe man stated that having sex with a pregnant woman would bring infection.

The older men and women who lack substantial knowledge of HIV/AIDS have strong beliefs in traditional healing and it is difficult for them to understand the 'new disease' (HIV/AIDS). A number of older people are mixing up AIDS with traditional diseases such as Depathi.

A Khwe man stated:

I don't know where this disease comes from. In our tradition, when your spouse passed away, we stayed away for some duration of time and get healing from a traditional doctor. These days, we don't follow the tradition, therefore, a person will get bad blood and become sick and die. We should follow our tradition so that we don't get AIDS.
(Tobere)

A Khwe woman stated:

We don't follow the traditional beliefs anymore, but the person who had AIDS seems to have the same symptoms as the traditional disease. So I think these diseases are same. (Kaputura)

There is a discrepancy in knowledge levels among minority groups. San people tend to demonstrate inaccurate knowledge. Khwe and Ju/'hoansi people also often express frustration with the lack of information. In general, Hambukushu people seem to have better basic knowledge. One possible reason is that they tend to live closer to larger villages where regular access to health clinics and a hospital in Gumare, the regional government headquarters, are available. At the same time, it also appears that the San and other minority groups have different attitudes toward

gaining knowledge. There is no significant difference in knowledge between men and women; however, their behaviours are different. Women tend to show a more pragmatic and realistic understanding of the risk of HIV/AIDS.

b. Access to Information

Most villagers have heard of HIV/AIDS through radio, at health clinics, schools, kgotla meetings, and from other villagers. In addition, TOCaDI staff obtained some knowledge at workshops hosted by NGOs, ACORD in particular.

Despite the common remarks “I don’t know anything about HIV/AIDS”, many villagers revealed that they had a basic knowledge of HIV transmission and prevention, especially the younger generation. At the same time, their knowledge is often fragmentary and superficial. Many villagers demonstrate difficulty understanding basic biological concepts such as conception. There seem to be three possible contributing factors to this difficulty: first, the older generation did not go to school; second, talking about sex is a taboo in their culture, therefore education on reproductive health by parents does not occur; and third, a popular African Independent Church active in the area, reportedly, preaches myths about conception, resulting in confusion among villagers.

There is a large discrepancy in the levels of knowledge and understanding among groups of people: some demonstrate very little knowledge while others have a basic understanding and a willingness to learn more. Two characteristic groups have very little knowledge. The first group consists of the residents of small villages and settlements in the extremely remote areas of Dobe and N!oaxom. All live in the

more remote areas where there is no electricity. Their information sources are limited access to radio broadcasts in Setswana and local clinics, which are not always available. The second group consists of elderly men and women who only speak their mother tongue. The lack of information available in their own language (most of the information disseminated by the government is in Setswana, if not in English) appears to be an important factor.

4.1.2 Attitudes toward HIV/AIDS

As an outsider, it is often difficult to know actual behaviour patterns of particular groups, however, one's behaviour reflects the attitudes and beliefs of the person. The main attitudes I observed during the focus group discussions can be described as rejection, denial, resistance, fear, and acceptance leading to attempt to take action.

a. Rejection

Overt rejections came from two small settlements in the Dobe area. In an isolated small settlement, a CDF and I found several older women with a few young people gathering under a tree. We were rejected when we offered to have a discussion about HIV/AIDS. A few older women said one after another:

We don't want to know anything about AIDS. We are hungry, but you didn't bring food for us. Why are you trying to tell us about AIDS when we have nothing to eat? (Ju/'hoansi women, Bate)

Eventually, after a brief exchange of words, and with the support of a younger woman, we were able to show an educational video. However, the older women refused to discuss HIV/AIDS even after the video viewing. The CDF later informed me that most of the women in the settlement were widows, although, we could not know whether their husbands died from AIDS or other diseases. She suggested that the women were afraid that they might also die from the debilitating illness.

Another rejection came from the residents of a remote Ju/'hoansi-Herero mixed settlement in the Dobe area. The same CDF and I had been trying to visit the new settlement to disseminate information on HIV/AIDS. When we went back to the settlement for the second time, as suggested by the villagers, we encountered a rejection. Older women and a young man sitting around a fire refused to talk because they were too busy to listen to the information about HIV/AIDS. One woman said:

Why did you come here without bringing food for us? I don't want to know about AIDS. We are hungry. (Ju/'hoansi, Magopa)

Perhaps, there was a reason unknown to us behind the rejection. I was with a Ju/'hoansi CDF from the area who speaks their language and has been working with the community through TOCaDI. It is important to explore the reasons for the rejection so that we could provide adequate support to those villagers.

b. Denial

A lack of ownership and internalisation of knowledge is evident among staff and villagers alike: many informants used a third person term in discussions. For

example, “They don’t go for testing”, and “People should know their status” instead of using “I” or “we”. No one failed to state “ABC” (Abstain, Be faithful and Condomize) as promoted by the government when answering a question on preventive measures. However, many staff members admit that those measures are very difficult to practice because they do not conform to social norms in their culture. One staff member (Khwe) stated: “Sticking to one partner is very difficult for a grown-up man like me”. Other Khwe staff said: “They (villagers) don’t want to know. They are ignorant”.

c. Resistance

Resistance is often expressed as ignorance. In some Hambukushu villages and Khwe/ Hambukushu mixed villages, participants responded with indifference, saying that they already knew about AIDS and had no questions to ask. However, they stated that they did not know their own HIV status because no one had been tested. Despite much anxiety shown, the men and women stated that they did not know the symptoms of AIDS while they had seen many people die, young and old, following debilitating illnesses. Resistance is common among villagers: people resist accepting this ‘new disease’ and new information, and resist the preventive measures particularly the usage of condoms.

Resistance to Condoms

There is strong resistance to condom usage. I find that the condom issue sensitive because it reflects the complexity of the cultural norms, which includes a

conflict between the effort to maintain traditional values and the demands of modernisation, gender inequality and a generation gap. There are many ambivalent feelings toward condoms. Strong resistance toward condom use comes from older participants in Hambukushu and San villages, who demonstrate confusion and misunderstanding of HIV/AIDS. Condoms require a change in cultural practice by altering women's position in sexual relationships. Discussion on condoms also results in breaking the taboo of openly talking about sex, especially across generations. Condoms are also contraceptives and therefore the usage of them is contrary to the cultural norm of having many children.

Most churches preach against condom use, saying a condom kills the babies in the semen, equating usage of a condom with committing murder. This argument prevails among the villagers who lack a basic knowledge of the biological process of conception. In Botswana, churches, especially African Independent Churches, have a strong influence on people, particularly in rural areas. In addition, missionaries who do not promote the use of condoms continue to have influence in the rural areas. The villagers are confused by the contradictory messages coming from churches and missionaries vis-à-vis the government through schools, clinics and other AIDS workers.

In general, women seem to be more convinced of condom use as a mean of protection. However, they are often denied the use of condoms due to gender inequality, especially in Hambukushu society. Some women reported that if a woman suggests a condom that means she might have been unfaithful to her husband or she may be accepting her husband's adultery. Many express mutual

mistrust between men and women. Unless changes occur in the gender balance, promotion of condoms will have minimal success.

Mistrust in condoms is used as an excuse for not using a condom: the lubricant on the condom is said to give a rash to some people, and the condom itself is infected with HIV, for example. Some people believe that HIV was brought to Africans by white people to reduce the population growth of Africans. Some people argue that it is a strategy by the government to control the population. Many older people argue that condoms are the source of HIV prevalence.

AIDS is transmitted by condoms, because there was no AIDS before the condoms came around. (Khwe woman, Tobere)

d. Fear

Some people resist accepting the existence of HIV/AIDS and new information about the disease because of fear. This fear inhibits absorbing accurate information about HIV/AIDS. As one staff member said, "They don't want to understand it". What are they afraid of? Staff and villagers state that they are afraid of knowing that they will die; they do not know what to do and feel hopeless if they are found to be HIV positive.

If I went for testing and was found to be HIV positive, I will go into the bush and hang myself. (Khwe male staff, Kaputura)

They are also afraid of the painful and debilitating course of the illness. And, most of all they are afraid of stigma.

They will laugh at me if they know I am HIV positive. (Khwe female staff, Ngarange)

e. Acceptance and Will to Take Action

In some villages, residents demonstrated the courage to accept the reality of HIV/AIDS prevalence and willingness to take action to prevent further infections. For such acceptance to occur, it sometimes takes one or two villagers to speak up positively, emphasizing the importance of caring for people who are affected by HIV/AIDS. Residents in a Hambukushu village openly talked about HIV after one courageous woman insisted that they must not be ashamed of being HIV positive. The village formed an AIDS committee with half of the members being women. The participants from this village, who later attended a workshop, repeatedly emphasized the importance of community development around the challenges of HIV/AIDS.

4.2 Factors Perceived as Contributing to HIV/AIDS

Questions were asked as to how staff and villagers perceived problems related to HIV/AIDS. The concerns demonstrated in relation to the spread of HIV/AIDS are divided into the following five categories: poverty; gender inequality; conflicts between traditional beliefs of illness and HIV/AIDS information from modern medical system; marginalization and stigma. Although not part of the analytical framework, a sixth factor contributing to HIV/AIDS emerged from focus group discussions and interviews. This sixth factor is the generation gap, social disintegration and conflicts in the communities which is brought about by and further contributes to HIV/AIDS.

4.2.1 Poverty

Poverty is a major effect on HIV/AIDS prevalence as it is a major concern of life for the villagers. Away from major centres, people in the Okavango District are extremely poor. They are not only income poor, but also have limited access to basic needs. The majority lives in one-room thatched roof huts without electricity. They have to haul water from a borehole (a drilled well) or government provided piped water at village standpipes. Sanitation systems are extremely limited. People use a public outhouse (a few for the entire village if they are available), or more likely, 'bush toilet', referring to anywhere away from village huts.

Very few are employed. Villagers, on a rotational basis, may work on roads, clearing bush, for example, for minimal pay as part of a government drought relief program. Staff explained to me that welfare systems are difficult to access due to lack of knowledge and difficulty meeting the requirements. Villagers living by the Okavango River survive by fishing, others earn pocket money through short-term construction work. Most income sources are in the informal sector. Some people sell local vegetables and crafts such as woven baskets and ostrich eggshell jewellery for minimal cash. Some work in the fields growing sorghum, millet, and maize for themselves. There are no cash crops; very few vegetables grow due to the poor soil and lack of rain in the area. The high unemployment rate (thought to be well above 90%) combined with a lack of recreational activities, and lack of hope, appeared to contribute to high alcohol consumption in all ages, and among both women and men. The San, especially Ju/'hoansi, live in very poor conditions. Their grass huts often do not have walls. Staff informed me that many have only one meal

a day and some only have a meal every two days. I often observed that they share one bowl eating mealie meal (consist of powered millet) among a family.

Poverty aggravates risky behaviour such as women and girls having sex in exchange for money and basic needs such as food and clothing. None of the villagers used the word 'prostitution', however, many residents reported that it has been happening on an on-going basis especially when a number of people come from outside (construction, cattle lung disease eradication program¹¹, drought relief program, among others).

When the cattle disease happened, so many men came to this area to kill the cattle. AIDS started after that time. (Khwe man, Ngarange)

The beginning of the drought relief program (along with it, many workers come to the villages) brought this disease. (Khwe woman, Tobere)

The villagers identified the lack of a hygienic environment and poor living conditions.

The villages are dirty; rubbish is everywhere. (men and women from N!oaxom villages: Ngarange, Tobere and Kaputura)

Although most villages and settlements are provided with clean water piped to village standpipes, limited access to clean water is a particular concern for the Khwe villages, because it makes keeping the environment clean and looking after sick people difficult. Lack of water is particularly critical in the Dobe area.

Poverty has affected the health of villagers due to poor nutrition. Staff members and villagers point out that food intake and nutrition are limited by poverty,

¹¹ The cattle disease eradication program wiped out cattle in the north of Maun in the middle 1990s. A high level of mobility in population took place at the time.

placing the body's immune system at risk whether the person is affected by HIV or not.

You say a person with HIV/AIDS needs to eat well. What can I eat if I have AIDS when there is nothing to eat? (Khwe woman, Shaikarawe)

Why are you talking about AIDS when we are starving? (Ju'hoansi woman, Dobe area)

A concern for alcoholism is frequently brought up at the focus group discussions. All villages except Tsodilo Hills express concerns with high alcohol consumption because of its correlation with risky sexual behaviour. Some say that poverty and unemployment promote drinking of cheap traditional beer among the young and old.

One staff member links poverty to marginalization. He states that the poor are more vulnerable because they are afraid of discrimination and tend not to seek health care services they need.

4.2.2. Gender Inequality

a. Gender Inequality as a Societal Norm

The second important factor identified is the role played by traditional norms with respect to sexual relationships – this include the polygamous custom common in the Hambukushu culture and women's unequal power in sexual relationships common in Botswana culture. Female staff express concern about gender inequality and the harsh lives women face, but they seem to accept it as a norm.

As one staff member reports, polygamous relationships and wife inheritance are still common practice in the Hambukushu community. Hambukushu women express a strong concern about their safety in sexual relationships that might result in an HIV infection. The voicelessness of women in their sexual relationships results in the difficulty when discussing condoms and convincing their husbands to use them. Women are worried that if they insist on condoms, their husbands will leave for other women.

If a wife refuses to have sex, a husband can go to the wife's parents to complain and she will be blamed for causing a marital problem.
(Wayeyi woman, Etsha 6)

Men are the ones who make decisions in the household. In Hambukushu culture, a woman has to obey her husband. When her husband dies, she will be the head of the household until her son grows up, then she will have to obey her son. (Hambukushu man, Ikoga)

If a wife asks her husband his whereabouts during the night, it will frequently result in spousal violence so women endure voicelessly. A Ju/'hoansi staff member states that domestic violence involving sexual partners is also common in Ju/'hoansi society.

Also, in Hambukushu culture, women are expected to bear many children. During group discussions, the importance of fertility was used to argue against usage of condoms by both men and women. Many men state that polygamy is common and accepted in the Hambukushu culture: "Nothing is wrong with having many wives in our culture" (a Hambukushu man, Etsha 6). At the same time, men

blame young girls for “sleeping around and getting pregnant” and “spreading HIV/AIDS” (Khwe and Hsmbukushu villages).

Staff members and villagers from the Khwe and Ju/'hoansi backgrounds stated that traditionally marriage was arranged by parents at a particular age and with one partner. There were initiation ceremonies and coming of age rituals for both girls and boys where they were taught the traditional way of life by elders. However, the villagers claim that since they encountered other cultures and interracial marriages have become common, this traditional norm no longer exists and girls have sex at a very young age. One staff member states that in these days, youth have sexual relationships at a very early age and with multiple partners. Parents have lost authority over their children's sexual behaviors. The taboo against talking openly about sex, particularly in front of elders inhibits open discussion about HIV /AIDS.

Hostels for residential schools¹² are especially blamed for creating the early onset of sexual behaviour and subsequent early pregnancies. School dropout rates due to pregnancy are very high among San girls. A Khwe woman demonstrates a serious concern that girls are often sexually exploited at the school hostels (by students and teachers). Then, the incidents are usually unreported or minimized. This indicates two issues: a significant level of acceptance of the gender inequality in society and the weakness of the Khwe parents in seeking justice for their girl children.

¹² In the studied area, due to the remoteness, many children attend residential school.

b. Gender and Poverty

In both Hambukushu and San communities, women are always poorer than men and often have no means of earning an income. Although villagers say women and girls are exposed to infection by having sex in exchange for money and food, they do not voice a solution to this problem. Early pregnancies result in school dropouts and make girls and women further unemployable due to lack of education. There is a repeated cycle of poverty: early onset of sexual relationships and early pregnancy, unemployment of undereducated women, and poverty as a result.

4.2.3 HIV/AIDS and Traditional Beliefs of Healing and Modern Medicine

Although percentages are unknown, belief in traditional healing is strong among villagers. Approximately half of the staff interviewed prefer to go only to a clinic while the other half use both traditional healers and a clinic. The choice is made according to their symptoms: some diseases are considered non-treatable at a clinic and have to be treated by a traditional doctor. No staff member reported that he or she would only go to a traditional doctor. At the same time, most staff members continue to believe in traditional healing and practices. For example, they would conform to a traditional healing process with a series of rituals in relation to a funeral so that they can avoid illness as result of breaking taboos.

Male participants from Hambukushu and Wayeyi villages lament that traditional values are neglected and this negligence is leading to the HIV prevalence. Khwe elders also echo similar sentiments and claim that loss of traditional practice is causing an AIDS epidemic in the community.

In our tradition of healing, when a spouse died, the husband or wife stayed isolated to go through a healing process. These days, people don't go through this process and meet with other woman/man so he or she will get contact with bad blood. We should follow this tradition so that we don't get AIDS. (Khwe man, Kaputura)

We see a person swell first and then shrink, and die. If you take the person to a traditional doctor, he will get rid of bad blood then it will help. But if you take him to hospital, the person will die. (Khwe man, Tobere)

TOCaDI staff explained to me that Depathi is caused by breaking established taboos such as refraining to have sex with a woman who had a miscarriage before she completes the cleansing ritual. The symptoms resemble those associated with full-blown AIDS: headache; pain in the back and legs; weakness; and loss of weight, for example. The traditional belief is that Depathi has to be treated by a traditional doctor, and if the patient is taken to a clinic and receives an injection, the person will die immediately. It appears very difficult for many villagers to understand a disease to which this traditional concept does not apply. A Khwe traditional doctor whom I interviewed explained the spread of HIV/AIDS:

When a cold drop from the sky falls and goes into your body, you get AIDS. (Khwe male traditional doctor, Ngarange)

Traditionally, the San believed in a supernatural world with many gods (Lee, 2003; Marshall, 1999). The San deal with illness and healing by righting wrong through re-establishing good relationships between the gods and themselves. Healing dances and medicinal wild plants are central to their healing (Lee, 2003; Le Roux & White, 2004; Tlou & Campbell, 1997). However, when Bantu-speaking people came in contact with San, Bantu beliefs presented a major challenge to San

people, particularly sorcery and witchcraft. While San believe that illnesses come from external power of gods, sorcery seeks the source of the misfortune within the community, therefore, setting kin against kin and neighbour against neighbour (Lee, 2003, p. 138 -139). My observations and information from interviews and group discussions indicates that most San continue to believe in their traditional concepts of illness and healing and do not really understand HIV/AIDS. The concepts brought in by Bantu-speaking people and missionaries have created further confusion in understanding of HIV/ADS. Some villagers, especially Hambukushu, believe that illnesses are caused by witchcraft (as a result of a curse by neighbours or family members).

As they believe most illnesses are caused by witchcraft, breaking of a taboo, or ancestral gods, the concept of an immune system is completely foreign to them. Most villagers tend to seek traditional healing when they fall ill or wait for a long time before seeking medical attention from a clinic. The traditional diseases can create severe implications, however, there is no stigma attached to them while AIDS is stigmatized. One reason why people prefer to believe in traditional diseases rather than trying to understand AIDS is perhaps that traditional diseases will not bring shame on the person.

At the same time, although strong beliefs in traditional healing are evident among the villagers during the group discussions, this tradition is being gradually weakened.

We see people are getting sick like having diarrhoea but we are not getting any help. We go to traditional doctors, we go to a clinic, we go to everywhere, but can't get help. (Khwe woman, Kaputura)

Those people who go to traditional doctors must know that they are in denial. Botswana people believe in witchcraft, but those people are the ones who are making us sick. (Hambukushu woman, Etsha 6)

Traditional doctors may also have difficulty understanding HIV/AIDS. The traditional doctor I interviewed said that if patients came to see him too late, he would not be able to cure them.

4.2.4 Marginalization

People living in this area are marginalized. They are marginalized from the mainstream economy of the country and live in extreme poverty while the rest of the population enjoys the comparative prosperity of Botswana. They are marginalized from mainstream information dissemination due to language barriers. Also, the information given is not culturally sensitive and is often beyond their comprehension. They are marginalized because they are not part of decision making in the health care or education systems. Children of school age in N!oaxom and Dobe areas attend boarding school in larger villages, many from grade one. Senior secondary education is only available in Maun (400km to south) or Ghanzi (500km to south - west). Away from home communities, with no cultural consideration in the curriculum, discrimination and abuse are common for San children (Le Roux, 1999). School dropouts are a serious problem.

Lack of access to adequate health services is one of the major concerns expressed by villagers. Villagers feel that they have been marginalized through lack of access to adequate health services. All staff interviewed stated that poverty in the

area resulted in lack of access to adequate health services because there is no affordable transportation to health facilities. Also, many raised concerns regarding the current health care services: accessibility, skill levels of nurses and mistrust in the health care system in general.

a. Lack of Access to Health Care

Villagers note a lack of adequate health services in the remote areas where they live. According to the Botswana health service policy, small villages and settlements with a population under 500 receive only monthly mobile clinic visits by a nurse, which do not materialise whenever a problem arises with a clinic vehicle. Villagers report that when residents give TB test samples, the test result often comes back so late that the patient would die before learning the result. Many villages do not have an adequate home-based-care program that is crucial to patient care at home. Lack of transportation is also of concern since there is no public transportation in two of the three TOCaDI catchment areas. The villagers have to travel many hours on foot on heavy sandy roads to access a nearby clinic. Most villagers do not have money to hire private transport.

We asked the clinic to transport a patient but they never sent a vehicle. So, we had to take him on the back of a donkey to the clinic 17 kilometres away. (Ju/'hoansi man, Dobe area)

b. Attitudes of Health Care Providers

Many concerns and complaints relate to the attitudes of the health care professionals. The San particularly feel that health professionals are negative and

discriminatory towards them. Hambukushu who live in the N!oaxom area also express dissatisfaction with health care professionals' behaviour toward poor villagers who visit the clinic.

c. Lack of Communication between Clinic Nurses and the Patients

Since the patients are usually accompanied by a translator (family member or a health clinic staff), lack of communication is more likely due to a cultural issue and marginalization than to a language issue. San people have a tendency not to express their symptoms explicitly and assertively to clinic staff, and end up not receiving the care they need. The communication breakdown results in mistrust in health service and non-compliant behaviour.

When you go to clinic because you are coughing, a nurse will tell you to go home and drink hot water. (Khwe woman, Shaikarawe)

We can't explain what is wrong with us; many of us don't tell a nurse that we have cough for a long time or we have a chest pain. (Khwe woman, Shaikarawe)

When we go to a clinic for different symptoms, a nurse will gives us the same pills. (Hambukushu man, Ngarange)

Many villagers complain about the difficulty of going to an HIV testing and counselling centre; an ARV treatment centre was only available in Maun at the time of this fieldwork. However, the complaint might be used as an excuse for not going for an HIV test, as one woman stated:

If you want to be tested, there are many ways to do it. If you really want to go to the testing centre, you will take a bus and go, you don't wait until someone pays for your bus fare. (Hambukushu woman, Ikoga)

4.2.5 Stigma

The leading perceptions among the staff regarding community reactions toward people affected by HIV/AIDS are divided almost equally between shame and rejection, and acceptance and caring. Denial and ignorance are listed as the third common reaction. This result reflects highly ambivalent feelings among the staff: seven staff members, Khwe and Hambukushu, pointed to shame and rejection as a common reaction in their villages. Some villagers are afraid to touch an ill person because they think that they might get the same disease. Whereas, one staff member states that a tradition to care for the sick still exists in the San community. The difference in opinions seems to indicate that there is a breakdown of traditional values after contact with other cultures. At the same time, staff demonstrate concerns about denial of HIV/AIDS and ignorance of the information by the villagers. During my stay, no staff members or villager officially informed the TOCaDI or myself that he or she was HIV positive, while some stated they went to testing and were negative. Stigma is pervasive in the communities.

4.2.6 Disintegration of the Society - Generation Gap

Along with the diminishing traditional values, almost all villages complained about a communication breakdown between the young and the older generations as a serious concern. Hambukushu adults often blame youth for spreading HIV by being sexually active. In turn, young people blame their parents' generation for ignoring information and protective measures. Hambukushu participants state that parents do not talk to their children anymore and youth do not listen to their parents.

In Khwe villages, older men and women repeatedly express similar concerns. The Khwe parents also feel that they no longer have control over their children's behaviour. The San youth express frustration with their parents for their denial of HIV/AIDS and neglect of protective measures against the virus. Due to a taboo of talking about sex, youths state that they are unable to discuss HIV/AIDS openly.

It is difficult to explain HIV/AIDS to elders because of the certain words which are not supposed to be used by youth with elders. (Khwe youth, Ngarange).

Parents fear that their traditional way of life will be rejected by youth and tradition would diminish. Dwelling on the fear, older people are not able to accept the new concept of "HIV/AIDS" while youth are more open to the new information.

4.3 Discussion

Based on my data, the connections among the five themes of the analytical framework, namely, poverty, gender inequality, traditional beliefs of illness and healing, marginalization, and stigma, as well as the linkage with HIV/AIDS prevalence are discussed. Each factor, as well as the connections among them, influences behaviour, knowledge and attitudes.

4.3.1 Poverty

The extreme poverty combined with their noted marginalization makes it difficult for people to deal with HIV/AIDS in these rural communities. Major affects of poverty on HIV/AIDS prevalence in these rural communities include poor health

status including malnutrition, vulnerability of women, poor educational attainment, marginalization, lowered morale, reinforcement of stigma and disintegration of the society.

The poor living conditions make people susceptible to infections. High prevalence of tuberculosis, malaria and STDs are reported among the San, particularly women (Felton & Becker, 2001, p. 47 - 51). Their immune systems are weak due to a lack of nutrition and exposure to other diseases. Lack of funds to travel makes access to HIV testing and ARV treatment very difficult. Also, if found to be HIV positive, their body may not be able to tolerate ARV therapy. Some people do not believe that the treatment will make a difference in their life when they have little hope for their future. Thus, people are discouraged from going for testing even if they overcome the stigma. This means a delay in starting treatment.

Losing a family member to illness in their prime results in further hardship in the family. Deaths of parents create more orphans who have very limited support in poor communities. Poverty is a serious problem that aggravates the problem of HIV/AIDS in rural northern Botswana communities.

4.3.2 Gender Inequality

Gender inequality is one of the major factors exacerbating HIV/AIDS prevalence in the rural Botswana. Gender inequality is rooted in the traditional cultural norms in Botswana society. Combined with the disadvantaged conditions in which women live, women do not have a decision making power in their sexual

relationships as Lesetidi (1999) argued. Poverty only aggravates women's vulnerability by encouraging risky sexual behaviour.

There is a strong disagreement between men and women regarding HIV/AIDS prevalence. Men seem to feel a loss of control over the issue and blame women as a source of HIV infection. Women tend to have more realistic ideas of HIV/AIDS, perhaps because they are the ones who look after the sick. Women also blame men, especially because of their multiple sexual relationships. It appears that some women are caught in the middle between their knowledge and desire to use condoms and the fact that they are not allowed to do so. The common societal norm that emphasizes women's fertility is reinforced by the teaching of the churches that preach use of condoms as murder of babies. It places women who want to use condom in a hopeless position.

Cultural norms for gender relationships have affected women in different minority groups differently. Women have many restrictions particularly in Hambukushu culture. Cultural encounters and intermarriages with other ethnic groups have affected San women regarding their positions in sexual relationships. Lee (2003) reported a high status of women relative to men in J'hoansi in his research conducted in 1960s, while pointing out that there were major changes after 1970 (p. 192). Fulton and Becker (2001, p. 15 -16) argued that the relative gender equality appeared to be linked to the extent to which gathering continued to be an integral part of livelihood of the San groups. Women were the main gatherers and were proud of their contribution to family sustenance from foraging. Through encountering neighbouring communities and intermarriage, the San women's status

has changed. The literature is not clear as to when and how these encounters occurred. However, Felton and Becker (2001, p. 51 - 53) warn that there is a discernible acceleration in the spread of HIV/AIDS among the San, and San women in particular, combined with an increase in gender-based abuse and alcohol abuse. Although San women had more autonomy in their traditional life style, in contemporary San life, "San women throughout southern Africa experience many forms of violence both inside and outside the San communities" (Felton & Becker, 2001, p. 55).

4.3.3 Traditional Beliefs of Healing

For many people in the research area, understanding HIV and AIDS means confronting their own traditional cultural values especially beliefs in traditional healing. Traditional beliefs are the values that marginalized people can uphold. It is the way they can show their autonomy, authority and ownership. However, it makes understanding the dynamics of HIV/AIDS extremely difficult, especially when they believe that symptoms of a traditional disease and AIDS are the same. Villagers, especially from older generations, refuse to face reality, resist accepting new information and knowledge, and resist changing behaviour.

Beliefs in traditional healing are extremely important for the residents in these rural communities because they are the core values of their culture. There are obvious conflicts between traditional healing and modern health care system, on which the GOB built their HIV/AIDS policies. In the Botswana National Health Policy, it is recognized that the traditional health system continues to be an integral

part of cultural values and beliefs in Botswana, however, it considers it is so different from the modern health system that they cannot be fully integrated (Abt Associates South Africa, Inc., 2002, p. 54). However, if these conflicts are not addressed, there will continue to be barriers to behavioural change.

The strong beliefs in traditional healing held by older generation create generation gaps, difficulty in understanding HIV/AIDS and marginalization of the communities that believe and practice traditional healing.

4.3.4 Marginalization

Marginalization of the rural communities is reflected in the forms of lack of adequate health care services, poor educational attainment, high unemployment rates, especially among youths, exclusion from decision making processes regarding their lives and lack of access information. Remoteness, poverty, non-mainstream cultures with their own languages, strong beliefs in traditional illness and healing and gender inequality all fortify marginalization.

Marginalization is not only a matter of physical conditions but it also affects people's mentality. Exclusion from the mainstream of the society creates resentment and resistance to changes. Most of the villages are struggling to survive. They have a minimal amount of food, and their cultural identity is at risk, as is their health. This situation leads them to distrust the government and the system and despair of the entire situation.

4.3.5 Stigma

HIV/AIDS-related stigma plays into, and reinforces, existing social inequalities (Aggleton & Parker, 2002, p. 9). Feeling powerless and hopeless as result of stigma makes people turn away from the reality of HIV/AIDS. Poverty, gender inequality, and marginalization, exclusion from the mainstream economy and opportunities in the Botswana society affect the sense of self-worthiness of people and the communities. HIV/AIDS related stigma reinforces people's vulnerability and reduce their coping ability. As Aggleton and Parker (2002) argued, empowering communities through a participatory process that unleashes their own knowledge and experiences is crucial in reducing stigma (p. 18).

4.4. Conclusion

My data analysis and discussion demonstrate that the connection and interaction between the five themes of the analytical framework. The five factors are all important, ranking them is beyond the scope of this research project. However, when they interact with each other, they exacerbate HIV/AIDS prevalence and create serious barriers for the marginalized people, especially women in the rural area.

Reaching beyond my analytical framework themes, I felt that many communities face disintegration of society, particularly in the form of generation gaps. The older generations feel that their values are lost in the modern age. They have difficulty accepting the fact that HIV/AIDS is threatening their future. It appears that they are confused as to which way they should lead the community. In turn,

youth feel frustrated and blamed. The flexible minds of youth understand HIV/AIDS more easily and many are ready to make changes, however, they feel stymied by the older generation. Youth in the rural communities are also somewhat confused because the knowledge they obtained from outside sources such as school and clinics contradicts the knowledge they gained from the elders. They are not getting guidance from their own people. The conflicts between generations obstruct dissemination of accurate and adequate information on HIV/AIDS and development of supportive communities.

In the Khwe villages in N!oaxon area, youth who accepted the disease took initiatives to reduce the risk. Village youth live in a highly challenging environment with poverty, almost no employment opportunities, remoteness, high alcoholism, and the cultural taboo regarding talking about sex and sexuality with the older generation. Nevertheless, village youth formed HIV/AIDS youth committees and sought training to improve the HIV/AIDS situation in their communities. The incentive to work on HIV/AIDS issues seems to give village youth motivation and hope to improve village life for themselves and for others.

Chapter Five

Conclusions and Recommendations

5.0 Conclusions:

HIV/AIDS in villages of north Okavango replicates the large-scale picture that is taking place on the global level. My research confirms the analytical framework describing the core factors of HIV/AIDS as poverty, gender inequality, beliefs of traditional healing, marginalization, and stigma. The problems of HIV/AIDS in the Okavango District are highly complex and intertwined with social, cultural and economic challenges in the area. The area is the most marginalized in Botswana due to its remoteness as well as its highly diverse population and non-mainstream cultures. Without untangling these issues, the problems imposed by HIV/AIDS will never be resolved in the area. A summary of the main results follows.

The communities are sensing the creeping impact of the HIV/AIDS pandemic and feel forced to change. However, without understanding the reality of HIV/AIDS and internalising the knowledge, people resist change. It is not just individuals' behaviour but the whole social structure, societal values and norms, and culture that must change. It is extremely difficult for communities that have very limited resources and are clinging to their traditional values to survive. If they have to change, in what ways should they change and what changes are more acceptable to them? People need to take ownership of the problems and develop the strategies they can act upon effectively.

Saturated in international donors' funds, the GOB strategies are largely based on western cultural values and concepts. The Botswana Government policy does not reflect the respect for traditional views of illness and healing widely held by its residents. Simply imposing western concepts of illness and treatment on villagers will not bring success in reducing the HIV pandemic.

My research identifies poverty, cultural conflicts that involve gender inequality and beliefs of traditional illness and healing, and marginalization as the key contributors to HIV/AIDS in the area. These factors reinforce stigma that is pervasive, and create barriers to prevention strategies for marginalized minority groups in the Okavango District.

Poverty is a significant issue in the area. Poverty affects people's health status not only physically but also mentally. Poor nutrition weakens the immune system and makes it vulnerable to HIV infection. Poverty is linked to a life style that is prone to high alcohol consumption and related high-risk behaviours in poor rural communities. Poverty predisposes women to HIV infection as women struggle to survive. Poverty often makes people feel powerless; hunger is often felt to be degrading. Poverty may also stigmatize people and prevents people from facing the reality of HIV/AIDS and seeking the medical services and care they need.

Gender plays a central role in HIV prevalence in Africa. Women in the Okavango District are placed in perilous positions in relation to HIV infection and gender-based violence. Women also infect their babies during and after pregnancy. Without changing gender dynamics in the local communities, many women will continue to die of AIDS. Gender has close ties to poverty and is also dictated by

traditional cultural values. Gender relationships play a highly sensitive role in the community and are difficult to change. Nevertheless, empowering women, especially young girls, economically and socially is pivotal to success in any HIV prevalence program.

Significant disagreement is found between traditional beliefs and modern medical systems that disseminate information on HIV/AIDS and promote strategies for HIV prevention. This disagreement is causing confusion and people also feel authorities are untrustworthy. Further education is needed. However, the mainstream system also needs to understand the importance of local cultural values based on traditional beliefs. I felt that the older generation was seeking assurance that their most important cultural values would be respected. Culture change is a dynamic process. However, the ultimate change in societal values will have to come from within the community. Ignoring traditional culture and forcing them to change will only result in resistance. In the rural communities in the Okavango District, cultures are interwoven in the most complex way through intermarriage and cultural exchanges. Nevertheless, cultural values and languages need to be taken seriously when disseminating information. HIV/AIDS education needs to be created so people understand HIV/AIDS through existing knowledge based on their cultural values and religious beliefs. When the information given is unfamiliar and not understandable, people will absorb inaccurate and misleading information.

Minorities, particularly the San in the Okavango District, are marginalized to an unthinkable degree. The cultures, economic status and education of the minority groups are ignored by the Botswana government policy. The San people in

particular are having a difficult battle for survival with minimal resources and minimal assistance while their autonomy is denied. It is time to re-evaluate real factors that are contributing to the spread of HIV/AIDS outside of existing medical and behaviour models. In shifting a view from the medical and behavioural models to development and cultural aspects, voices of the marginalized minority groups need to be heard and reflected in policy making so that it reflects their true needs.

Stigmatization of people infected with HIV is common, especially in Africa. However, particularly in the Okavango District, stigma is reinforced by marginalization, poverty, gender inequality and traditional societal values. Women are much more likely to be blamed for the spread of HIV. Stigma creates fear and denial and results in indifference. Castro and Farmer (2005) reported that introduction of quality HIV care led to rapid stigma reduction in their study in Haiti. Their research suggests building a structure that provides care for the people living with HIV/AIDS is essential in reducing stigma in the Okavango District.

During my fieldwork, I met many young people who are eager to learn and work on HIV prevention. Sadly, few income sources and employment opportunity are available to them. Sources available to actualize and support their wishes are almost non-existent in the communities as well as at TOCaDI. Little research has been done on the active role that youth can take in the community in HIV/AIDS prevention and patient care, especially in rural areas. Few resources are allocated to this type of program.

The Botswana government demonstrates a certain level of commitment and offers various programmes that are of a high standard compared to other African

nations in general. Despite this effort, most of the population does not know its HIV status (GOB, 2002). There are several shortcomings of the policy and strategies.

In the National HIV/AIDS Assessment for Strategic Framework 2003 -2009, the Government identified several socio-cultural determinants for the HIV/AIDS epidemic. Subordination of women that affects decision making in sexual relationships was highlighted along with the exploitation of young girls, called the 'sugar daddy' problem. The Framework connects the 'sugar daddy' problem to poverty and discrepancy in wealth distribution in society (GOB/NACA, 2002, p. 12). Population mobility and limited access to schooling are listed as other socio-economic factors contributing to HIV/AIDS. Population mobility relates to both the traditional livelihood that depends on cattle and agriculture, and the modern life of urbanization and mining. Limited access to schooling in the remote areas makes children live away from parents where there are inadequate support systems and supervision. The Botswana HIV/AIDS strategies do not seem to include programs for poverty reduction such as income generation and employment opportunities in the local communities, or improvement of primary education systems (GOB/MoH, 2002).

Stigma is listed as a significant source of fear that induces people to believe that they would rather not know their HIV status (GOB/NACA, 2002, p. 5). This denial and fear contribute to a low rate of voluntary testing and reluctance of families to take care of persons living with HIV/AIDS at home and to seek support for such care (Abt Associate South Africa Inc., 2002, p. 39). However, the national policy and

strategies continue to focus on the medical aspect of HIV/AIDS and emphasize the behavioural change campaign (GOB/MoH, 2002; GOB/NACA, 2003a).

In implementing health care programmes, Botswana faces a chronic scarcity of trained health care workers, which often leads to fragmentation of services. For example, home-based care has a fault in its practice: actual home-based caregivers are volunteers who only receive minimum allowance for transportation costs to the patient's home. They are given basic training, however, the skills and services are inconsistent and turnover rates are high.

5.1 Recommendations

Based on my preceding analysis, the following recommendations are made to Government of Botswana and TOCaDI.

Recommendations to Botswana Government policy change:

1. GOB needs to commit to a multifaceted approach to the HIV/AIDS epidemic, that is, to incorporate social and economic development work into the HIV/AIDS programmes. At this moment, the scope of its strategies is narrowly tied to medically and behaviourally oriented approaches. The government has not done a comprehensive and holistic socio-economic assessment of the most vulnerable and marginalized groups of the country. This research should include their economic status (such as means of income and average household income), life expectancy, participation in education, school dropout rate, number of orphans and HIV prevalence rate among the minority groups as well as other qualities of life.
2. GOB needs to acknowledge the history and existence of the San as

indigenous people in Botswana. Efforts to ensure their culture and identity, and support their existence must be developed as policy.

3. GOB needs to use participatory bottom-up communication in order to understand the grassroots needs. There is distrust of the government including its health care system among rural area residents. Resources should be provided to promote and develop a health care system that respects the uniqueness of each culture. Village health committees or local health advisory committees need to be structured to ensure all voices are taken into account. Home-based caregivers should be treated as trained workers and be paid the salary they deserve. In rural villages where extreme poverty is the standard of living, volunteerism is unrealistic.

4. Health care professionals should be trained in cultural sensitivity and better communication skills. In order to reduce stigma, a support system needs to be established in each community that empowers people with knowledge and hope for the future.

5. Funds from international donors should be spent on actual expenses to look after the sick; for example, blankets, dressing materials, food, adaptive equipment such as wheelchairs, pressure relief mattresses and transportation to make home based-care easier for the family and more feasible for the local government.

Recommendations to TOCaDI:

1. TOCaDI should continue its effort to integrate HIV/AIDS-related issues into its day-to-day programs. At this moment, there is a clear division between the managers and local staff that is reflected in the mistrust of managers. Fear and

stigma related to HIV/AIDS exist within TOCaDI. Empowering and embracing local staff as key players in the work against HIV/AIDS will assist in the internalization of HIV/AIDS and reduction of stigma. TOCaDI managers need to ensure there is an on-going open dialogue between the local staff and the managers.

2. An AIDS workplace policy has been drafted and needs to be adopted in order to ensure a safe place for all staff and staff who are HIV positive so that they can seek assistance when necessary.

3. Work to mainstream HIV/AIDS should be based on teamwork rather than on one individual. Considering the cultural sensitivity shown by staff and the villagers related to HIV/AIDS, the local staff will have the most success in working in their communities. A HIV/AIDS Task Force has been formed to address the issue of HIV/AIDS within TOCaDI and in the communities, and now it is led by a female staff member from the local community. TOCaDI should continue to provide as much support as it can to the Task Force.

4. TOCaDI should provide continuing education and training to staff at all levels including managers. All education should have a component to address reduction of HIV/AIDS-related stigma.

5. Income generation projects are crucial in terms of eradicating the extreme poverty in the villages especially in N!oaxom and Dobe areas. The income generation program should be expanded so as to benefit the whole village, and especially more women and youth.

6. TOCaDI should take gender issue seriously and incorporate projects that

empower women. For example, recruiting more women at the management level, and having women direct the education program. Also, educating men and youth in ways that bring fundamental changes in gender relationships is important.

7. TOCaDI should reinforce the collaborative working relationships with other organizations including government departments and other NGOs. The Coping Centre for People Living with HIV/AIDS (COCEPWA) is the one of several organization that can provide support to staff in overcoming stigma. TOCaDI also should familiarise themselves with resources available in the community: especially Shakawe, Gumare and Maun.

8. ToCaDI should build a dialogue/ communication system with communities in a culturally sensitive manner and with an effort to understand and address the conflict issues at the grassroots level.

5.2 Direction for Further Research

My research objectives were to understand the complexity of socio- economic and cultural backgrounds for the HIV/AIDS-related behaviours presented by villagers and staff in this remote area of Botswana. In the local context, I have made the linkage between the social, economic and cultural issues and apparent behaviours targeted by the current GOB policy. By doing so the barriers to the current strategies are identified. I believe that my research will benefit informants who are local residents as much as my academic interest. I believe that my research helps TOCaDI understand the needs of local communities and develop an effective HIV/AIDS program. The area that my fieldwork covered was vast and diverse. The

complexity of HIV/AIDS problems in the area suggests further research needs in the following areas:

1. The gender issue needs to be considered as urgent and central to HIV/AIDS research in the area. Particularly, two topics are thought to be useful: empowerment strategies for women including women-oriented and -directed income generation programs; secondly, the changes in the roles of the San women in their communities in relation to gender relationships. This research may show how San women can be empowered in their communities and take a leadership role in the fight against HIV/AIDS.

2. I have made every effort to make my research beneficial to local residents who suffer from HIV/AIDS prevalence in their daily lives. HIV/AIDS research, especially from development point of view, must have the most benefit to people who are studied. The research and case studies conducted in the similar settings such as in rural Zambia helped make my research beneficial. More HIV/AIDS research needs to be done in rural and remote areas in southern Africa with respect to their coping strategies and stigma reduction. Strategies for stigma reduction need to be researched in the light of cultural and socio-economic backgrounds.

3. My research is limited in determining the impact of HIV/AIDS on particular ethnic groups, especially the San, who are the most marginalized and poorest people in Botswana. San specific research may be necessary to learn the significant impact of HIV/AIDS on the group and to protect their cultural and physical survival. The research should be led or at least involve the San and should be carried out for their benefit, since the group has been heavily 'researched' as

subjects in the past. The participatory action research model such as conducted by SASI (2003) should be explored and tried in the area.

These recommendations are by no mean inclusive of all potential solutions. My fieldwork was limited and my research plan needed constant adjustment. Since the area I studied was vast and culturally complex, my data collected have limitations. I was an outsider and had limited time. However, despite these limitations, my working relationships with TOCADI staff from the local communities and villagers were positive, and invaluable. Their input in my fieldwork was extremely helpful in making my research meaningful for TOCaDI and the communities. I do hope my recommendations will stimulate dialogue within TOCaDI, between TOCADI and local communities, and TOCADI and the Government of Botswana.

Bibliography

- Abt Associates South Africa Inc. (2000). *The impact of HIV/AIDS on the health sector in Botswana*. Gaborone: Government of Botswana Printer.
- Ackermann, L. & de Klerk, G.W. (2002). Social factors that make south African women vulnerable to HIV infection. *Health Care for Women International*, 23,163-172.
- ACORD. (2003). *Knowing and doing: A study of knowledge, attitudes, practices and behaviour on HIV/AIDS in Ngamiland west*. Gumare, Botswana; District Health Team.
- Aggleton, P. & Parker, R. (2002). *A conceptual framework and basis for action: HIV/AIDS stigma and discrimination*. UNAIDS. Geneva: United Nations.
- Airhihenbuwa, C.O. & Webster, J.D. (2004). Culture and Africa context of HIV/AIDS prevention, care and support. *Journal of Social Aspects of HIV/AIDS Research Alliance*. 1 (1), 4 -13.
- Barnett, T. & Blaikie, P. (1992). *AIDS in Africa: Its present and future impact*. London: Belhaven Press.
- Baylies, C. (2000). Perspectives on Gender and AIDS in Africa. In C. Baylies & J. Burja (Eds.), *AIDS, sexuality and gender in Africa: Collective strategies and struggles in Tanzania and Zambia*. London: Routledge.
- Baylies, C., Chabala, T., & Mikandawire, F. (2000). AIDS in Kanyama: Contested sexual practice and the gendered dynamics of community interventions. In C. Baylies & J. Bujra (Eds.), *AIDS, sexuality and gender in Africa: Collective strategies and struggles in Tanzania and Zambia*. London: Routledge.
- Berik, G. (1996). Understanding the Gender System in Rural Turkey: Fieldwork dilemmas of conformity and intervention. In D. L. Wolf, (Ed.), *Feminist dilemmas in fieldwork*. Oxford: Westview Press.
- Blair, C., Ojaka, D. Ochola, S. A., & Gogi, D. (1997). Barriers to behaviour change: Results of focus group discussions conducted in a high HIV/AIDS incidence area of Kenya. In D. C. Umeh (Ed.), *Confronting the AIDS epidemic: Cross - Cultural perspectives on HIV/AIDS education*. Trenton: Africa World Press.

- Bujra, J. & Baylies, C. (2000). Responses to the AIDS epidemic in Tanzania and Zambia. In C. Baylies & J. Bujra (Eds.), *AIDS, sexuality and gender in Africa: Collective strategies and struggles in Tanzania and Zambia*. London: Routledge.
- Buseh, A. G., Glass, L. K., & McElmurry, B. J. (2002). Cultural and gender issues related to HIV/AIDS prevention in rural Swaziland: A focus group analysis. *Health Care for Women International*, 23, 173 –184.
- Butchart, D. (2000). *Wildlife of the Okavango*. Cape Town: Struik.
- Castro, A. & Farmer, P. (2005). Understanding and addressing AIDS related stigma: from anthropological theory in clinical practice in Haiti. *American Journal of Public Health*, 95 (1), 53 - 60.
- Chumbo, S. & Mmaba, K. (2002). *The Khwe of the Okavango Panhandle: The past life*. Shakawe, Botswana: The Teemacane Trust.
- Cohen, B. & Trussell, J. (1996). *Preventing and mitigating AIDS in Sub-Saharan Africa: Research and data priorities for the social and behavioural sciences*. Washington, D.C.: National Academy Press.
- Cresswell, J. (1998). *Qualitative inquiry and research design: Choosing among five traditions*. London: Sage.
- De Waal, A. (2003). How will HIV/AIDS transform African governance? *African Affairs*, 102, 1 - 23.
- Farmer, P., Connors, M., Fox, K., & Furin, J. (1997). Rereading social science. In P. Farmer, M. Connors & J. Simmons (Eds.), *Women, poverty and AIDS: Sex, drugs and structural violence*. Boston: Institute for Health and Social Justice.
- Felton, S. & Becker, H. (2001). *Regional assessment of the San in Southern Africa: A gender perspective on the status of the San in southern Africa*. Windhoek, Namibia: Legal Assistance Centre.
- Government of Botswana (GOB). (2002). *National HIV/AIDS assessment for the strategic framework: 2003 - 2009 review of the medium term plan II for HIV/AIDS. Second draft*. Gaborone: Government Printer.
- Government of Botswana (GOB/ Ministry of Health (MoH). (2002). *National sexual reproductive health programme framework*. Gaborone: Government Printer.

- Government of Botswana (GOB)/ Ministry of Health (MOH). (2003). *Adolescent sexual and reproductive health implementation strategy*. Gaborone: Government Printer.
- GOB/National AIDS Coordinating Agency (NACA). (2002). *Guidelines on streamlining sectors for effective national response*. Gaborone: Government Printer.
- GOB/ National AIDS Coordinating Agency (NACA). (2003a). *Status of 2002 national response to the Ungass Declaration of commitment on HIV/AIDS*. Gaborone: Government Printer.
- GOB/ National AIDS Coordinating Agency (NACA). (2003b). *Second generation HIV/AIDS surveillance: A technical report*. Gaborone: Government Printer.
- Green, E. & Zokwe, B. (1996). Indigenous healer associations and a South African AIDS-prevention project. In P. Blunt & M. Warren (Eds.), *Indigenous organizations and development*. London: Intermediate Technology Publications.
- Greenway, P. & Swaney, D. (2001). *Botswana*. Victoria, Australia: Lonely Planet.
- Howson, C. P., Harrison, P. F., Hotra, D., & Law, M. (Eds.). (1996). *In her lifetime: Female morbidity and mortality in sub-Saharan Africa*. Washington, D.C.: National Academy Press.
- Jackson, H. (2002). *AIDS Africa: Continent in crisis*. Harare: SAfAIDS.
- Joint United Nation Programme on HIV/AIDS (UNAIDS) and World Health Organization (WHO) (2002). *AIDS epidemic update: December 2002*. Retrieved in October 2003 from <http://unaids.org>
- Kalichman, S. C. & Simbayi, L. (2004). Traditional beliefs about the cause of AIDS and AIDS-related stigma in South Africa. *AIDS Care*, 16 (5), 572–580.
- Kaya, H. (1999). Beyond the Statistics: HIV/AIDS as a socioeconomic epidemic in Africa. In K. R. Hope Sr. (Ed.). *AIDS and development in Africa – A social science perspective*. New York: The Haworth Press.
- Khwe Oral History/ Testimony Programme. (2003). *The Khwe of the Okavango Panhandle*. Shakawe, Botswana: The Teemacane Trust.

- Klein, C., Easton, D. & Parker, R. (2002). Structural barriers and facilitators in HIV prevention: A review of international research. In A. O'Leary (Ed.), *Beyond condoms: Alternative approaches to HIV prevention*. New York: Kluwer Academic/ Plenum.
- Lee, R. B. (2003) *The Dobe Ju/'hoansi (3rd ed.)*. Toronto: Wadsworth.
- Lesetedi, G. (1999). HIV/AIDS and the status of women in Botswana. In K. R. Hope Sr. (Ed.), *AIDS and development in Africa – A social science perspective*. New York: The Haworth Press.
- Le Roux, W. (1999). *Torn apart: San children as change agents in a process of acculturation*. Shakawe, Botswana: Kuru Development Trust.
- Le Roux, W. & White, A. (2004). *Voices of the San*. Cape Town: Kwela Books.
- Marshall, L. (1999). *Nyae Nyae !Kung beliefs and rites*. Cambridge: Harvard University Press.
- Mbilinyi, M. & Kaihula, N. (2000). Sinners and outsiders: The drama of AIDS in Rungwe. In C. Baylie & J. Bujra (Eds.). *AIDS, sexuality and gender in Africa: Collective strategies and struggles in Tanzania and Zambia*. London: Routledge.
- Morris A. (1996). Trophy skulls, museums and the San. In P. Skotnes (Ed.), *Miscast: at the South African National Gallery*. Cape Town: University of Cape Town Press.
- Mwale, G. & Burnard, P. (1992). *Women and AIDS in rural Africa: Rural women's views of AIDS in Zambia*. Aldershot, England: Avebury.
- Nyakabwa, K. (1997). Uganda and the challenge of AIDS. In D. C. Umeh (Ed.), *Confronting the AIDS epidemic: Cross-cultural perspectives on HIV/AIDS education*. Trenton: Africa World Press.
- Nyblade, L., Pande, R., Mathur, S., MacQuarrie, K., Kidd, R., Banteyerga, H., & Kidanu, A. (2003). *Disentangling HIV and AIDS stigma in Ethiopia, Tanzania and Zambia*. Washington, DC: International Center for Research on Women.
- Okafor, J. (1997). AIDS campaign in Nigeria: The effort of the federal government. In D. Umeh (Ed.), *Confronting the Aids epidemic: Cross-cultural perspectives on HIV/AIDS education*. Trenton: Africa World Press.

- Packard, R. M. & Epstein, P. (1991). Medical research on AIDS in Africa: A historical perspective. In E. Fee & A. M. Fox (Eds.), *AIDS: The making of a chronic disease*. Berkley, CA: University of California Press.
- Pakleppa, R. & Kwononoka, A. (2003). *Where the first are last: San communities fighting for survival in southern Angola*. Windhoek, Namibia: WIMSA
- Penn, N. (1996). "Fated to perish": The destruction of the Cape San. In P. Skotnes (Ed.), *Miscast: at the South African National Gallery*. Cape Town: University of Cape Town Press.
- Piot, P. & Pinstrip-Anderson, P. (2002). AIDS: The new challenge to food security. In *AIDS and food security: International Food Policy Research Institute (IFPRI) 2001-2002 Annual Report*. Washington, DC.
- Saitoti, G. (2002). *The challenges of economic and institutional reforms in Africa*. Hampshire: Ashgate.
- San Institute of Southern Africa (SASI). (2003). *Life forces and life choices: ≠khonani San action research on HIV/AIDS*. Kimberly, South Africa: SASI
- Saugestad, S. (2001). *The inconvenient indigenous: Remote area development in Botswana, Donor assistance, and the first people of the Kalahari*. Uppsala, Sweden: Nordiska Afrikainstitute.
- Schoepf, B. G. (2001). International AIDS research in anthropology: taking a critical perspective on the crisis. *Annual Review Anthropology*. 30, 335 – 361.
- Schwab, P. (2001). *Africa: A continent self-destructs*. New York: Palgrave.
- Sikwibele, A., Shonga, C., & Baylie, C. (2000). AIDS in Kapulanga, Mongu: Poverty, neglect and gendered patterns of blame. In C. Baylies & J. Bujra (Eds.). *AIDS, sexuality and gender in Africa: Collective strategies and struggles in Tanzania and Zambia*. London: Routledge.
- Simbayi, L. (1999) AIDS Awareness and sexual behavior change in South Africa. In K. R. Hope Sr.(Ed.). *AIDS and development in Africa: A social and science perspective*. New York: The Haworth Press.
- Simmons, J., Farmer, P., & Schoepf, B. G. (1997). A global perspective. In P. Farmer, M. Connors, & J. Simmon (Eds.). *Women, poverty and AIDS: Sex, drugs and structural violence*. Boston: Institute for Health and Social Justice.
- Smith, A., Malherbe, C., Guenther, M., & Berens, P. (2000). *The bushmen of southern Africa: A foraging society in transition*. Cape Town: David Phillip.

- Stillwaggon, E. (2002). HIV/AIDS in Africa: fertile terrain. *The Journal of Development Studies*, 38, 1-22.
- Susser, I. & Stein, Z. (2000). Culture, sexuality, and women's agency in the prevention of HIV/AIDS in southern Africa. *American Journal of Public Health*, 90 (7), 1042-1049.
- Suzman, J., (2001). *An introduction to the regional assessment of the status of the San in southern Africa*. Windhoek, Namibia: Legal Assistance Centre.
- Symonds, P.V. & Schoepf, B.G. (1999). HIV/AIDS: The global pandemic and struggle for control. *Reviews in Anthropology*, 28, 189-209.
- Tangwa, G. (2002). The HIV/AIDS pandemic, African traditional values and the vaccine in Africa. *Journal of Medicine and Philosophy*, 27 (2), 217-230
- Taylor, M. (2000). *Life, land and power: Contesting development in northern Botswana*. Unpublished PhD theses. University of Edinburgh, England.
- Teemacane Trust. (2003). *Map of Okavango Panhandle*. Shakawe, Botswana: TOCaDI.
- Thapelo, W. (1997). *The traditional Tswana kgotla*. Gaborone: Department of Printing and Publishing Services.
- Tlou, T. & Campbell, A. (1997). *History of Botswana*. (2nd ed.). Gaborone: Macmillan Botswana.
- Trust for Okavango Cultural and Development Initiatives (TOCaDI). (2003). *Map of TOCaDI catchment*. Shakawe, Botswana: TOCaDI.
- Treichler, P. A. (1991). AIDS and HIV infection in the Third World: A First World chronicle. In E. Fee and D. Fox (Eds.) *AIDS: The making of a chronic disease*. Berkley, CA: University of California Press.
- United Nations Development Programme. (1997). *Human Development Report 1997*. New York: Oxford Press.
- United Nations Development Programme. (1998). *Human Development Report 1998*. New York: Oxford Press.
- United Nations Development Programme. (2004). *Human Development Report 2004*. New York: Oxford Press.

Uwakwe, C. (1997). Socio-cultural factors that predispose women to HIV/AIDS in the middle belt of Nigeria. In D. Umeh (Ed.), *Confronting the AIDS epidemic: Cross-cultural perspectives on HIV/AIDS education*. Trenton: Africa World Press.

Webb, D. (1997). *HIV/AIDS in Africa*. Chicago: Pluto Press.

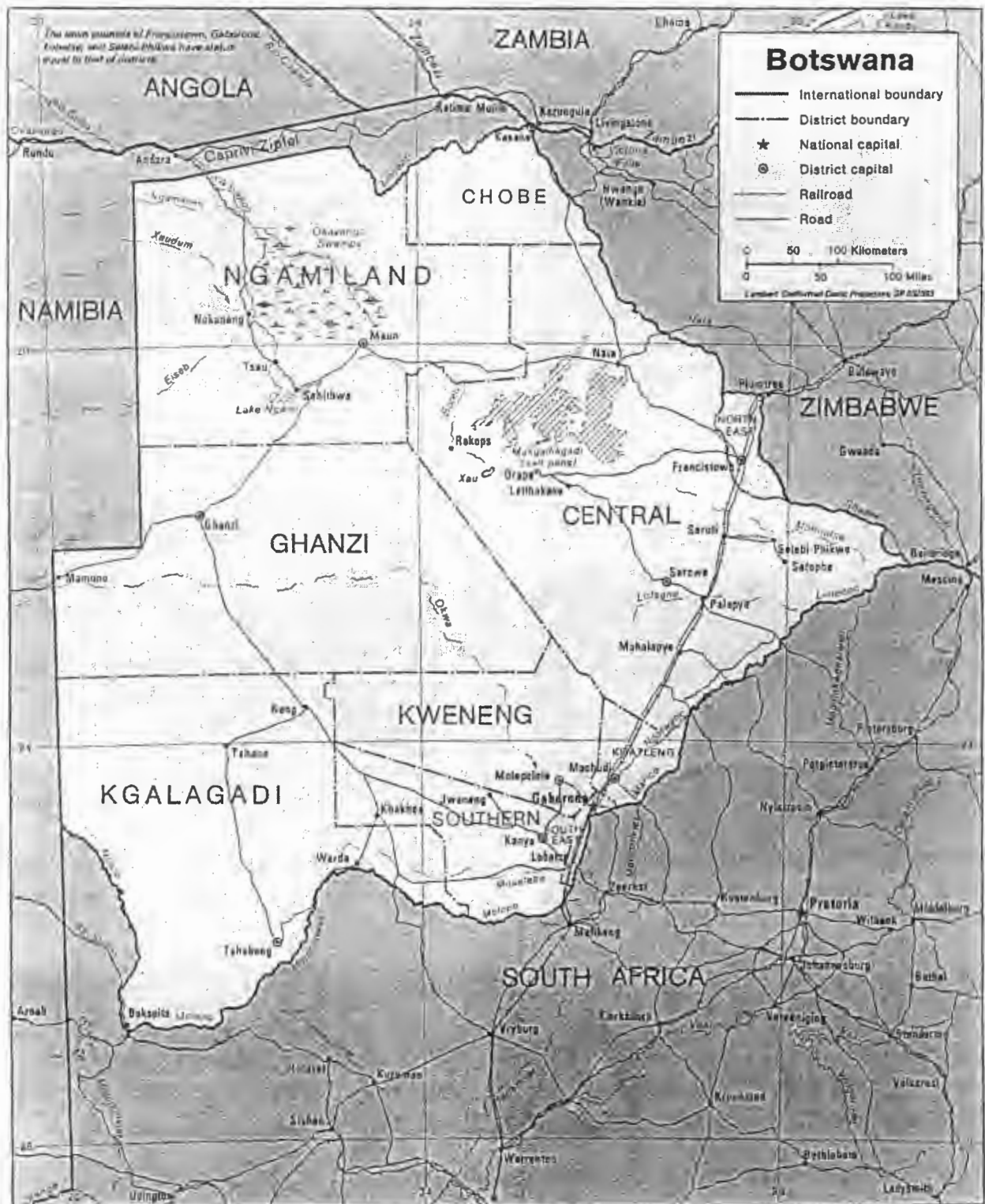
Weiser, S., Wolfe, W., Bangsberg, D., Thior, I., Golbert, P., Makhema, J., Kebaabetswe, P., Dickerson, D., Mompati, K., Essex, M., & Marlink, R. (2003). Barriers to antiretroviral adherence for patients living with HIV infection and AIDS in Botswana. *Clinical Science*, 34. 281-288.

Willis, R. (2002). *The AIDS Pandemic*. Lincolnshire, England: The Stanborough Press.

Wolf, D. L. (1996). Situating feminist dilemmas in fieldwork. In D. L. Wolf (Ed.), *Feminist dilemmas in fieldwork*. Oxford: Westview Press Inc.

www.only-maps.com/botswana-map.html. (2005). *Map of Botswana*.

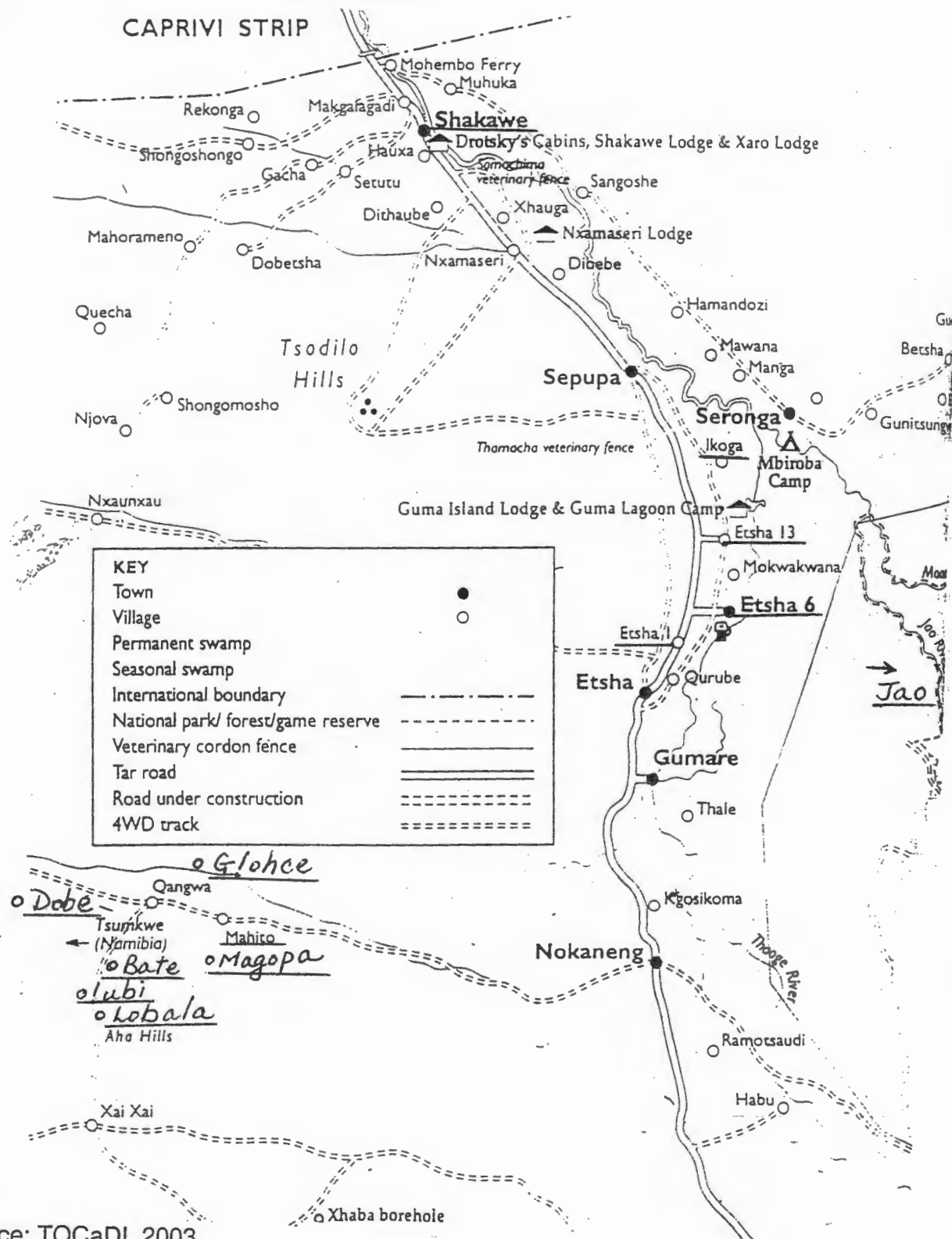
Appendix A - 1: Map of Botswana



Source: www.maps-only.com/Botswana-map.html

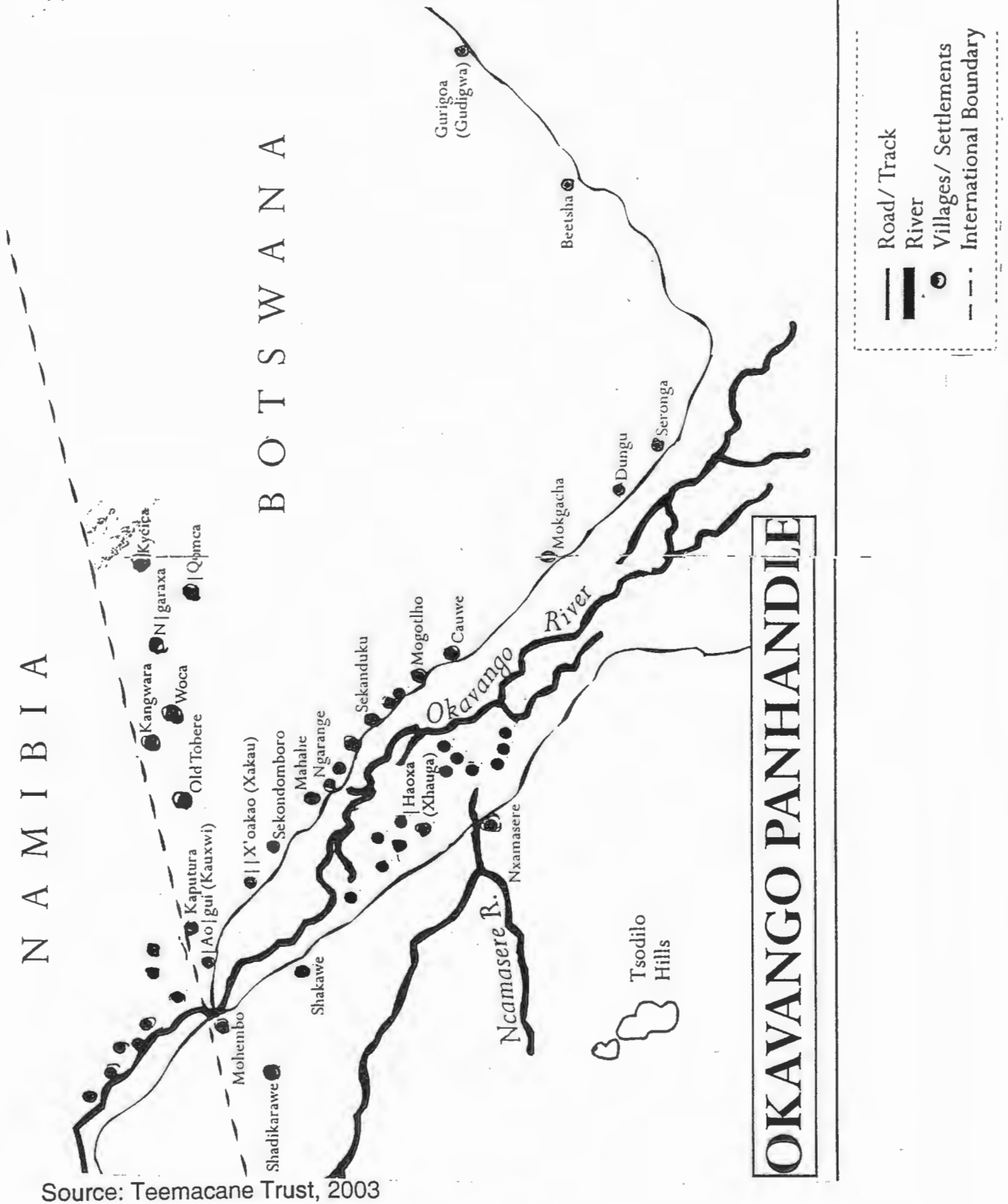
Appendix A – 2: Map of TOCaDI catchment

CAPRIVI STRIP



Source: TOCaDI, 2003

Appendix A – 3: Map of Okavango Panhandle



Source: Teemacane Trust, 2003

Appendix B: Letter of Support from ToCaDI, Member of the Kuru Family of Organizations



Dr. Fiona MacPhail
International Studies
University of Northern British Columbia
3333 University Way
Prince George, British Columbia, Canada

January 26, 2004

Dear Dr. MacPhail

RE: SEIKO WATANABE'S RESEARCH PROJECT ON HIV/AIDS

We are writing to inform you of the status of Ms Watanabe with our organization, the purpose of her research as we understand it and our support of her work.

Seiko arrived in Shakawe in November of 2003 and she will be here for one year; World University Services of Canada supports her with a living allowance while she is working for TOCaDI. Due to the severity of HIV/AIDS in Botswana in general and in this rural area of the country in particular, she has been engaged to mainstream HIV/AIDS into our development and cultural work with San and other marginalized people.

We understand the purpose of Seiko's research for her Master's Project to be as follows: to understand the fundamental needs of the communities in which TOCaDI works with respect to HIV/AIDS and to identify effective intervention strategies. Identifying these strategies will enable her to train TOCaDI staff to effectively help village residents to deal with and help prevent HIV/AIDS. This organization expects to benefit from this research in that it will improve our efforts to reduce the impact of this virus.

We understand Seiko will conduct her research in a participatory manner that will involve all staff, including field workers and managers as well as villagers to the extent possible.

As a NGO that assists community organizations in this depressed area of northwestern Botswana, TOCaDI fully supports Seiko's planned research; we also support her doing her research as an integral part of her work here. We are happy to have her doing her research and we know that her efforts will assist indigenous people here to deal with HIV/AIDS in the future.

Yours sincerely

Willemien le Roux
Culture and Education Advisor
Letloa
Kuru Family of Organisations

Appendix C: Interview Questionnaires
Interview Questionnaire #1 :

Date:
Initial:
Sex:
Age:
From:

1. Please tell me about what you know about HIV/AIDS.
2. Where did you hear about this disease?
3. Can you tell me how it is transmitted?
4. Who are the people who are most at risk of getting HIV?
5. How can you avoid getting this disease?
6. Can you cure the disease? If so, what cures the disease?
7. Is it shameful to have this disease? What is a reaction of your community when someone has this disease?
8. Please tell me the problems you see in your community regarding HIV/AIDS.
9. Please tell me what are the causes of or reasons for the problems you have, in your opinion.
10. Please tell me what needs to happen, or what you want to see happen.
11. What do you think will help to make difference?
12. Do you encounter problems/ difficulties related to HIV/AIDS when you work in your community (CDFs)?
13. What are the problems that the women are facing in the rural area where you live?
14. What can I do to help you to make things better for you or to help you help people?

Interview Questionnaire #2 :

Date:

Name (Initial):

Area:

Age:

Sex:

1. What did you learn about HIV/AIDS during the past four months?
2. Has your behaviour changed? If so, how?
3. Do you know your HIV status?
- 3a. (If the answer is NO) Why don't you know?
4. Do you think traditional cultural values and way of living have changed in your community?
- 4a. Do you think those changes are affecting the spread of HIV/AIDS?
- 4b. What are those changes affecting the spread of HIV/AIDS?
5. Are there traditional values that have affected the spread of HIV? If so, what are they?
6. Do you prefer to go to traditional doctor to the clinic?
Why? When do you go to the traditional doctors?
7. How is poverty in your community affecting the spread of HIV/AIDS?
8. How poverty is affecting treatment and well-being of HIV/AIDS patients in your community?

9. Do you think that women are more vulnerable to infection? Why?
Or, are women disadvantaged in protecting themselves? How?

10. What are the most important changes we have to make?

11. What will help to make those changes?

Thank you for your cooperation.