Life Forces Life Choices

South African San Institute

ǂKhomani San Action Research on HIV/AIDS

Siyanda District, Nothern Cape Province,
South Africa
Commissioned by
UNESCO

LIFE FORCES
LIFE CHOICES

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ACRONYMS IN THIS REPORT

AIDS	Acquired Immune Deficiency Syndrome
CPA	Communal Property Association
CRAM	Cultural Resource and Management Programme
HIV	Human Immuno-Deficiency Virus
HSRC	Human Sciences Research Council of South Africa
IEC	Information and Education Communication
IKS	Indigenous Knowledge Systems
PLWA	People Living with AIDS
PNI	Psycho Neuro-Immunology
SASI	South African San Institute
STD	Sexually Transmitted Disease
TB	Tuberculosis
TKS	Traditional Knowledge Systems
UNESCO	United Nations Educational Scientific Cultural and Communications Organisation
VABO	*Voorkoming van alkoholmisbruik in die Benede Oranje*
WIMSA	Working Group of Indigenous Minorities in Southern Africa

FOREWORD

It is my pleasure to write the foreword for this important piece of action research conducted by Claire Barry and her team of ‡Khomani[1] San[2] health educators. The ‡Khomani community has been through many difficult times during the 20th century. Freedom was a memory while poverty and racism were the daily reality. There were times when the elders were not sure their people would survive to see a new dawn. With the coming of democracy in our country, that new dawn is upon us. The ‡Khomani now own substantial tracts of land, which were taken over by settlers and removed from them by racists and colonial legislation and courts. Daily life is still a challenge but the opportunity to live a dignified and fulfilling life is now within the grasp of the community.

As the ‡Khomani prepare to redefine themselves and identify their appropriate path for ‘development’, they are now challenged by a new reality: the Human Immuno-Deficiency Virus. HIV, known to cause the Acquired Immune Deficiency Syndrome (AIDS) has devastated many communities across Africa and around the world. HIV does not know colour or language, geography or sexual identity. It only knows its transmission routes and how to occupy its human host, wherever he or she may be.

It has been my great privilege to work with ‡Khomani elders in understanding their culture better and turning this into a resource for the next generation. In this report we see a vivid example of how old knowledge and the core culture of the San people can be a resource for facing this newly arrived epidemic. In particular, the knowledge system of the elders may represent an important new (or rather ancient and rediscovered) paradigm for coping with AIDS in a resource poor community.

Ouma |Una Rooi is one of the last ten N|u speakers on earth. The N|u language is the last of the !Ui language family that once spread right across South Africa before it was eradicated by colonisation. Ouma |Una explained two counter-balanced concepts in her ancient language. |Qo[3] is a devil or evil spirit, capable of possessing an individual and bringing them great suffering. |Qi on the other hand is ‘life force’. All living things are infused with this power. This concept of inherent life force features at the core of the observations from shaman and healers and described in this report.

1 San languages are so phonetically complex that they have additional letters to represent their unique click consonants. The clicks used here are based on the International Phonetic Association standard alphabet. ‡ (palatal), ! (alveo-palatal), | (dental), || (lateral). The bilabial click is represented as ‘ǂ’ in the N|u language. N|u is also known as ‡Khomani and ||Ng of Gordonia / Postmasburg. It remains unclear where the term ‡Khomani came from or who it designated. It is possible that either there was a mix up or that the term ‡Khomani was an exonym given by another group to the San of that area. This confusion of terms is significant as it plays out in the lives of the descendants today. The amalgam of different people of San ancestry adopted the name ‡Khomani to represent the identity of their newly re-united community.

2 The ‡Khomani San are also known as the Kalahari Bushmen. Traditionally San groups have identified themselves according to individual languages… almost all labels referring to San collectively were coined by non-San and are pejorative. (Berger and Masive 2002: 9)

3 The ‘q’ indicates that the vowel is pharyngealised, as with a’a in Arabic.

In brief, both humans and HIV have |qi. It is ignorant to think that one is ‘better’ than the other. They just both ‘are’. Where prevention has not been successful, the challenge for the healer is to help the human host and the virus find a balance to live with each other. The idea that illness is caused by sin or a vengeful God is absent from this hunter-gatherer worldview. It is much closer to the views of Western scientists, although entirely couched in the non-literate culture of the world’s First Peoples.

This report was written out of the experiences of a team of people facing health care and survival challenges in the southern Kalahari. They have awoken something in the hearts of a people who are busy trying to know themselves, to remember their past and build their future. It is an excellent example of how indigenous knowledge can be linked to world knowledge and science to help empower a community.

It is fitting that this first San action-research project on HIV / AIDS was launched and funded by UNESCO. UNESCO is one of the most influential international bodies attempting to protect our diverse global cultural heritage. UNESCO, through its programmes and the General Conference, creates forums for dialogue about the importance of seeing cultural diversity as a resource and source of wealth. Recent initiatives inside UNESCO are creating new opportunities for indigenous peoples to defend their cultural self-determination and participate on an equal footing with dominant peoples.

The UNESCO Universal Declaration on Cultural Diversity (UNESCO 2002) sets out a platform that links together issues of cultural diversity, economic development, the role of the state in managing diversity and valuing pluralism, and the promotion of diverse voices in national and international media and communications. The Director General of UNESCO has also dedicated budgetary resources for supporting the use of Information and Communication Technologies (ICTs) by indigenous peoples.

It is against this background and the objectives of the International Decade of the Worlds Indigenous People (1995-2004) that this project is implemented in close co-operation with the Division of Cultural Policies and Intercultural Dialogue (UNESCO) with the National Commission for UNESCO of South Africa, other national authorities as well as the various leadership structures and networks of the southern African San populations.

SASI thanks UNESCO for its generous support. We also extend our most sincere thanks to Claire Barry and her team for their exciting work and we hope that you, the reader, take something valuable away with you.

Nigel Crawhall, SASI Cultural Programme Manager
August 2003

INTRODUCTION

South Africa has one of the fastest growing HIV infection rates in the world.[4] The epidemic, which has been making its way down the continent, is now well established in the urban areas and some rural areas. The migratory labour practices draw the viral infections into rural communities with devastating results. The high incidence of teenage pregnancies, lack of proper knowledge about the virus and methods of transmission and various cultural malpractice compounds the problem.

Whereas there are specialized clinics, anti-retroviral programmes and other care and support programmes in the major metropolitan areas, the rural areas of South Africa are typically poorly serviced. The southern Kalahari region is one of the most remote areas of this country. It has a low density population of some 1000 adults covering a vast area of which a few hundred are resettled on reclaimed land and more are moving into the area.

This project represents the first practical experience of the South African San Institute (SASI) in implementing the conceptual and methodological framework of the joint UNESCO/UNAIDS Project "A Cultural Approach to HIV/AIDS Prevention and Care", with a view to contribute to sustainable human development in South Africa.

During 2002 the ǂKhomani San in the Kalahari experienced a health crisis in relation to the spread of tuberculosis (TB), Sexually Transmitted Diseases (STDs), teenage pregnancies. The general lack of institutional support to the San, one the most marginalized communities in one of the most remote parts of the country, contributed to this crisis. Less than 10 years ago a formal village life was non-existent in Andriesvale[5]. This community was relocated here as a success of the land claim[6] and hence is still forging a sense of community spread over an area of six farms. By and large it was left to non-governmental organizations (NGOs) and volunteers to assist and support this community in building a life for themselves in their new environment. There is no clinic or school, no public transport or church, no community centre or sports facilities; sparse telephone communications with no landlines are available. There is one local grocer and a tourism lodge and no normal television reception is available for this area.

4 see also in this report the section HIV/AIDS Telling It Like It Is
5 Andriesvale is a village about 60 km outside the Kgalagadi Transfrontier Park just outside the border of Botswana. See the Map on page 23
6 In 2002 the land claim was finally resolved to award the San:
- Ownership of over 26 000 hectare of the KTP where they are entitled to hunt, gather, conduct ecotourism ventures.
- Commercial rights over an area between the Park and the Auob river. They alone are entitled to conduct walking or camping tours, all guided and protected by trained San trackers.
- Symbolic and cultural use rights over an area of approximately 4000 square kilometres, where they can visit traditional hunting, gathering or symbolically important sites and two Hotel lodge developments, the one a shared development in the contract park with the adjoining contract park owned by the Mier community, and the other a luxury lodge at the confluence of the Auob and Nossob rivers.

The survival of ‡Khomani San in South Africa is very fragile and important. San hunters-gatherer are the descendants of the first *Homo sapiens* who have occupied Southern Africa for the last 120, 000 years (see also page 23). They are an indigenous group of people who are still steeped in tradition and culture and as a result were able to endure. Any attempt in addressing the HIV/AIDS issues amongst the San requires a cultural approach, as does any other development work.

This is the community and environment that was to be the site of focus of SASI-UNESCO Action Research project on HIV/AIDS.

PART 1 — THE STARTING POINT

PURPOSE AND OBJECTIVES OF THE RESEARCH PROJECT

1. To design and implement an action research project with the ‡Khomani San from the perspective of the UNESCO/UNAIDS Cultural Approach to HIV/AIDS prevention and care. It includes:
   - Researching current perceptions, knowledge and attitudes of youth and adults to HIV/AIDS,
   - Investigating traditional methods for immune boosting, identifying ethno-botanic knowledge that may play a role in future prevention and care programme.
2. To train a select few youth and adults in action research techniques and health promotion techniques that would constitute a core group of field workers and HIV/AIDS activists.
3. To promote awareness amongst the local San community by:
   - Running workshops on reproductive health and gender empowerment
   - Conducting HIV/AIDS awareness workshops.
   - Dissemination of relevant HIV/AIDS information media with a view to raise consciousness and awareness and to combat misconceptions and negative myths about the disease.
4. To assist the community in improving the management of the growing TB infection and treatment situation in the Kalahari because of its close relation to HIV/AIDS (see section on Tuberculosis)

A CULTURAL APPROACH TO HIV/AIDS ☐ The Methodological Framework

Firstly '**cultural'** in this context refers to the definition of culture as set in the preamble to the Mexico Declaration on Cultural Policies (UNESCO, 1982), which defines culture as "…*a set of distinctive, spiritual and material, intellectual and emotional characteristics, which define a society or social group. In addition to the arts and letters, it encompasses ways of life, the fundamental rights of the person, value systems, traditions and beliefs*'.

Those adopting an epidemiological approach frequently misinterpreted the cultural references and resources as defined above as monolithic, rigid systems, which cannot be modified or adapted, since they are supposed to represent an intangible asset, which is to be protected unconditionally[7]. Observing real situations clearly

7 Theoretical issues regarding this have been adequately addressed by Michel Caraël in his paper *The dynamics of HIV epidemics in Sub-Saharan Africa: What are the determinants*? Delivered at the Nairobi Inter-regional Conference on A Cultural Approach to

shows that there is not necessarily a contradiction between culture and change, since all societies and cultures evolve over time :

- Initially, because of their intrinsic dynamic aspects, and
- Secondly, because they interact with all kinds of external economic, social and cultural transformation processes.[8]

The *Declaration of Commitment on HIV/AIDS*[9] was adopted by the Special Session of the United Nations General Assembly on HIV/AIDS held in June 2001. Paragraph 20 of this declaration states that such a framework should be " ***emphasizing the role of cultural, family, ethical and religious factors*** *in the prevention of the epidemic and in treatment, care and support, taking into account the particularities of each country as well as the importance of respecting all human rights and fundamental freedoms "*[10]

As regards HIV/AIDS prevention and care, taking a cultural approach means that any population's cultural specificities: ways of life, value systems, traditions and beliefs, fundamental human rights, will be considered as key references for policy, planning and implementation in prevention and care. They will also be seen as resources and as a framework for action, in order to obtain in-depth and long-term changes in people's behaviors and giving full consistency to medical and sanitary strategies and projects, Information and Education Communication (IEC) and appropriate capacity building.

This needs to meet a number of requirements:

1. Grounding actions on mentalities, traditions, beliefs and value systems, for practical and ethical reasons. Actually, some of these may hamper needed changes, if they are not correctly identified and will anyhow interfere with the action taken. Moreover, it belongs to populations themselves to re-evaluate their corpus of traditions, in the perspective of beneficial change as seen by them.
2. Mobilizing the cultural resources of the given population, in order to benefit from their support, in order to bring about the necessary changes in thinking

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HIV/AIDS Prevention and Care 02-04 October 2000, that was convened by UNESCO, in cooperation with the African Itinerant College for Culture and Development and the Kenya National Commission for UNESCO. (Cf. UNESCO 2000b: 45-58)

8 UNESCO 2001a: 9

[9] *Declaration of Commitment on HIV/AIDS*, U.N. G.A. 26th Special Sess., U.N. Doc. A/Res/S-26/2 (2001), New York, U.S.A, June 25-27, 2001 [hereinafter *Declaration of Commitment*]. The Declaration also relies on the pledges made at regional conferences held in the months leading up to the Special Session, including the Abuja Declaration and Framework for Action adopted by African governments; the ESCAP Regional Call for Action to Fight HIV/AIDS in Asia and the Pacific of April 2001; the Caribbean Partnership Against HIV/AIDS of February 2001; the European Union Programme for Action: Accelerated Action on HIV/ AIDS, Malaria and Tuberculosis in the Context of Poverty Reduction of 14 May 2001; and the Central Asian Declaration on HIV/AIDS of 18 May 2001. *Id.* 6, 40.

10 Handbook for Project Design, Implementation and Development, UNESCO 2001b.

and behaviors regarding sexuality through the joint identification of issues, needs and action to take.

3. Contextualising the HIV/AIDS issue within the socio-economic conditions, in other terms, situations of extreme poverty.[11]

In dealing with HIV/AIDS within a cultural framework we will have to deal with both tangible and intangible cultural resources. Crawhall as described in Written in the Sand defines these[12].

It is not the task of this report to argue the applicability and the pros and contras for adopting a cultural approach to HIV/AIDS prevention and care, a case for such an approach has been successfully motivated through the myriad of literature available on this matter developed both by UNESCO and numerous academics and practitioners internationally.

The experiences discussed at the Kampala Conference have made a strong case for such an approach. It is against this background that the South African San Institute had made a strategic decision to adopt the *cultural approach* as the most appropriate framework in its work on HIV/AIDS amongst the ǂKhomani San in the southern Kalahari.

The main task of this project was to test the methodology of the cultural approach developed by UNESCO in the San population of the southern Kalahari.

[11] UNESCO, 2000: 10

12 Crawhall 2001: 12

Tangible cultural heritage

A tangible heritage is one that can be stored and physically touched. This includes items produced by the cultural group such as traditional clothing, utensils (such as beadwork, water vessels) or vehicles (ox wagon). Tangible heritage also includes monuments such as pyramids, temples, market places and public buildings. Though a tangible heritage can perish it is generally more obvious how it can be conserved than items of intangible heritage.

Intangible Heritage

An intangible heritage is that which exists intellectually in the culture. It is not a physical or tangible item. Intangible heritage includes songs, myths, beliefs, superstitions, oral poetry, as well as various forms of traditional knowledge such as being able to read animal tracks. Tracking involves practical skills that anyone can learn over time, but it is an intangible heritage when it is informed by stories and information passed from generation to generation. For the Southern Kalahari San, each tree and many other physical sites are as part of their intangible heritage as their history is associated with these sites through stories, names, healing practices and songs.

GUIDING PRINCIPLES AND STRATEGIC APPROACH

A number of principles need to be considered when embarking on any **intervention** that seeks to address issues of health with a hunter-gatherer people who are economically and politically extremely vulnerable and yet are also culturally and intellectually rich with a strong knowledge based linked to the ecology of the environments. *The approach taken in conducting this programme has been the Cultural Approach developed by UNESCO* whilst drawing on the integrated method of Behavioural medicine (i.e. mind-body medicine). We found that within the field of Behavioural medicine, Psycho neuro-immunology (PNI)[13] was an important base which we could identify with and could inform our work.

In this programme we have addressed a number of critical challenges prevalent in the ‡Khomani San Community. We began by constructing the basic guidelines that need to be considered in any culturally appropriate health related intervention such as this. Bearing this in mind, we explored an integrated programme, constantly taking into consideration the wellness and development of the individual on all levels. These levels include physical, emotional, mental, cultural and spiritual.

The challenge in an emerging discipline has always been in its clinical application. Behavioural medicine as we know it today, is not based on any one system of healing. It is eclectic and acknowledges the research, techniques and therapies suggested by contributors from various disciplines. In a community as diverse and unique as that of the ‡Khomani San there are no simple answers. Thus we have attempted to develop strategies for clinical application by means of Behavioural medicine in all areas of healthcare. As a result we developed a holistic understanding of the relationship between culture, psychosocial factors, behaviour, immunity and health and this has been central to all our work.

The concepts, ideas and interventions used in the programme, have of necessity, been exploratory. The programme being only six months in duration and the community exposed to such for the first time has inevitably meant that all interventions have been offered on a basic initiatory level. This has been the first time a health programme of any nature has been available to this community.

Behaviour change communication reflects the emphasis on relevant processes for attitude and behaviour change rather than information giving only. Wouters and

13 Psycho neuro-immunology (PNI) is a complex multi disciplinary field that spans immunology, psychology and neuroendocrinology. PNI research forms the foundations of the bio-psycho-social model, our understanding of psychophysiology, and supports the work carried out in the field of Behavioural Medicine, which extends beyond the scope of PNI but includes it. The field of Behavioural Medicine was officially named in 1977 at the first Conference on Behavioural Medicine at Yale University and was born from the need to develop a clinically based speciality that would take into account the research from the field that was later to become PNI.

Simonetti (2001) describe a practical behaviour change model outlining a step-wise continuum towards effective and sustainable behaviour change. They emphasise the need for situational analysis of personal, socio-cultural and other environmental forces, which reinforce behaviour change.

The guiding principles of de Koker[14] have also informed our previous behaviour change interventions in addressing health issues amongst the ‡Khomani San including dealing with HIV/AIDS. It is imperative that any intervention:

- should facilitate the awareness and transformation of behaviours, perceptions and responses that are risk factors for disease;
- should facilitate a change in behavioural and physiological response to enhance well being;
- should improve compliance to any chosen treatment;
- should facilitate a change in the way health care providers, at all levels, approach people with mental or physical illness, and assist in supporting them in their efforts to improve health and alleviate suffering;
- should acknowledge the basic right of people to participate actively in their healing process.

DATA COLLECTION, MANAGEMENT AND ANALYSIS

Principles of collecting data

The following data collection guidelines were agreed with stakeholders and respondents alike:

1. This research, launched jointly by UNESCO and SASI is done with the permission and co-operation of the San community in the southern Kalahari and their representative bodies including the CPA, San Council of South Africa, The San Council of Elders, SASI and the Working Group of Indigenous Minorities in Southern Africa (WIMSA).

2. The San community today speaks Afrikaans as their first language, and therefore all materials and interviews would be conducted in Afrikaans. The final results will be made available to the San in the language of their choice being Afrikaans.

3. Another important principle that was employed is the issue of anonymity of respondents, even though the respondents did not feel it important.

14 De Koker 2002

Instruments and methods of data collection:

Various methods of qualitative research have been used for the study, in particular:

Fieldworker training workshops

20 workshops were held in total some of which the six fieldworkers were trained to assist with the research and information dissemination. These workshops also served as an invaluable resource where the lessons learnt helped shape the design of further research work.

Desk research

Gathering existing information in the Northern Cape and nationally.

1. Internal and external organisational reports.
   These include reports from within the organization of previous development work done amongst the ǂKhomani San and other San communities. This information informed much of the work of this programme as well as this report.

2. The Internet
   The Internet has been valuable in keeping abreast with current statistics, debates and HIV/AIDS reports and other national and international thinking around this issue.

3. Statistics, books, articles from various sources including media, libraries, resource institutes, resource centres and other researchers.

Questionnaire

A sample of 80 out of a possible 180 respondents were chosen randomly in the community to test their knowledge on HIV/AIDS, to analyse the existing knowledge, attitudes, beliefs and behaviour.

The questionnaire was designed with full participation and involvement of persons from local San leadership, youth and elders who are fully grounded in this community and have a firm understanding of the issues facing the San, its history, traditions, social norms, values and culture.

As members of the San community are not used to filling out forms and long questionnaires we decided that it will not be wise to do this in a single group, that it should be conducted on a one-to-one basis and small groups. Where low levels of literacy existed a member of the research team should lead the

questions and do the recording her/himself. Although this is admittedly a tedious task it was clearly the most appropriate method.

The research team were thoroughly trained before embarking on the information gathering fieldwork.

Semi-structured interviews

Several semi-structured interviews were conducted with key informants. This method of data collection was mainly employed with the elders and youth who were central to the CRAM programme, members of the Council of Elders, and particularly the ǂKhomani San Traditional leader. It served to be a valuable means of information gathering since most of the elders in the San community have had very little or no formal schooling and is not "literate", in the conventional sense i.e. as far as reading and writing is concerned.

In-depth Interviews

In-depth Interviews with strategic elders were conducted to establish traditional knowledge and resources available. This method of data collection was mainly employed with the traditional healers, San leadership, members of the Council of Elders, the CPA and particularly the ǂKhomani San Traditional leader.

Information Dissemination workshops

Workshops with the CPA – the association that manages the land claims and represents the community at a political and socio-cultural level.
Discussion Workshops with youth - Discussions were held with selected community members and groups with the objective of learning more about their cultural beliefs, sexual behaviour and attitudes, their treatment-seeking behaviour and their attitudes to life-threatening illness.

Other field activities were:

Four medicinal herb collection field trips were undertaken with elders into the desert. Awareness programme for youth at World AIDS Youth Rally

Audio recordings and note taking

These instruments were extremely valuable for analysis of information collected during informal discussions and interviews. As many of the elders are not "literate", a lot of the information was in the form of long stories. An oral tradition is part and parcel of San culture and day-to-day life.

Data Management, Processing and Analysis

This became a daunting task as new information constantly came to the fore. Keeping track of information from various activities and field workers was only possible with regular reflection sessions by the research team. The Project co-ordinator regularly consulted with the Programme Manager.

In the analysis of the data, stakeholder involvement was crucial. As far as possible the fieldworkers who come from within the San community were involved because they were partially in a better position to make value judgements and long after the research would be done the project would live in their community.

As all communications and research conducted was done in the local language-Afrikaans, all data first had to be interpreted properly and translated into English and then captured electronically for proper processing and analysis. This was done with the participation of some elders and youth from the San community. The field workers played an invaluable role in this process.

Analysis of data was done thematically.

THE ACTION RESEARCH TEAM IN TRAINING

Six Fieldworkers from within the community commenced training at the outset of the HIV/AIDS Action Research Programme: two adults and four youth (with one person on each farm). Three youth did not complete training, of which two young men found more lucrative employment. The third person to leave the programme had proved to be too young (16 years) to cope with demands of the fieldwork. The youth who left the programme completed half the course work. The skills they acquired i.e. through the HIV/AIDS awareness and training as well as the practical First Aid training are still within the community.

The three remaining Field Workers have proved to be dedicated and enthusiastic community workers and completed the full programme as indicated in Table 1.

As the ǂKhomani San Groups living on the farms are at least 6 km from the central point, Andriesvale, it is necessary for each farm to have a trained Field Worker. No public transport or telecommunications exist for people living on the farms. Youth keen to participate in such training have been identified.

TABLE 1: Tuition and Attended Workshops

SUBJECT	**DETAIL**
Questionnaire research methods	Field Workers were taught basic skills on compiling a questionnaire and interview techniques
HIV/AIDS	Information and the dissemination of information. Care and counselling for people with HIV/AIDS
First Aid	A training course was given by Metro West Ambulance Service
Gender Based Violence	Presented by the Victim Support Centre from Upington. Field Workers attended six workshops
Substance Abuse	VABO[15] introduced their Horizon and Cottage Programmes. Field Workers attended six Workshops
Field Trips	Field workers were present at the majority of interviews held with Elders and participated in all four field trips

See also Appendices for Profile of Action Research Team

15 Prevention of Alcohol Abuse in the lower Orange River region

PART 2 — THE CONTEXT

BACKGROUND TO THIS PROJECT

The ‡Khomani San in the Kalahari experienced a severe health crisis during 2002. This crisis involved mainly the spread of tuberculosis, STDs, teenage pregnancies. The general lack of institutional support to the San, one of the most marginalized communities in one of the most remote parts of the country contributed to this crisis. The Project co-ordinator of this action research project worked amongst the ‡Khomani San as a volunteer at the time, to help alleviate this problem.

By mid-2002 she approached SASI to assist in establishing a local health support programme in response to these health concerns in the Kalahari. The programme included HIV/AIDS prevention and care work. It is in this context that an action research project developed.

This laid the foundation for an HIV/AIDS programme amongst the ‡Khomani San in the southern Kalahari with the aim of implementing and practically applying the joint UNESCO/UNAIDS cultural approach, conceptual and methodological framework. The strategy was to engage and involve the ‡Khomani San themselves in identifying and addressing the problems and issues in their struggle against HIV/AIDS taking into account their own cultural references and resources.

It should also be noted that this project was undertaken against a background of other important research work already conducted and still in process such as the Cultural Resource and Management Programme (CRAM) also supported by UNESCO as well as the SASI Ethno-ecological project. SASI has been working in partnership with several international agencies to help the San community audit its traditional knowledge and identify cultural resources that can help it build a better future[16]. The basic premise is that hunter-gatherers such as the ‡Khomani San possess highly sophisticated knowledge of their environment and natural resources and have been able to harness these resources to ensure their survival for millennia.

During 2000 to 2001, the CRAM programme concentrated on identifying the botanical and ecological knowledge of the elders. Several of the San traditional medicines have been identified as useful immune boosters and helpful for treating opportunistic infections. (see also the Ethno-botany section below)

16 For a full report of this work refer to Written in the Sand by Nigel Crawhall,

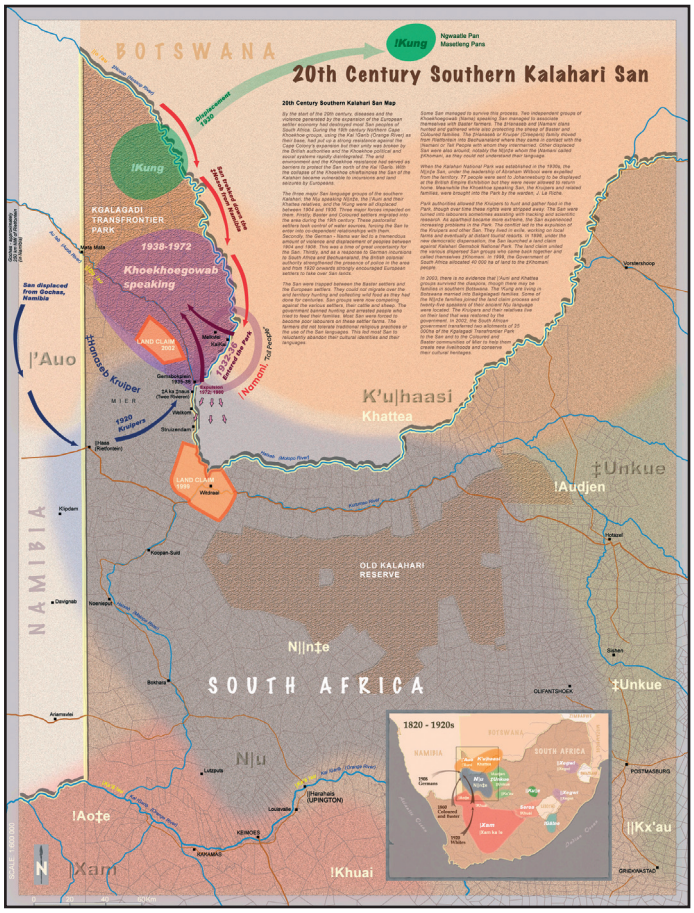
By November 2002 the SASI Action Research Project on HIV/AIDS was launched. The basic considerations that underpins this initiative can be summarized as follows:

a) HIV/AIDS should be located in a broader approach to health promotion in the context of the interaction between HIV/AIDS, culture, indigenous knowledge systems (IKS) and human development.
b) The San people possess a great deal of knowledge about traditional healthcare and this can be a valuable resource at minimal cost.
c) Anti-retroviral therapy or even basic medicines are unlikely to become readily available in the rural areas of South Africa and particularly the southern Kalahari and as a result there is an urgent need for prevention, as treatment needs to rely mainly on immune boosting and stress reduction techniques as well as reduction in alcohol consumption.
d) It is important that bio-medical knowledge about how the virus works and its transmission methods are introduced into the San community and to mesh these with existing concepts of health and sickness in order to dispel existing taboos, myths and misconceptions around HIV/AIDS.
e) Creating an alliance between youth and elders is strategically significant in that it revitalizes social institutions, promotes self-respect, becomes a means for the transfer of traditional and cultural knowledge and gives the youth a stronger ethical and moral framework than that which they have experienced thus far.
f) The adult community is likely to experience high rates of infection and are the least likely to modify their behaviour. Nonetheless education and building a culture of compassion is important to help this constituency.

THE ‡KHOMANI SAN — About The Past, About The Future

The San are the first peoples of Southern Africa. Most indigenous peoples were decimated during the process of colonisation in South Africa. The only San community to survive with their identity, some of their traditional knowledge, language and culture intact are the ‡Khomani San. The ‡Khomani San are spread over several thousand square kilometres of the Kalahari Desert in the magisterial district of Siyanda, Northern Cape Province, South Africa.

In recent prehistory, it appears that the first peoples of South Africa were all from one language family, known as !Ui or Southern Khoesan. They were pushed into remoter and drier regions by two major relatively recent migrations of other peoples. 2000 years ago the sheep and cattle herding Khoekhoe peoples migrated down from Namibia and Botswana, pushing !Ui speaking peoples away from the coast and river areas. 800 years ago a major migration of Black, Bantu-speaking peoples entered eastern South Africa. These food-producing people brought with them cattle, agriculture and metallurgy.



MAP 1: Showing location of San in the Southern Kalahari

It appears that the early relations between hunter-gatherers and the agro-pastoral peoples was positive and involved a high degree of intermarriage and yet the retention of the independence of San languages and culture. This changed with the arrival of European explorers and settlers in the 16th and 17th centuries. The expansion of European colonisation caused a great strain on land resources. !Ui speaking hunter-gatherers were victimised by the European settlers as well as Khoe and Bantu-language groups who were all competing for resources in the face of European territorial expansion. (WWW.sanculture.org.za)

Over the next three hundred years warfare, disease and other genocidal conditions destroyed most San peoples in South Africa. Today, there are only about 1500 San of South African origin, a further 5000 San who have emigrated to South Africa, and some 90 000 San in neighbouring Namibia, Botswana, Zimbabwe, Zambia and Angola.

Under the racial administrative system of Apartheid[17] (1949 – 1993), all indigenous peoples were forced to be registered as other racial groups, with most being classified as "Coloured" or mixed race. With the process of democratisation in South Africa, the government has taken certain steps to recognise the particular vulnerability of indigenous peoples, notably the ǂKhomani San. The constitution, for example, recognises the need for affirmative action with regards the languages of the Khoe and San peoples.

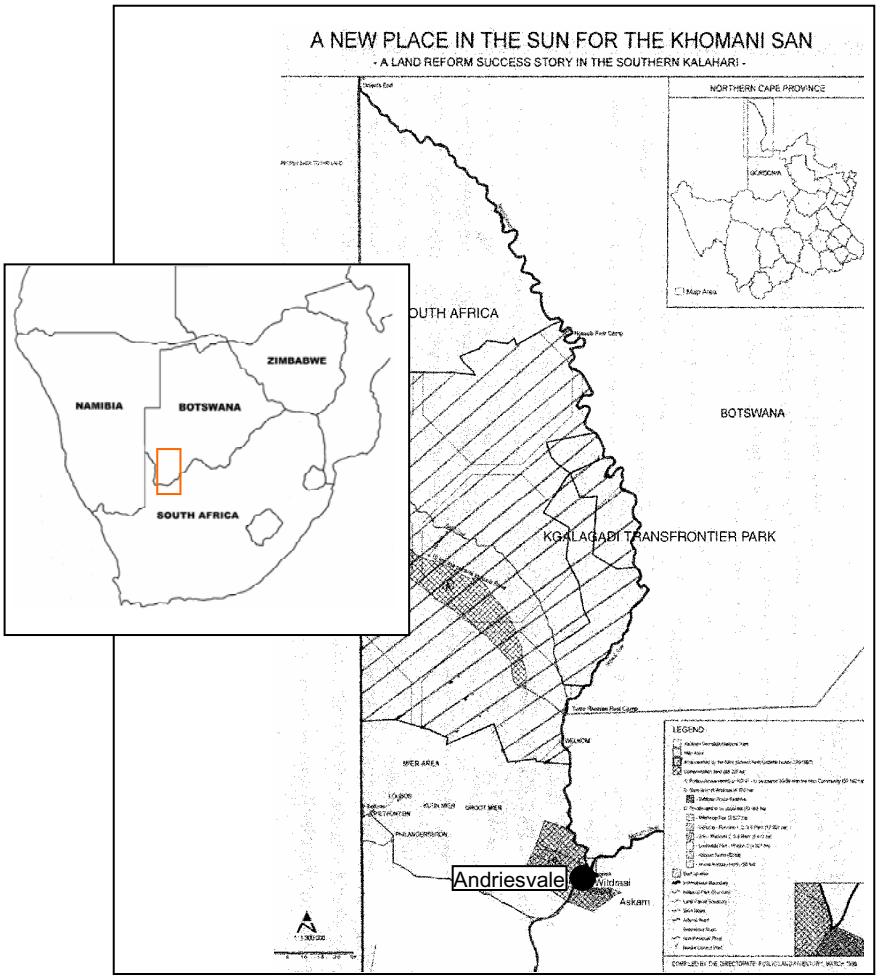
The last peoples to be affected by the European expansion were the peoples of what is now Siyanda District. This territory, away from the Orange River, was so dry that none of the food producing peoples could penetrate it easily with their cattle and crops. Various San groups co-existed in the area until the 20th century when settler technology allowed the European and Coloured settlers to sink boreholes and seize the lands of the San. From 1920 onwards most San were forced into various types of poverty and servitude. Most of the !Ui languages rapidly died out. **Today only eleven elders still speak N|u, the last of the !Ui languages.** A sizeable portion of the ǂKhomani community (a composite of the various surviving San peoples) speaks Khoekhoegowab, and all community members use Afrikaans as a first or primary language.

In August 1995, the surviving core members of the ǂKhomani San community worked with SASI to formulate and launch a land claim on behalf of their community. On 21 March 1999 (Human Rights Day), Deputy President Thabo Mbeki and the then Minister of Land Affairs, Derek Hanekom, presided over the most joyful and

17 Apartheid means separateness in Afrikaans. It was the official policy of the White minority government of South Africa from 1950-1991 to separate racial and language groups into different territories with different economic opportunities that favoured the White population.

significant land claim yet to be resolved in South Africa. This country's acknowledgement of the aboriginal land rights of its First People has received wide international coverage. The community now collectively owns 40,000ha outside the Kgalagadi Transfrontier Park and 25,000ha inside the Park.

Bredekamp quotes President Mbeki saying: "*I owe my being to the Khoi and San whose desolate souls haunt the great expanses of the beautiful Cape - they who fell victim to the most merciless genocide our native land has ever seen, they who were the first to lose their lives in the struggle to defend our freedom and independence, and they who, as a people, perished in the result*" (Kuper 2003:192)



MAP 2: Showing the site of practice and the land claim

Geographic area

The southern Kalahari is a desert region with no surface water some 300 kilometres north of the Orange River. Through years of community research and outreach over about 400 people have been registered on the land claim that was granted. Further research has shown that another 1000 direct descendants are still found scattered

over a 250 km radius throughout the greater Gordonia district. A large amount of San lives in the Upington area, which is historically a predominantly “coloured” area. The others lives from as far as the remote Rietfontein, next to the Namibian border to Olifantshoek almost 500 km to the East.

The research team operated from a centre on one of the farms, known as Brosdoring, in Andriesvale (see Map 2). This is a central development node for the six farms reclaimed in the ǂKhomani San Land Restitution claim (details on the claim see Page 9). The nearest small rural town is called Askam 15 km away, and the closest town is Upington located about 200 km to the west of Askam.

CULTURAL HERITAGE AND INDENTITY OF THE ǂKHOMANI SAN

As part of their land claim process and to help restore a sense of identity and pride to the community, the ǂKhomani San embarked on a ‘cultural audit’ of the knowledge of their elders. SASI and its British partner, Open Channels, supported this project. This work has led to numerous community initiatives including ethno-botanic research, tracker training and accreditation programme, new tourism ventures, a successful arts and crafts project, and new projects in fabric painting and tour guiding. The methodology of the work has been published by UNESCO’s Division for Cultural Policies and is available on the Internet at www.sanculture.org.za

ǂKhomani culture has been strongly influenced by their unique climate and ancient occupation of this territory. The territory, once solely occupied by the San was a vast and diverse area. Surface water is rare and often non-existent. People rely on infrequent rains or on important water-bearing plants such as the wild *tsamma* melon (citrillus lanatus). Wild animals were once in abundance, hence hunting remained a major source of nutrition into the 20th century. The desert is host to many important plants that have both nutritional and medicinal value.

The San emphasise that their view of life was to accept nature and live with it, rather than attempt to transform the world to suit human needs. Their houses were temporary and they moved across the land using special techniques to access food and water while maintaining the fragile ecosystem. Precisely how integrated San life was with nature is difficult for the left-brain, patriarchal system of western society to grasp today. An economic and cultural system that was non-hierarchical with a rich spiritual life ensured peaceful co-existence of peoples in this arid land. Artificial geographical borders did not exist. Management of population numbers also helped protect the delicate ecosystem.

“The nomadic hunting and gathering lifestyle of the San dictated that small family bands were the most efficient method by which they could move through the Kalahari and adequately provide for their members. The average band was a fluid group, which fragmented and realigned continuously. It was interrelated with other bands through ties of kinship, marriage, friendship and trade.” (Bishop K 1997:2)

Dominant, aggressive cultures have always shown a lack of sympathy, understanding and acceptance when such come into contract with, what are seen as, less sophisticated societies. San knowledge systems are based on the complexity of biodiversity, ancient technologies and environmental management. Community values of mutual respect were abused by invading colonial agricultural or industrial peoples.

As the San have inhabited Southern Africa through the millennia, their cultural heritage is unique. Nowhere else on earth have a people lived in one geographical area for as long. Migration has, of course, taken place. Migration has occurred within Southern Africa rather than across continents or oceans. As a result, although cultures constantly under go changes many aspects of San culture have remained constant.

Today, San leaders are concerned that the knowledge of the old people is dying out. Young people are not hunting and gathering in the bush. They do not learn patience and discipline as the old people once did. Poverty, denigration of human life and aggressive racism has all had an impact on the mental health of this indigenous community.

In SASI’s support programme to the ǂKhomani San, youth and elders work together to learn about what aspects of their culture can serve as a resource to the younger generation. The philosophy is that people only learn what it is that they can put to functional value. That value may be creating a job for themselves, or it could equally be regaining their dignity by understanding their history. Many San youth did not know they were San until their parents came forward to be registered in the land claim. It is a big challenge for the youth to understand the world of their ancestors.

Throughout the action research project, the San field team worked with different generations and helped identify which types of knowledge would be useful in serving the community.

A CONVERGENCE OF CULTURES

In order for the San to have survived for thousands of years the transfer of traditional knowledge has been key to their survival. Traditional practices or intangible cultural heritage was passed on from generation to generation by stories and myths. Like most indigenous cultures the San have made use of myths and stories to conserve their delicate environment. Akin to the First peoples of North America the San has a great respect for animals and plants. As also noted by Kuper: ”It is nevertheless often assumed that each local native group is the carrier of an ancient culture. In familiar romantic fashion, this culture is associated with spiritual rather than with material values”[18]

Although many traditional cultural practices and beliefs still exist, colonialism and Christianity have caused a great deal to be lost. A great number of the San have renounced their traditional practices as un-Christian, though in practice many traditional healing activities have continued. During our research we picked up the tension of some of the people towards Western/Judeo-Christian views on the one hand, and traditional beliefs and approaches on the other. These two co-exist in an uneasy balance within this community.

As stated by one of the San elders, Oupa Andries Olyn: “Our parents did not know how to build a church. We were stupid then. We would dance out in the open and speak to God while we danced. God gave our people power to heal. But we were not Christian then. Now we go to church.”

San elders are dispersed over a wide area. Individual elders may hold small pieces in the jigsaw of the knowledge systems. These pieces need to be brought together for a clear picture to emerge.

Apart from persevering indigenous or traditional knowledge systems (IKS / TKS), there is concern amongst the entire community about the high level of violence against women, teenage pregnancies, substance abuse and poor nutrition, which is a bitter legacy wrought by the last century. Both men and women in the community feel disempowered in their efforts to control these social problems.

18 Kuper, 2003: 2

TRADITIONAL LEADERS

Historically the San were hunter-gatherers and moved in small groups, “my elders told me that at the turn of the last century, each community – consisting of 20 to 30 families residing at one waterhole.” Leadership was passed down from father to son much in the same way as the passing on of traditional knowledge.
Today, “San leaders is not so apparent; because it is dissimilar to the common hierarchical leadership structures and because we chose to make decisions by reaching consensus.”[19]

In the case of the ǂKhomani San, the present traditional leader, Dawid Kruiper comes from a long line of traditional leaders. He father was Regopstaan Kruiper whose father was Makaib. These were the old patriarchs of the ǂKhomani San tribe[20]. Regopstaan Kruiper initiated the Land Claim but died before it was realised.

Parallel to the traditional leadership, the ǂKhomani San now have an elected Council of Elders who assist in advising the traditional leader. Recently, since the relocation, another elected body, the Communal Property Association of which the traditional leader is a member, takes the responsiblity of administering and managing the properties that were reclaimed by the San. Recently the San formed a national body known as the South African San Council who represents the San nationally including the ! Xun and Khwe, a group of 2000 San living in the Kimberley area as well as a group of San from Kwazulu Natal.

The traditional leader is consulted by the community particularly around issues that affect or threaten their well-being and is generally understood as having a great knowledge of the traditions and cultural practices of the community. Traditional healers also seem to play a leading role and elicit great respect from the community.

[19] Joram /Useb 2000
[20] (see www.sanculture.org.za - photo exhibition)

THE ‡KHOMANI SAN YOUTH

SASI's work is often about the past. Land claims and restitution rely on the memory of the elders, on maps of the land and on continuity of occupation. People prove their claims with old photographs, with their stories, their language, and their heritage.

SASI's work is also about the future, about the youth. Many of these young people have never seen a wild animal, have never been in a trance dance, and know little about how to benefit from the resources offered by trees in the desert. They are re-inventing what it means to be San. They are redefining themselves.

In Botswana, San youth are learning how to handle Global Positioning Systems to chart the territory of their elders. In South Africa, San youth use koki pens to trace the family trees of their relatives. In Namibia, San youth learn about managing conservancy areas and how to record life histories with tape recorders and computers. In all three countries youth are providing the motivation for turning their ancestral languages into written media with standard alphabets.

"Most San youth have low self-esteem. This results in a lack of vision and in exposure to high levels of violence and substance abuse. In addition, low self-esteem results in the youth undervaluing cultural identity."[21]

To be San today in Siyanda District means different things to different people in the community. Some people still live in their traditional leather clothing, most dress in western dress like the majority of South Africans. A lot of the young people have very little idea about their heritage. The very old people in the community know pieces of their history and have a lot of traditional knowledge and skills. SASI works together with the ‡Khomani leadership to help young people and old people come together to talk about the past, their history, and learn skills, which can be used to create new types of livelihoods.

‡Khomani San youth find themselves having to deal with issues of San identity having been forced to assimilate to a coloured identity during the apartheid years, which included speaking Afrikaans and denying them using their native tongue. In the Kalahari they are isolated from resources, no opportunities for work unless they leave for the city. Problems facing this community is wide spread alcoholism, unemployment, tuberculosis, large percentage of teenage pregnancies, drug abuse, STDs and lately HIV/AIDS.

21 SASI 2002

Most of the ‡Khomani San young women are single parents. The majority of the youth are unemployed, while some of them are lying at home unemployed, depending on government maintenance grants, others are crafters or involved in some of the development projects.[22]

The youth who have often become demoralised about their conditions have organised themselves into youth committees in Askam, Witdraai, Brosdoring, Erin, Scottiesfort, Philandersbron and Welkom. They meet regularly to raise issues pertaining to all youth and direct their concerns to the CPA. The survival of any group of people depends on the youth. The South African San Institute employs three youth field workers to assist the youth and support their activities. For World Aids Day (see also section on World Aids Day) 200 youth from all over the Gordonia district were out in full force taking part in the activities and marching to the clinic.

HIV/AIDS – TELLING IT LIKE IT IS.

The HIV/AIDS epidemic caused a record number of deaths and infections around the world this year, according to a UN report released Tuesday 25 November 2003.

The report by UNAIDS[23], the UN agency responsible for coordinating global efforts to fight the disease, said the epidemic killed more than three million people so far in 2003. And five million more acquired the human immunodeficiency virus in 2003, bringing the number of people living with HIV to between 34 million and 46 million, the Associated Press says.

"This is an epidemic that at the start was a white middle-class gay man's disease. Today, if you use a stereotype, the face of AIDS is a young woman from Africa," Dr Peter Piot, executive director of UNAIDS, told a news conference in London.

HIV/AIDS in sub-Saharan Africa

Indeed, sub-Saharan Africa is already home to 29,4 million people living with HIV/AIDS and the numbers are steadily increasing. In the last year alone, the epidemic has claimed the lives of 2,4 million people and in the year 2002, there were 3,5 million new infections. South Africa as a country has the world's highest and fastest growing number of HIV infections, namely 5 million.

About twice as many women as men are being infected, the reason being that women contract HIV more easily by means of unprotected heterosexual sex than

22 Jacobs, 2003: 4
23 http://www.unAIDS.org/wad/2003/Epiupdate2003_en/EpiUpdate2003_en.pdf

men does. Heterosexual sex is the main mode of HIV transmission in sub-Saharan Africa, and women are particularly prone to infection.

HIV/AIDS in South Africa

In the last 12 years, the HIV prevalence in South Africa rose from less than one percent to way over twenty percent, according to statistics revealed by UNAIDS.

National mortality rates for South African men between the ages of 20 and 40 have increased by more than 150% since 1998, and the mortality rate for women has risen even more, according to statistics cited at the 2003 South African AIDS conference in Durban.

5,3 million South Africans were HIV positive by the end of 2002, according to the Department of Health's statistics, which were extrapolated from surveys at antenatal clinics nationally. But the good news is that the rapid growth of the South African epidemic may be slowing down, as there has been a reduction of infections in women under the age of twenty.

Providing adequate care and support for those suffering from HIV-associated diseases, is an increasing problem, placing a heavy burden on the South African health care system. The most recent UNAIDS statistics reveal that the percentage of hospital beds occupied due to AIDS, ranges from 26% to 70% for adults and from 26% - 30 % for children.

HIV/AIDS within the San community

No official statistics exist about HIV/AIDS specifically in the San community because the San are interspersed with other communities. At this point no studies were conducted that concentrated solely on the San with respect to incidence, growth and deaths related to HIV/AIDS. All statistical research conducted to date was done with the San as a part of a broader population group of the Northern Cape Province.

There are only two studies available. The first is the ongoing research done by the Department of Health as a national project; the latest statistics available from this research shows figures of 2001. This study was conducted solely by HIV tests on pregnant mothers that make use of the state clinic and hospital services.

The other study that is available is the research done by the Human Sciences Research Council of South Africa (HSRC). This involved dual-purpose risk behaviour and the saliva tests of small pockets of randomly chosen people throughout the Northern Cape Province. Once again in the research analysis and statistics

published, the San people were not treated as a separate group but rather as a part of the broader population in the province. See appendices for a brief overview of the most important statistics available from these two sources.

When this project was started there was a few isolated cases of HIV/AIDS. Unofficially there are at least ten members of the community who have been positively identified to have HIV and AIDS. It is difficult to ascertain precise figures because in general the San have more confidence in their own traditional medicine. They also have an aversion for needles as it would become clear further in this report and only in extreme cases make use of the clinic. As a result it is only when the disease has already manifested itself by affecting their health in a drastic way that they are willing to seek medical help. Therefore a large part of the work of this project has been raising awareness and demystifying the disease.

SOCIO-CULTURAL ASPECTS OF HIV/AIDS IN SOUTH AFRICA

South Africa has the largest number of people living with HIV/AIDS in the world, and the fastest growing epidemic. The reasons for this are complex; nevertheless, certain socio-cultural factors have been identified as responsible for the rapid spread of the disease.
These include the following:

- Political transition and the legacy of apartheid
- Poverty
- Commercialisation of sex
- Violence and sexual violence
- Lack of knowledge and misconceptions about HIV/AIDS
- Stigma and discrimination
- Gender inequality and male dominance
- Cultural beliefs and practices

Political transition and the legacy of apartheid

The early years of the HIV/AIDS epidemic in South Africa coincided with the end of the apartheid era, a period of complex political transition and societal instability. Leadership was distracted by the then more immediate concerns of the struggle towards democracy, with the result that crucial time was lost in the fight against AIDS.

Elements of the apartheid regime - such as migrant labour, the homelands system, the Group Areas Act and forced removals - contributed to the widespread poverty,

gender inequality, social instability and unsafe sexual practices that now continue to influence the spread of HIV/AIDS.

The migrant labour system has been particularly important as a vehicle for HIV transmission. Labourers were prevented from settling where they worked in the urban areas, but maintained links with their families in rural parts, and moved between the two. This to-and-fro migration has been a major factor in the spread of HIV and other STDs (which, in turn, increase the risk of HIV infection). Migrant labour patterns persist because of uneven development and employment opportunities, both within the country and in neighbouring African states.

Another form of migration occurred when the former revolutionary cadres, such as umKhonto weSizwe, returned from the north of South Africa's borders in 1994 and were incorporated into the national defence force. Their return, from areas of high HIV prevalence, contributed to the rapid growth of the epidemic. Refugees from neighbouring African states also entered the country, often bringing new strains of the virus with them.

During the apartheid years the San were dispersed in small family groups who mainly lived a nomadic lifestyle working on farms throughout the Northern Cape, whenever work was available.

Poverty

"It is common knowledge that poverty is one of the major driving forces of the HIV/AIDS epidemic. Poverty is not only a cause but also a consequence of HIV/AIDS. The epidemic deepens the poverty level of infected families and communities who have to channel their often meager resources into the treatment of opportunistic infections, into providing terminal care and funerals, added to the loss of income due to the unproductiveness of the sick.

Women are among the poorest of the poor and this contributes significantly to their vulnerability. The ability of families to care for their infected loved ones and help their terminally ill die with dignity depends to a large extent on their level on income."[24]

High levels of unemployment and an inadequate welfare system have lead to widespread poverty, which renders people more vulnerable to contracting HIV because of the following factors:

[24] Paper delivered at by Ngozi Iwere at the Expert Group Meeting on "The HIV/AIDS Pandemic and its Gender Implications" in Windhoek 2000

1. The daily struggle for survival overrides any concerns people living in poverty might have about contracting HIV.

2. Strategies adopted by people made desperate by poverty, such as migration in search of work and “survival” sex-work, are particularly conducive to the spread of HIV/AIDS.

People living in deprived communities where death through violence or disease is commonplace tend to become fatalistic. The incentive to protect oneself against infection is low when HIV is only one of many threats to health and life. Poverty may also breed low levels of respect for self and others, and thus a lack of incentive to value and protect lives.

Poverty is generally associated with low levels of formal education and literacy. Knowledge about HIV/AIDS and how to prevent it, as well as access to information sources such as schools or clinics, is subsequently low in poor communities. Ironically, socio-economic development and poverty relief can, in fact, sometimes drive the epidemic. This is particularly the case when development is linked to labour migration, rapid urbanisation, and cultural modernisation – all of which occur to a significant extent in South Africa. Thus, although poverty contributes to the spread of HIV/AIDS, alleviating poverty can do likewise. For example, improved infrastructure such as new transport routes and improved access are seen as positive developmental goals. However, this often results in a larger migrant population, and facilitates the spread of AIDS to previously inaccessible parts of the country.

Commercialisation of sex

A prominent aspect of South African culture that undoubtedly contributes to the HIV/AIDS epidemic is that sexuality is frequently seen as a resource that can be used to gain economic benefits.

The country has seen the rapid development of a relatively affluent black middle class with a desire for material goods, and a sexual culture that associates sex with gifts. Men gain social prestige by showing off material possessions and being associated with several women.

Young women are often persuaded to have sex with “sugar daddies” – older, wealthier men – in exchange for money or gifts. Some girls enter the sex industry for similar reasons. Young women infected with HIV by sugar daddies then infect younger men, who in turn infect other young women and in time become HIV-positive older men themselves – and so the cycle continues. Older men also infect older

women, usually their wives. Both younger and older women give birth to children, some of whom will be HIV-positive.

Physical and sexual violence

Violence against women is a major problem in South Africa, and is linked to its male-dominated culture. Men often use violence in an attempt to maintain their status in society and prove that they are “real men” by keeping women under their control. Physically abusive relationships limit women’s ability to negotiate safer sex: many men still do not want to use condoms, and some become violent if women insist on protected sex. Women may not even raise the issue of safer sex for fear of a violent response.

South Africa, where a woman has about a one in three chance of being raped in her lifetime, has the highest sexual violence statistics in the world – with obvious implications for the spread of HIV/AIDS. The genital injuries that result from forced sex increase the likelihood of HIV infection; when virgins and children are raped, the trauma is more severe, and risk of infection even higher. In cases of gang rape, exposure to multiple assailants further increases risk of transmission.

Increasing numbers of rapes of female children may represent men’s attempts to seek sexual relations with young girls to avoid HIV infection or because of the belief that sex with a virgin will cure AIDS. Women with a history of being sexually abused are more likely to risk unsafe sex, have multiple partners, and trade sex for money. Men who are violent to their partners are also more likely to have sexually transmitted infections (STIs). These factors combine to put women who suffer sexual violence at very high risk of contracting HIV/AIDS.

Lack of knowledge and misconceptions about HIV/AIDS

It appears that the majority of South Africans have heard about AIDS, and have a fairly good level of knowledge of the basic facts i.e. that the disease is spread sexually, and that condoms reduce risk. Nevertheless, there are still many people, especially those with low levels of formal education and who lack access to accurate, relevant information on HIV/AIDS and sexuality, who are unaware of the risks. The San have extremely low levels of formal education particularly the adults of whom most are largely illiterate.

Women in particular have high rates of illiteracy, and many girls do not complete basic education. Also, women may be unaware of risks because their time is taken up with tending the home, and they have limited links with the outside world.

Added to this is the problem that dangerous myths and misconceptions about HIV/AIDS abound. These include believing that the virus can be contracted by sharing food, that infected people can be recognised by their symptoms, and, perhaps the most notorious of all, the belief that sex with a virgin can cure the disease. Beliefs such as this give people a false sense of their level of risk, and contribute to confusion about how HIV is transmitted.

People who do possess some knowledge about HIV often do not protect themselves because they lack the skills, support or incentives to adopt safe behaviours. High levels of awareness among the youth, a population group particularly vulnerable and significant as regards the spread of HIV/AIDS, have not led, in many cases, to sufficient behavioural change. Young people may lack the skills to negotiate abstinence or condom use, or be fearful or embarrassed to talk with their partner about sex. Lack of open discussion and guidance about sexuality is often lacking in the home, and many young people pick up misinformation from their peers instead.

Stigma and discrimination

The stigma attached to HIV seriously hinders prevention efforts, and makes HIV-positive people wary to seek care and support for fear of discrimination. People who are infected may also be reluctant to adopt behaviour that might signal their HIV-positive status to others. For example, a married HIV-positive man may not use a condom to have sex with his wife; an HIV-positive mother may continue to breastfeed her baby. Many people might not want to get tested for fear of their community finding out.

Gender inequality and male dominance

South African culture is generally male-dominated, with women accorded a lower status than men are. Men are socialised to believe that women are inferior and should be under their control; women are socialised to over-respect men and act submissively towards them. The resulting unequal power relation between the sexes, particularly when negotiating sexual encounters, increases women's vulnerability to HIV infection and accelerates the epidemic.

Women's inferior status affords them little or no power to protect themselves by insisting on condom use or refusing sex. Abstinence and monogamy are often seen as unnatural for men, who try to prove themselves "manly" by frequent sexual encounters, and often the aggressive initiation of these.

Examples of other prevalent ideas which result in sexually unsafe behaviour include the following: sex on demand is part of the marriage "deal"; sexual violence is a sign

of passion and affection; men have natural sexual urges that cannot be controlled in face of women's powerful attractions; sex is necessary to maintain health and gender identity. These views serve to justify men's sexual behaviour to some extent: men are given license to be sexually adventurous and aggressive, without taking responsibility for their actions.

Women's respectability is derived from traditional roles of wife, homemaker and mother. Childbearing and satisfying her husband, sexually and otherwise, are key expectations for a wife - even if she is aware that her husband is unfaithful. Refusing a husband sex can result in rejection and violence.

The low status accorded to a woman without a male partner may be an additional reason making women less likely to leave an abusive relationship. Too much knowledge about sex in women is seen as a sign of immorality, thus insisting on condom use may make women appear distastefully well informed. Married women who request safer sex may be suspected of having extra-marital affairs or of accusing their husbands of being unfaithful.

Cultural norms and practices

Certain prevalent cultural norms and practices related to sexuality contribute to the risk of HIV infection, for example:

Negative attitudes towards condoms prevail, as well as difficulties negotiating and following through with their use. Men in southern Africa regularly do not want to use condoms, because of beliefs such that "flesh to flesh" sex is equated with masculinity and is necessary for male health. Condoms also have strong associations of unfaithfulness, lack of trust and love, and disease.

The importance of fertility in African communities may hinder the practice of safer sex. Young women under pressure to prove their fertility prior to marriage may try to fall pregnant, and therefore do not use condoms or abstain from sex. Fathering many children is also seen as a sign of virile masculinity.

Urbanisation and migrant labour expose people to a variety of new cultural influences, with the result that traditional and modern values often co-exist

PART 3 – HARNESSING TRADITIONAL KNOWLEDGE FOR HIV/AIDS PREVENTION AND CARE

ESTABLISHING A BASELINE □analysis of HIV/AIDS questionnaire

A questionnaire was put to 80 people in the community to establish their knowledge on HIV/AIDS at the outset of this Action Research Programme. A fieldworker was assigned to each farm – Witdraai and Erin, together with Miershoopan and Uitkoms were coupled, as the population density is low.

The questionnaire attempted to determine respondents basic awareness of HIV/AIDS, how it is transmitted, how transmission can be avoided, whether they are able to recognise the symptoms of the disease, appropriate action it then goes on to explore cultural issues such as stigmatisation, myth, attitudes, the relation of alcohol-drug abuse with respect to infection and issues of social behaviour that impacts on infection, prevention and care.

Sampling: Eighty people aged 13-60 were interviewed, the focus being on the 13-39-age group.

TABLE 2: Age breakdown of respondents

Age group	No of respondents
13-19	21
20-29	42
30-39	8

TABLE 3: Education levels of respondents

Education levels	No of respondents
Grades 1-6	4
Grades 6-9	34
Grades 9-12	22

The research revealed that 90% of respondents knew of the existence of the virus, however less than 40% believes that it is a deadly disease. Misconceptions about ways of contracting the virus is quite prevalent for example some people believe that if a baby drinks from someone else's breast that baby will automatically get AIDS while others believe that one can contract the virus by someone spitting in someone's face. On the other hand a fair amount of ǂKhomani San and particularly young people are aware that having sex with an infected partner puts one at risk. As well as blood transfusion and rape.

What has been quite surprising is that only 10% of the respondents were confident that the disease is fairly new. Some respondents had the following to say:

"This disease has been around for a long time."
"People before were much healthier than now, so they didn't get it so seriously. People used to use herbal medicine and eat 'veld' plants so they lived longer."
"Herbal medicines can cure anything."

In response to the question *whether there are people who does not get AIDS,* most of the responses were positive asserting that people of good moral character does not contract AIDS. 75% of respondents believe that herbal medicines can make an infected person live longer.

Almost 90% of respondents questioned believe that one can contract HIV/AIDS through the use of needles whilst less than 50% believes that the disease can be contracted through sexual intercourse. The San do not appreciate needles, they dislike clinics and worry that their babies might contract HIV/AIDS when they are immunised. So the needles in this case do not refer to intravenous drug abuse. Such abuse of drugs are minimal if not absent in this community.

Half of the respondents believe that it is shameful to have this disease. More than 80% of all respondents believe that alcohol and drugs plays a role in contracting HIV/AIDS. These are some of their comments*: "drugs change your behaviour, you lose your sense of self worth…Alcohol often leads to murder…Men rape when they are drunk. When a woman is drunk she does not know who she has sex with."*

When asked what the possible things are to be done to stop the spread of HIV/AIDS, respondents offered: *"we need to create sports facilities to occupy the youth…run community awareness campaigns around AIDS, alcohol and drug abuse…counsel young people not be promiscuous…teach boys to respect girls and not to force them to have sex…make people aware of traditional medicines."*

In-depth interviews were conducted with strategically chosen elders particularly for their extended traditional knowledge. HIV/AIDS, myth and misconceptions, herb lore, spiritual attitudes and beliefs were discussed. The information gathered formed the basis on which dissemination of information took place.

A sample interview with an elder can be found in Appendices. This interview shows the type of interaction we had utilising open-ended interview techniques. A number of the team took time to speak with different adults and elders about their views of HIV/AIDS without using the formal questionnaire described above.

ǂKHOMANI SAN AND THE ENVIRONMENT

The San elders emphasise that they are 'a natural people'. Their approach to health care and well-being needs to be in accord with the life of the Kalahari ecosystem. People see themselves in this natural context. What follows are comments from some of the elders:

" *Animals are just like People."*
"The Gemsbok with her painted face is the girl ready to become a woman, the duiker who sheds tears would never be killed."
" The rocks are also people they have many secrets".
" Jackals are just as clever as people. When I am out hunting a jackal I have to be as clever as I possibly can, because otherwise, they will be more clever than I am."
"I'm not sure about this AIDS thing. I think I have to get this thing myself. How am I going to manage that! If I get it myself then I can understand it better and find the right herbs to use to cure other people. I have already helped people who have this but I feel I must get it myself to really understand it".
"I know all the plants in this area. When I was young, my father taught me about the plants and herbs. He knew a lot about them."

"When people come to me about something that is troubling their body or if they have some problem which is making their heart sore, I can tell by seeing light, which comes off them what the matter is with them. Particularly their hands. I always look at their hands and then I can see what their complaint is. Then I go out into the 'veld' usually in the early morning. I talk to the plants to see which one is the right one for the particular person. A plant may have the right properties for the person but it may not be the right one. Each person is different so I have to very careful and listen to what the plants are telling me. Often more than one herb is needed. Sometimes a person has a problem with their stomach or another organ, which sounds the same

as the problem of another person. But the herbs they need could be different because the heart and feelings of each person is different. The herb and plants also have their different characters so they know which person will benefit from them and which person will need other plants. I am able to do this because I was born with the caul. I am psychic. My father also had this ability. Unfortunately I don't think any of my children have this but maybe one of my grand-children will be born this way. Being born with the caul makes a lot of things clear to me especially the spirit of things."

Hunting too is an integral aspect to San culture and well- being. San men still hunt small game. Unfortunately large game, which was present on the restitution land, has been poached. This situation has yet to be addressed. If this can be remedied it should be possible for the San to hunt once more albeit to a lesser degree. Being out in the wide open spaces, tracking and hunting, will ease a great deal of the frustration experienced by the men, both young and old, whose hearts yearn for this age old way of life.

THE TRANCE DANCE

The most important component of the old healing culture was the 'trance dance'. This custom, known throughout the San world, involved medicine men and women coming together, building a fire, singing and clapping rhythmically until the male dancers, circling the fire could cross over to the other world in trance. Once in trance the shaman could bring important diagnostic messages and help heal sick people.

Only vestiges of 'trance dance' still exist today. A corrupted form of a celebration to life, rainmaking, gathering food and herbs, hunting and healing remain. Trance dancing is mostly done only at the request of tourists or researchers and usually only for money. Although community members acknowledge the importance the healing dance, where mind, body and spirit are sung into harmony, alcohol addiction and the dominant religion of the white colonists, have left this an empty desire.

The will to live, the celebration of life and focusing on realistic goals could enable people to live longer fulfilled lives. Trance - dancing could play an important role in bringing those states of minds together.

Now that the land issue has largely been resolved, the focus of the San community is on important areas such as health, HIV/AIDS, cultural and spiritual aspects life, and the integration of a fragmented community. Self-determination for the San means

making decisions for and about their own development and seeking ways of being economically and spiritually self-sustaining.

OTHER SAN HEALING PRACTICES

San philosophy and healing practices are remarkably similar to the self - healing principles put forward by PNI. This discipline is considered to be “new”.

Michael Shaun Fereira has described how a San shaman working within their healing paradigm, would describe helping someone with HIV/AIDS.

An unseen, subtle, physically manifesting Spirit, enters the human, a very tangible physically manifesting spirit. The motivation of the HIV spirit is in line with the Great Spirits’ eat and be eaten natural order and will to celebrate. Unlike a mosquito or tapeworm, HIV will eat until the human dies. Then the HIV virus will die too. Then, the day- to- day, part of the Great Spirits’ party will be over for that particular HIV spirit and that particular human spirit. The Great Spirit will have been the all-devourer of them.

They will now each party further for a while, in the after death stages of their lives, being digested in the stomach of the Great Spirit. The human and the HIV must now let go, or else, they will give the Great Spirit indigestion and they will become stuck. When digested, both Spirits will re-emerge into day-to-day party life as part of some further manifestation of the Great Spirit. Maybe they will become porcupine or mantis. Maybe the human will become HIV or the HIV will become human. The Great Spirit is the all conceiver of that.

The important thing for a human to do is to take action in line with the Great Spirits’ eat and be eaten natural order and, will to celebrate. Whatever action the individual human may take in the process of relating to the HIV that has entered him, they would do well, and we healers would help them to steer clear of becoming ‘diseased’. (Fereira 2002)

The belief is that, although humans are physical beings we are Spirit, not that we have ‘a spirit’. All forms of life, i.e. animate- and a number of those the Western mind would consider inanimate such as rock outcrops and rock faces, on which beings are painted, are also considered animate and thus are Spirit. Although some spirits are too small to be seen (e.g. the HIV virus) or cannot be seen because they are “dead”, they are known to exist by various means. The ways they are known could be through traditional knowledge – through trance or lately Western information spread

by verbal communication or radio, literature and television. Many San, particularly older people are illiterate, although illiteracy is not exclusive to elders.

As all spirits are manifestations of the Great Spirit, people are not more important than other Spirits. All Spirits being equal, there can be no differentiation between those, which are benevolent or malevolent to humans. Malevolent influence would be seen as a challenge to the afflicted person. However, "afflicted" too would be a Western concept. Traditionally the malevolent influence e.g. HIV would be seen as just another spirit, living the "eat and be eaten" way. Typically, the person living with HIV/AIDS would use herbal remedies, consult a psychic, and community members would offer physical, emotional and spiritual support.

The person living with HIV/AIDS would then be encouraged to deal with the emotional and spiritual disease present. The focus is essentially on attitude or mentality. The intention was not to destroy one spirit or the other, but rather to propagate harmony between the two. If the outcome were death, that too is a natural function of the relationship between the person and virus. Neither outcome more loaded than the other. Death is just a change from one state of being to another.

People Living With HIV/AIDS (PLWA) who choose to co-exist with the virus (de Koker 2002),as does David Patient,[25] who together with Neil Orr, pioneered PNI techniques, follow a very similar premise. In a PNI intervention the virus and the Person living with AIDS enter into a "contract". A contract is entered into which allows both the person and the HIV virus to co-exist. Physical, emotional and spiritual needs are met and dealt with to the utmost capacity by the person living with HIV/AIDS. Life is celebrated as it is, for what it is, while it lasts.

ETHNO BOTANY – Medicinal herb gathering and identification

The trainees, elders and project co-ordinator, undertook four field trips to collect herbs. Thus a communal herb pool has been established.

Phyto-Nova, a local company has shown substantial success with the marketing of *Sutherlandia fructescens subsp microphylla* tablets. This bush grows in the southern Kalahari and Karoo deserts and is well known amongst the San elders and considered to be one of their most powerful immune boosters. Other plant extracts such as the plant sterolins from the *African Wild Potato* are playing an important national role in boosting people immunity after infections.

25 David Patient was diagnosed HIV positive 19 years ago. His life expectation at that time was 6 months.

When herbs are collected, the traditional way is to pray the day before, to be guided to where herbs grow in abundance. A trip to collect herbs may have been a few days walk or gathered near at hand. Elders would confer, the decision on who should collect the herbs would be made, and, that person or number of people would prepare for the day ahead. Gathering started before dawn. Once the gatherers returned, the elders once more came together, to distribute herbs. Herbs were carried in a slim pouch. This pouch having been part of an animal and now having a specific purpose is an Animate Spirit being.

As Elders are unable to walk great distances and "young people are too lazy and they know nothing" a vehicle was used to convey the gatherers on herb collecting expeditions; the ancient ways of communal purpose were adhered to. When what is known as a 'fountain' i.e. a large number of one herb growing together, was found, great joy was expressed. Domestic animals have taken their toll on the biodiversity of this fragile region. The herbs were dug or cut in a manner, which revered that Plant Spirit. At each plant, never was the whole plant taken, a gift was left. This could be some small coin, hair plucked from the head or beard, a piece of cloth torn from clothing worn at the time, or water. These would tell the Plant Spirit that it was honoured. Unused material would be carefully buried next to the plant from which it was taken.

Up to this point, in general the San is loathe to admit whether they have HIV. Most of them avoid being tested. However, those who suspect that there is a possibility they may have contracted the disease, do take some of the immune boosting herbs.

ISSUES IMPACTING ON HIV/AIDS WORK AMONGST THE SAN

Public Health Service

The nearest Government Clinic is situated at Askham, 12 – 22 kilometres away from the farms. No public transport system exists. At least three trips a week to the clinic ensured that very ill adults and children could make use of this facility. The clinic does not provide any training on HIV/AIDS or information other than free booklets. Once off counselling, pre- and post-testing is provided for HIV/AIDS. The initiation of this programme made condoms readily available for the first time. Although condoms are stocked at the clinic, 15-22 kilometres is a long way to go for even the most responsible person with transport.

HIV blood tests are done at the Clinic in Askham; a distance of 15 km, analyses is not done at the Clinic but in Upington, the nearest town, 200 kilometres away. The results take two weeks. As testing is confidential, counselling can be provided on the farms only if the affected individual should ask for such counselling. Such counselling has not yet been requested. This is, in part, due to lack of knowledge around counselling, which is a very new concept here. The HIV/AIDS, Gender Based Violence, Perpetrators and Substance Abuse programmes, which have been implemented since the advent of the HIV/AIDS Action Research Project, have provided a platform for people to speak out, and introduced the benefits of group and individual counselling.

A Government doctor pays a one-hour bi-monthly visit to the clinic. The doctor refers patients, who need hospitalisation, to the provincial hospital in Upington 200 kilometres away. Births are also supposed to take place in Upington. More often than not, babies are born at home with the help of a traditional midwife or in an ambulance. An ambulance, to transport patients in an emergency is usually available. The ambulance can be expected two and a half hours after call-out. Pregnant women are not routinely tested for HIV at the Askam clinic.

People Living with AIDS who are in need of hospitalisation, could be admitted to the Provincial Government Hospital in Upington on a short-term basis. The State Hospital does not have the financial resources, sufficient beds or nursing care to accommodate such patient's in the long term.

TABLE 4: HIV/AIDS Medication Currently Supplied by the State

Condition	Treatment
Rape Victims	3tc & AZT plus HIV Test Within 24 hrs
	Emergency contraception: overall, 2 state repeats after 12 hrs
Pregnant women	Neverepine - 6 hrs before birth.
New born Babies	Neverepine syrup within 24 hrs, repeat after 12 hrs

The high incidence of teenage pregnancies and unplanned pregnancies indicate the absence of safe sex practice and hence the possibility of HIV infection.

Primary Health Care

Primary Health Care has been central of all programmes initiated during the HIV/AIDS Action Research Programme. This was to ensure that the community feel

supported and cared for. Well-being requires confidence that basic human needs are met. Health care plays a large part in that self-confidence. Using the most basic medication in conjunction with Herbal Medicine, many ailing adults and children were successfully treated. The use of Herbal Medicine has been actively promoted for use in non-life -threatening ailments. Such medicines are relatively readily available and are culturally accepted. 70% of the community made use of this service.

Nutrition

Nutritional status is extremely poor throughout the community. In some instances people may have enough to eat, but the quality and variety are always poor. Many adults and children do not eat every day or even every second day.

Traditionally gathering was the major source of food supply. Although meat was eaten regularly, hunting did not take place daily and was not always successful. Food gathered was obviously organic, varied and of high nutritional quality.

Today, the 'veld' is barren by comparison to earlier times. Human exploitation, diminished rainfall, goats and sheep have depleted the natural food bank. A small number of young people would not consider eating '*veld'* food. The rest of the community, however, talk with longing of '*veld'* food. Everyone expresses the desire for meat, which is too expensive to eat regularly. When meat hunger becomes overwhelming, the nearest donkey is slaughtered.

The staple food is bread ' rooster brood' baked on a fire, and meat when it can be afforded. A limited variety of fruit and vegetables can be obtained at the local grocer on Andriesvale. Fresh produce is not always available and is too expensive for most members of the community to purchase.

All pregnant or breast feeding mothers were given multi-vitamin supplements as a part of primary health care. Children, besides being treated for the usual childhood illnesses, such as measles, coughs and colds, were treated for worms. All children treated for worms were given multivitamin supplements. This was highly successful. Children nutritionally supported regained their appetite and put on weight. Undernourished children and sometimes adults were also given nutritionally enhanced porridge. Unfortunately not all such cases could be supported in this way.

First Aid for scorpion stings, snakebites and stab wounds was frequently called for – usually at night. Primary health care was administered daily, including weekends.

Tuberculosis

Tuberculosis (TB) is a disease that kills approximately 2 million people each year. It is estimated that between 2002 and 2020, approximately 1000 million people will be newly infected, over 150 million people will get sick, and 36 million will die of TB - if control is not further strengthened[26].

TB is the leading cause of death among HIV infected people. It has been estimated that TB accounts for up to a third of AIDS deaths worldwide. About a third of the 40 million people living with HIV/AIDS at the end of 2001were estimated to be co-infected with TB (Mycobacterium tuberculosis).

Because TB can spread through the air, the increase in active TB among people infected with both TB and HIV results in:

- more transmission of the TB bacteria
- more people with latent TB
- more TB disease in the whole population

People with latent TB are increasingly becoming infected with HIV, many more are developing active TB because HIV is weakening their immune system. People who are co-infected with both HIV and TB have a 800 times greater risk of developing active TB disease and becoming infectious compared to people not infected with HIV.

People with advanced HIV infection are vulnerable to infections or malignancies that are called 'opportunistic infections' because they take advantage of the opportunity offered by a weakened immune system. TB is an HIV related opportunistic infection. A person that has both HIV and active TB has an AIDS-defining illness.

Also:

- TB is harder to diagnose in HIV-positive people.
- TB progresses faster in HIV-infected people
- TB in HIV-positive people is more likely to be fatal if undiagnosed or left untreated
- TB occurs earlier in the course of HIV infection than other opportunistic infections
- TB is the only major AIDS-related opportunistic infection that poses a risk to HIV-negative people

[26] This data was drawn from an article: HIV, AIDS and Tuberculosis (TB) published on the web at www.avert.org

At the outset of the research programme the 10 existing TB patients were offered a multivitamin complex, Hypoxis – an immune booster – as well as a nutritionally enhanced porridge at least once a day. Two patients, one of whom developed MDR chose, not to take part in this programme. The fieldworkers took over and maintained this part of the programme, physically giving medication and supplements daily.

Medication was collected weekly from the local Clinic, which supervised the progress made by patients. All TB patients taking medication as well as supplements tested negative after the first month.

On completion of the programme:

- All but two people with TB, had completed their medication and tested negative.
- One TB case not yet on medication as the Clinic nursing sister – was away on leave. Members of the family have not yet been tested.
- One new TB case refused medication.
- One new patient initially refused medication. The patience and perseverance deployed by a fieldworker was successful in persuading the person to take his medication.

Rites of Passage

Although ǂKhomani San no longer practice puberty rites, a generation ago, such rites were still celebrated on a small scale. Despite the lack of initiation rites, teens are considered adults once they become what the community deems as ‘strong’. Some young women are working with women elders to resuscitate the important young woman’s rites of passage celebration known in Afrikaans as ‘*hokmeisie’* .

This practice is found in both Khoe and San traditions. When a young woman menstruates for the first time she is isolated from the rest of the tribe or community. She is taken to a hut where she has to stay for two weeks. She is tended by the women elders who bath her and feed her. When the two weeks comes to an end, she is bathed and dressed and painted with herbal paints. The patterns on her face are that of a gemsbok, an animal which has great symbolic significance for the San.

The entire community comes out in celebration of her womanhood and she is taken to a river or lake where she is sprinkled water, a sign of purity. She also has to sprinkle the herbal powder (boegoe) into the fire. In some cases the men in her family are beaten with a stick as part of the ritual. There have been three such events in the last year. According to the women the purpose of the ritual is her introduction

to womanhood, she may now be married and her patience and endurance is tested for her life as a San woman.

These were comments from the elder women[27]:

"How old was the young girl when she entered the shed?"
"That time, Sir, she was fourteen years old. Her grandmother took her and chased her in and bolted the door"

And how long did she stay in the shed?
"She was left there for fourteen days. If a young girl cannot sit in the shed for fourteen days, then she is in a hurry across the world. She does not want to be civilized, protected.

"Like when the "hokmeisie" leaves the shed, then you powder the boys and the young girls and there where you make the fire, there you throw powder."
"And Sir, you know there where the young men and old men are beaten with a "ganglat"[28]. I beat him, I beat Piet Rooi. "

Marriage practices

For the last five years there has been no marriages amongst the San, traditional or otherwise, according to one of the fieldworkers. In the past traditional marriages was a simple practice. After a young woman had been through the rites of passage ritual she was eligible for marriage. According to one of the elders the couple was not sexually active without the permission of the parents. They would then be paired and live together. That would constitute the marriage. Some of the San who assimilated to a "coloured identity" got married in the church.

In the community where this research has taken place the older people have been married traditionally, but the younger generation live together. Many times the children of these marriages become the responsibility of the entire family. In isolated cases the fathers would help to support the mother if they had a job, but in the main the young mothers are left to care for the child on their own. Recent legislation has made it possible for mothers to receive state intervention when fathers refuse to take responsibility. The problem for the San women in the Kalahari is that many of the fathers are transitory. Child support up to the age of 9years is R130. 00 (US$ 17) per month.

[27] Interviews conducted in Cultural Resource Audit Programme 1998.
[28] a stick

Sexual practices and prostitution

No official research has been done or any other statistics to be found, but one of the youth community development workers in the area offered the following information: ”Prostitution was never a San practice. Young women were a part of the clan and well taken care of. Nowadays because people are starving we hear that some girls, in desperation are prostituting themselves to some of the tourists. Of course nobody knows who they are, it is not something to be proud of. It makes one wonder about HIV and AIDS.”

Rape

South Africa has the highest incidence of rape in the world. The Northern Cape Province, under which the Kalahari falls, has the highest incidence of rape in South Africa. For the six months prior to this report, rape formed 59% of the violent crime in Upington. 99% of total crime was violent.

The local police station at Witdraai, has male police only, none of the service men have had training in trauma counselling and no trauma room exists. When a girl or woman gets raped she is obliged to report to untrained staff. An ambulance is summoned from Upington. This vehicle transports her to the provincial hospital where it is highly likely that she waits for some time before being assisted medically. It would take at least 6 hours from reporting the rape to being attended to by medical personnel competent to deal with the rape victim.

Rape is very seldom reported in this community. The lack of correct facilities and personnel, the general disempowerment of women coupled with threats of retribution should the rape be reported to the police, ensure silent women. It is impossible to estimate the number of rapes taking place in this community. Alcohol, Mandrax and Marijuana are almost always present when the horrendous crime of rape is committed here. Misuse of cultural promotes the rape of young teenage girls by older men. Elders are adamant that this practice is not genuinely cultural.

Although many men on the farms have spent some time in detention where male rape is the norm, male rape is not common in civilian life. Homosexuality is rare and hidden.

There are members of this community who use Government Health facilities only in a life or death emergency. Illiterate people find the system difficult, many San do not have birth certificates and find it difficult to access Government financial aid.

Gender Based Violence

Violence is one of the most discernible experiences of contemporary San life. In its different forms violence dominates the intra-community relations of San as well as relations with other people. There is no doubt that the prevalent violence affects both male and female members of San communities. However, there are quite obvious differences along the lines of gender. While little in-depth research has so far been done on the topic of gender-based violence affecting San women, a unique research paper – where exploratory research was carried out and the text authored by a Namibian San woman, Elfriede Gaeses – has shown that San women throughout southern Africa experience many forms of violence, sexual and non-sexual alike, both within and outside their communities.

According to Gaeses' conclusions from her conversations with other San women, the main reasons for male violence within San communities were alcohol abuse, men's jealousy, and their fear of losing respect if women were better educated than they were. Violence against San women committed by people of other ethnic backgrounds, however, seemed to be linked to beliefs that San were inferior and San women the weakest members of their communities, and hence most easily abused.[29]

Global research has shown that Gender Based Violence is a high risk factor in the transmission of HIV/AIDS. Women and girls are particularly vulnerable.

The incidence of Gender Based Violence within the ǂKhomani San community has been of great concern to women and elders. Elders are shocked, horrified and despairing when consulted on this issue. All the elders questioned on their and their fore-mothers/fathers attitudes to violence in general and in particular against women and children, concurred that violence was rarely, if ever, perpetrated in "*the old days". Women and men "knew what they were supposed to do"* and were there to support each other*. "People walked together and did not do unnecessary things." "We feel very sad that people today have no feelings of remorse." "Our hearts are ashamed that younger people cannot live together in peace." "God who created us did not intend that women should be so insulted." "How will the children grow up knowing what is right or wrong?" "All us grandmothers and grandfathers, all we want is to live in a quiet and peaceful place. We do not want to live here among this noise and bad behaviour." "When it is quiet around me, my soul feels at peace and I can be nearer to God."*

29 Becker H, 2003: 4

Alcoholic and sober elders alike, agree that the consumption of alcohol and other drugs are the primary factors influencing the incident of violence within the community. *"It's not as it used to be, this is not the way my parents and family brought me up."*

Violence is not gender based alone; stabbing and stone throwing are popular methods for male on male violence. Firearms are not yet touted here.

The Victim Support Centre Upington, have presented three two-day workshops thus far. A 12-month programme has been devised to cater for the needs of this community. The following issues are being covered in this programme:

- HIV/AIDS and gender based violence
- Man Power - HIV/AIDS
- Rape – Legal Aspects – HIV/AIDS
- Child Abuse – HIV/AIDS
- The Girl Child – HIV/AIDS
- Child Maintenance
- Relationship Building
- Life Skills Programme
- 16 Days of Activism

Workshops are divided between a Perpetrators Programme, Youth and Violence Against Women and Children. Throughout this Action Research Project we have encouraged the San to attend these and other existing awareness and HIV/AIDS education programmes already in existence.

With violence against women still on the increase in South Africa, particularly in the Northern Cape, service providers within the sector are now poised at a critical point to evaluate the impact of strategies to fight Domestic Violence.

Upon reflection, in the area of training, it is clear that there is a need for capacity building among service providers to engage constructively with the legislation on domestic violence.

Women's rights to access and protection under the Domestic Violence Act is seen as a determinant to end the violence. However, in reality, accessing a protection order does not necessarily end the violence and certainly does not focus on why the violence has occurred. It has therefore become necessary that we rethink our empowerment programmes, as peace cannot be obtained if violence is still occurring in intimate relationships.

Many women in abusive relationships do not want to leave their partners. They merely want the abuse to stop.

Currently many programmess focus on empowering women to access legal remedies, which with counselling, focuses on helping women to rebuild their lives. Whilst this is very important, it is just the first step in the process of change. Intervention strategies should also focus on changing the power relations in abusive relationships to achieve peace between intimate partners, in the family and community.

In order to change the power relations between women and men, training initiatives need to address the current power imbalance in gender relationships. Such training should reflect an understanding of the analysis of power relations between women and men with a redefinition of gender roles.

Training also aims to help participants examine how their interventions can shift relationships to promote equality between sexes. The course aims to help the ǂKhomani San community develop a long-term, sustainable programme that will not only deal with the immediate crisis of being in an abusive relationship, but which also focuses on positive peace building initiatives to eradicate domestic violence.

If any inroads are to be made in the struggle to end domestic violence, it is imperative that constant reflection and evaluation be part of the strategy.

Central to transformation is the need to break the private-public divide so that this community can start to acknowledge that it has a role to fulfil in ending violence against women and children.

Substance and Alcohol abuse

Alcohol, marijuana and mandrax are the substances and drugs that play a major part in the apathy and lack of self - esteem evident, in particular, amongst the ǂKhomani San who would live a more traditional life. Today the smoking of marijuana has become common practice and an acceptable norm amongst the San as is clear from the following statement of an elder.

“Who are these people talking about ‘dagga’ (marijuana)? I don’t like this at all. Smoking dagga is our culture. There is nothing wrong with it. When Jesus went into the desert around the 26th or 27th December, it was very hot. He walked and walked. Eventually he came to a small tree. He said ‘Dag boom’ (Good day, tree).

The tree gave him shelter and he sat under it, and smoked some of the leaves. That is why the 'dagga boom' is sacred and why we like to smoke it".

Research does not show that marijuana was traditionally smoked. The elders who were questioned about this all agree that if someone habitually smoked marijuana, their skills in the '*veld'* would be impaired and that they would not be alert enough to keep safe in a place where all one's wits are required.

Honey beer

Honey Beer was traditionally brewed on occasions when an important event was to take place, an outcome desired, for healing, hunting, and celebrating life events or seasonal change. Spirituality being incorporated into everyday life and events, each aspect of life was celebrated. Honey beer was thus a part of life's celebration and talking to the Great Spirit.

People who were close to bees, understood the Bee Spirit, collected honey, never taking so much that the hive would be destroyed. Herb collectors brought herbs that had been chosen for a specific event. The brew was generally similar but ingredients changed according the celebration. *"Early morning when the dew is on the plants and the sky not quite dark, the stars losing their brilliance, that is the time to collect herbs. There is a substance made by the communal weaver, those birds that live together as one family, to bind the grass of their home together. - This we use when we want the dance to be deep and for us to see things and talk with the animals".*

"Sometimes this beer is made nowadays but not really for special events". "We had to stop making the beer when then the 'boere' came. The police did not want us to make beer any more, I don't know why. We had to drink the 'vaalwyn' (wine without colour) that the 'boere' had. This is what we drink now. One needs money for this type of drink. Also, honey beer is medicine, it's made from good things: honey and herbs, which are very healthy. When a person drinks honey beer they have no hangover the next day. You feel well and alive. When I drink 'vaalwyn' I don't feel so well and I have a headache". "If my parents tried to make honey beer and the police found them, the police would throw out all that good medicine and beat them with sticks or whips. They never drank a lot of honey beer, a small amount was enough."

Factors influencing alcohol abuse

The disappearance of honey beer and the advent of commercial alcohol played a large part in the discontinuation of the Trance - dance. Ceremonial dance is integral to spiritual well being. The loss of this spiritual aspect to life is as critical, if not more so, than the inability to hunt. The Dance involved the entire community, not only

young and adult men. Children, women and the elderly, also participated in the dance of life in all its aspects.

Substance Abuse plays a large role in the poverty, violence against women, general violence, HIV/AIDS, child abuse and helpless lack of self esteem experienced in the community. Many ancient cultural practices have been lost as a result of addiction.

It has been established that first nations are susceptible to Alcohol Addiction. Genetic predisposition plays a role together with disempowerment that arises when culture and spirituality are lost.

The first Dutch Colonialists arrived at the Cape of Good Hope in 1652. An alcohol-for-work system flourished on the new settlers' farms. This system, locally known as the '*Dop stelsel*" (Tot system) encouraged alcohol addiction which was passed down generation by generation. This system has not yet been totally eradicated. Once their land had been lost, many San worked on such farms.

VABO Report on Alcohol Abuse

Stella Carter's report investigated the alcohol abuse situation in the area. Since this report was written, the HIV/AIDS Action Research Project has been implemented. An NGO, VABO, based in Upington, presented 3, Two-day workshops in the Kalahari. VABO developed their programme specifically for farm workers in the Upington area.

THE COTTAGE PROGRAMME - ADULTS

Information / awareness – drugs and alcohol. Training grassroots community members to maintain substance programmes. VABO maintains a follow -up support programme.

HORIZON PROJECT - YOUTH

Schools information / awareness- alcohol and drugs. Building self-esteem, self-awareness and developing life skills.

FOETAL ALCOHOL SYDROME (FAS)

WOMEN and GIRLS

The effects of FAS effects on the foetus , children and adults was explained.

The Substance Abuse Programme implemented is at an introductory stage. These programmes need to run for at least a further 12 months to have any real impact.

‡Khomani San Children at risk

San children are emotionally, sexually and physically at risk at home and at school, if drastic measures are not taken, HIV/AIDS will soon become an unwelcome part of these children's lives. San children are often above normal school going age (six years old in South Africa) when they enter school. Some children reach their teens before leaving junior school.

‡Khomani San children suffer discrimination at the local junior school. The project co-ordinator and one of the fieldworkers have written a report on this issue. The following issues were highlighted and have been forwarded to the Ministry of Education, the Ministry of Welfare and the Commissioner of Police in Upington:

- Lack of supervision on the school grounds, hostel and surrounds.
- Bigger boys bully younger children especially at night.
- Sexual harassment is rife, sexual molestation (boys and girls) allegations of rape have been made.
- The Head master does not keep discipline.
- Food is bad and insufficient.
- Clothes and other items are stolen on a daily basis.
- ‡Khomani San children are called derogatory names based on ethnicity.
- No transport to and from school.
- Scholars abuse alcohol and sniff glue.
- Teachers get drunk and do not set a good example.

At the outset the intention was to visit all the farms on the ‡Khomani land claim in order to corroborate the rumours and allegations. After visiting two of the six farms we had enough evidence to support our stance. An investigation by state departments is currently in process.

In her book **Torn Apart** Willemien Le Roux writes a comprehensive study on the situation in which San children find themselves at school. The ‡Khomani San experience unfortunately mirrors her research. Le Roux writes: "During the fieldwork throughout Southern Africa, three distinct crises periods emerged in the life of a learner." [30]

Crisis period one: The first two (even three) years of the San children in formal school were mostly traumatic and culturally alienating. Some of the socio-economic issues contributing to their educational problems such as poverty and health

[30] Le Roux, W 2000

problems, started even before they entered school, so the age group 4-9 years was particularly vulnerable.

Crisis period two: Around puberty, from 10-14 years of age, both San boys and girls experienced a crisis period, since this was the age where the differences between their cultural background and the school environment manifested itself clearly.

Crisis period three: For those who managed to continue into secondary school, the period between Junior Secondary and Senior Secondary was a difficult one, since career and subject choices had to be made and financial assistance to continue education became a crucial issue. The pressure to conform to a peer group image became more difficult.

A pre-primary school (age 5 yrs to 6 yrs) does exist on one of the six farms. Unfortunately the present teacher and her assistant do not have the necessary training to prepare pre-primary children for school. When children commence their education they are already at a disadvantage

Neither the local Primary School nor the senior school have a special needs policy for San children. Teachers either discriminate against San children, or are proud to say they don't know who the San children are in their classes, thus are indifferent to any sensitivities that arise. San cultural child rearing practices are not taken into account. The situation at junior school has resulted in high absenteeism

Lack of self-esteem does not bode well for girls who ought to be able to say no to sex before they are ready or for girls who need courage to insist on safe sex. The girl child who has never been allowed to speak out, let alone have her story believed, or had competent adult help to rectify her situation, can not hope to find herself in a safe and loving relationship. The boy child, who is not heard, taught that his feelings have value or shown respect, will never know how to conduct a safe and caring relationship.

At school San children are taunted, called Bushmen, are told: "Why don't you go back to the bush and wear skins or go naked." Surnames are belittled especially when they are the names of animals.

San children enjoy a great deal of freedom. Breast-feeding continues for at least two years. Small children who are still breast-feeding toddle around, slightly older children walk and play at a 1km radius from their parents. Children are seldom left out of community events. The confines at school are hard to comprehend or adhere

to. When children are not treated well at school, they walk 15-25 km home. Children as young as seven take to the road and arrive at their parents' homes, sometimes after dark.

It is imperative that initiatives to enhance a sense of self be implemented. These, together with a Reproductive Health Programme, could prevent a catastrophic HIV/AIDS situation from developing in teenagers or even younger children.

HIV/AIDS INFORMATION WORKSHOPS / PRESENTATIONS

Fieldworkers attended 20 in-depth information workshops before the rest of the community was introduced to the programme. Once the Field Workers felt confident, they joined the project co-ordinator in presenting the information to the groups living on the farms. The final presentation was given on Groot Erin, where the Field Workers presented the information.

Information Presentations were held on the farms Brosdoring, Miershoopan, Groot Erin and Scotties Fort. Presentations were also given at outlying settlements across the desert including: Noenieput (150km) Swarkopsdam (180km) and Welkom (60km). Small groups of ǂKhomani San live in these settlements.

Observation on misconception and the lowest information levels: We saw a link between farms where education levels were lower and the amount of misinformation people believed to be true.

Community members were eager to gain information on HIV/AIDS, have their fears around contracting the disease validated and to understand precisely how the virus is contracted. Most people did not know what a virus is, but understood the concept that a virus exists even though it cannot be seen. San tradition has many beliefs, which accept that there are aspects to daily life, which exist but cannot be seen.

The farm Klein Erin, was the exception to this trend, new information was not welcomed. We were told*: "We are bored with people dying from TB and it would make a change if people now died of some other disease."* Booklets and condoms offered were not welcome. The field workers and the co-ordinator discussed this hostile attitude but no reason could be found. This small group, 20 people, did not attend workshops presented on other subjects.

Some questions that came from these sessions corroborated the misconceptions prevalent in the ǂKhomani San community:

“ Can one get AIDS from a dead animal?”
“ It is true that if a man sleeps with a woman who is having her period, he will get AIDS? ”
“ How come people are talking such a lot about this when ‘vuil siekte’ - dirty sickness” i.e. syphilis - has always been here and we have cured it with herbs?”
“ The babies are always getting injections at the Clinic, are they being given AIDS from the needles?”

WORLD AIDS DAY

From 29 November to 1 December 2002 SASI organised a youth weekend camp, attended by community leaders, youth workers and SASI representatives. This camp was held at Brosdoring to coincide with World AIDS Day. About 200 people attended, mainly youth. The aim of the camp was primarily to create awareness of HIV/AIDS among San communities in the Kalahari.

Attendees were introduced to the San HIV/AIDS Action Research Project and were informed about the nearest health centre, the Askham Clinic, as well as being given information about how infection occurs, symptoms, testing, attitudes towards people with HIV/AIDS and popular myths about the disease.

Despite summer temperatures nearing 50 degrees, by the end of the rally, the youth showed a good grasp on the information presented. T-shirts with the slogan “*I Care – Do You?* ” which was the theme of the World AIDS campaign and part of a national slogan, were printed and handed out to the youth. Attendees were shown videos from the Love Life Programme Scamto Groundbreakers, having no access to television the youth thoroughly enjoyed it.

The rally concluded by handing over a memorandum to the clinic nursing sister at the Askham clinic.

CONCLUSIONS

Taking into consideration that the concepts brought to the community have been new, response has been enthusiastic. The programmes have been sensitive to cultural values. Community feedback on the HIV/AIDS Action Research Programme has been positive. All members interviewed found every aspect informative and practical and have expressed dismay on hearing the project had reached conclusion. Although not all the members of the community participated, 70% attended. The implications that affect the prevention and care of HIV/AIDS are summarised as follows by comments from within the community.

"HIV/AIDS is a scary disease, I don't think young people here are paying much attention. We have all heard about this disease but I think we need more workshops and training for young people. I would like to be trained as a youth worker."

" Who is going to look after our children now. Our Children could have died if we did not have help close at hand. How are we going to get sick children to the clinic?"

" I've learnt something these past months. A man may think he's a man because he lies on top, but if you don't listen to what a women says and give her respect you will always be the loser."

" If people who drink all the time, stab each other and abuse women would stop we could all go back to having a peaceful life."

Evaluation and feedback from within the community

"I don't want to hear about any girls being pregnant. I am fed up with these girls who get drunk and make babies. They don't care about anything else except getting drunk or stoned. Then when they have the baby, who looks after it? And these young guys, they take advantage of these girls. They don't care about diseases, or AIDS. I keep condoms here for people to use, but when they are drunk, what do they care?"

" I will support these people when they come to talk about the drinking and smoking that goes on all the time. I don't like living amongst the swearing, these bad names that people call each other when they are drunk. Then they also start fighting as soon as they drink. I used to drink in my younger days but eventually I saw that that was not a nice way to live. I would like to understand the Cottage programme better so that I can talk to the people around here, have meetings so that people can stop

drinking. Also it is nice to have VABO people come out here and encourage those of us who don't drink. Life is very hard here, we often have no electricity, the water is not good, and children often go to sleep with no food. So these people help us to feel that it's worth trying to make life better".

"You know we did not know about all this drunkenness in the old days. My parents would beat me if I tried anything like these young people today. Where does all this come from? God does not approve of this way of life. People must listen to the word of God. My heart is not happy about this messing that goes on here. The people from VABO are right, drinking and smoking are bad".

"I am worried about the children at school. They are learning things and they see things when this drunkenness goes on. It will be a good thing for them to feel better about themselves and to know a better way of life".

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"I was shocked to hear how bad it is for the baby when the mother drinks while she is pregnant. I understand now why some children I have seen are the way they are and why we have such a problem here with some of the young people who do crazy things and don't care about themselves or anyone else. All the young girls should know about this so that they can think about what they do. And what about these diseases these days, like AIDS?"

RECOMMENDATIONS

There are a number of important lessons that emerge from our action research. The most important is that HIV/AIDS is impacting on our community right now. People have some information but they also believe things that are not true or are missing important information. The way that the ‡Khomani community will react to this health crisis can still be influenced by education and dialogue. As with our other work, we find it is valuable to draw on the knowledge of the elders and link this up with information from the outside world. Young people as always are an important target but need to be seen in the context of our cultural and human resources within the community.

The fieldworkers who were trained and supported during this Action Research project are keen to take their work further. Below are a number of key themes and actions we have identified for 2004.

In addressing HIV/AIDS amongst the ‡Khomani San, It is essential that the following programmes continue.

TABLE 5: Action Plan table

Theme	Needs & Issues	Actions
HIV/AIDS	The HIV and AIDS situation is going to get worse. This is being expressed through other illnesses at first, particularly TB and meningitis.	Youth workers continue to receive training in health education; HIV positive community members are supported and encouraged to be organised; Community Care Givers / Counsellors trained We look for treatment support We work with local healers to encourage good holistic treatment at home
Violence Against Women	There is still much work to be done before women are safe in this community	More training of health workers to help victims of violence and work with the men who are the primary perpetrators of the violence More dialogue in the community about the link between HIV, violence against women and substance abuse
Substance Abuse	This problem is entrenched in the community. It arises from the legacy of racism and poverty. It is linked to low self-esteem and has become a dangerous cycle that people	We can promote more dialogue and awareness in the community about the causes of substance abuse; We find that where young people are working with elders and creating new

	struggle to get out of. Foetal Alcohol Syndrome needs more attention	livelihoods their alcohol abuse is diminished Solutions need to be long term; Sustainable rehabilitation options need to be looked at
Primary Health Care	The local Government Clinic is difficult to access as transport or money for transport is almost non-existent.	Priorities include providing basic P.H.C, First Aid and affordable transport to the clinic. SASI is looking at a donkey cart project that would ease transport needs and be multifunctional; Advocacy work with local and provincial government is important
Nutrition	Nutrition and food security are serious problems in Kalahari. Likewise, access to clean water is a major concern for children's health.	Water-wise gardens need to be established to provide much needed vegetables to strengthen the collective community immune system; Elders can help train young people to cultivate medicine plants and bush food SASI needs to work with the community leadership on finding sustainable solution to food security and clean water access
Reproductive Health	It is essential to introduce this programme. Youth will benefit as this programme is aimed at empowerment and life skills, which are essential to any HIV/AIDS intervention.	Further training for San health care field workers; Work with community midwives on traditional knowledge and reproductive health
Education	Education remains a major challenge for San youth. Scholarships should be made available for Secondary and Tertiary Education	SASI continues to support the community 'bush' school project; San work more closely with local school to stop abuse and foster respect for their culture; San advocate more attention from government for the maintenance of their languages and science knowledge; Literacy continues to be promoted with young people and adults
Culture	A cultural /educational centre where literature, videos and theatre could be accessed should be built. Workshops could be here as well as P.H.C., which could include HIV/AIDS support	Advocate that the local government stop blocking the building of a community centre at Witdraai; Continue community education projects on the theme of cultural resources and intangible heritage Expand cultural work to Upington and

		other settlements
Traditional healer	A Traditional healer who also has 'Youth at Risk' skills would be the person to work with traditional people. This would enable a spiritual revival to take place as well as working with the youth most at risk.	Help support and organise San healers (*!Gaexa*); Make contact with other Sangomas Promote a forum for dialogue and learning on the themes of traditional healing, smearing of plant extracts, and the healing dance Mobilize traditional healers in the fight against HIV/AIDS and provide them with necessary training and information.

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APPENDICES

APPENDICES

PROFILE OF THE ACTION RESEARCH TEAM

Project Co-ordinator

Claire Barry Project Co-ordinator, South African San Institute Consultant

Claire is an Alternative Health and Psycho Neuro Immunology Practitioner. She became involved in HIV/AIDS and Women's' Issues counselling in Zimbabwe in the early '80s. Her main focus of counselling involved abused women. Her first introduction to the ǂKhomani San in the Kalahari was when she acted as translator for a BBC researcher. This interview gave her insight into the difficulties and conditions experienced by San women. In November 2001 she moved to Kalahari and worked as a volunteer for a year before UNESCO funding became available to the South African San Institute.

Research Trainees /Health workers

Most of the trainees who were recruited have a very low level of literacy but have a wealth cultural and traditional knowledge. People from the community were also recruited on the basis of the current work they are involved in, their enthusiasm to make a difference in their community and their willingness and commitment to take the HIV/AIDS project forward.

Jan van der Westhuizen

Current Chairperson of the Communal Property Association Jan does not become involved in different factions in the San community. He is one of the few people who are able to have dialogue with everyone involved. He is one of the most respected, sober members of the community. His mother was a San woman and his father a German. He is a devout Christian though he does not attend institutionalised church. He lives by his own interpretation of God and the Bible whilst he is not averse to traditional spirituality. He has a very strong sense of San identity and describes himself as a man who is close to nature and respects the earth as part of God.

Susanna Witbooi

Wimsa representative to the South African San Council - Body that represents the San peoples nationally. She is quite active in the community on many levels. She worked as a caregiver in an old age home for many years and has knowledge of first aid. She is also very knowledgeable of traditional culture and medicinal herbs.

Anna Rath Witbooi

She has been involved with caring for TB patients on a volunteer. Her ambition was to become a nurse; unfortunately she does not have sufficient schooling to study

nursing or medical. She has a gift for healing and is considering becoming a San traditional healer.

Juanita Roep, Manne Cloete and Hendrik Vaalbooi left the project after completing the training halfway through for personal reasons.

Willem Vilander and Sharon Windslaan are new recruits to the programme.

THE FIELDWORKERS AT THE EVALUATION OF THE PROJECT

Anna-Rath Witbooi.

I live on the ǂKhomani San farm Witdraai. I am a lady of 25 years and completed Std 6. This report is to say how I feel about what we've learned and what my problems have been.

I really wanted to do a First Aid Course and then it happened! So it was something wonderful to me. I learnt and heard things, which I did not know. I am glad to know what to do under such circumstances.

I also attended the VABO project. Things, which were bad, got better. Also with the violence against women and the men's programme, I learnt things that did not make me happy. The violence we live in as a community is terrible. I have enjoyed knowing that the herbs are going to be used more.

Positive Health, HIV/AIDS was something, which I prayed for and wondered if there would ever be anyone who could support me in what I wished for. It happened miraculously that I met Claire Barry who is the same sort of person that I am. We worked together well. Without her what would happened to the community. If she leaves things will go badly for us. I would like our programme to continue till the end of the year. There are many things I still want to learn.

I have experienced some difficulty with certain members of the community who tell me that I am not a nurse and that I think I am better than I am. I think these people will eventually accept what I am saying. I think that I am saying things that are new to them.

Jan van der Westhuizen

The work, which I did, was here in the San community. As HIV/AIDS Field Worker some things were strange to me. For me as someone who believes in the Bible to hand out condoms and to council people about HIV/AIDS, this was something I had not known about. I believe that a man should have only one wife and that you should be true to her and she to you. I believe that Solomon in his wisdom could maintain 300 wives, but this has not been given to us.

Many things were difficult for me to understand and my nerves took great strain. But now, after 6 months, after all the workshops and sessions we had, it is so worthwhile, so successful and good. Sometimes I found myself doing very difficult work. There were many nights I had to jump up to attend to scorpion stings or snakebites. I had to doctor bloody knife wounds; the project co-ordinator also stood by on these occasions, and tried to save peoples lives. To lessen the suffering of many community sicknesses which are transmitted through sex. For these I used herbal traditional medicines. We learned a lot from community members as well as from the books, which have been put together about San herbal knowledge.

All this has been a great success and my life has changed with the knowledge that I mean something to my people. This is because I am doing something worthwhile. This encourages me and lifts me up because I am doing my utmost to support the community in their time of need. Because I have been shown a new sun and the wonder that I am experiencing that I did not know before. The Metro West Ambulance Training gave me great confidence. The VABO workshops as well as the Child Protection and Women Protection Workshops inspired me. The research with San Traditional people about certain traditional herb plants, the old knowledge that was carried forward from the ancestors. How to know the plants, how to approach them so that their properties are kept and not destroyed. To know how to take the plant without hurting it

Now, I say if people don't know, they should not just take any root or buy one, because they don't know the traditional way or if the plant has been treated in the traditional way when it was taken out. Only a person who is a Traditional Herbalist should take out plants. With this knowledge and competence, I know how to mix herbs after I have diagnosed the complaint; I know what to do and what not to do.

I will always struggle to protect life and to alleviate the suffering, which is in the San community. I know how not to practice in a scandalous manner and how to treat a patient in confidence. How to behave in a professional way as far as appearance and language is concerned.

I've learned the importance of passing Traditional Knowledge on to the next generation. HIV/AIDS has become a threat, people believe, as I do, that this is a hateful scourge of an illness that God and Jesus Christ have poured over the earth to stop the disobedient, Godless way our people are behaving.

We say that HIV/AIDS is a long-term illness. It is the libido of people that causes this sickness. Death has made its jaws wide open to swallow our whole generation, which is already about to die out due to lack of knowledge. This lack of knowledge causes people to reward themselves according to their own desires but the only reward they will get is death. Much of this is caused by the evil alcohol, which leads people astray.

For these reasons we need to heal people physically as well as spiritually.

Susanna Witbooi

I enjoyed the HIV/AIDS programme because, personally, I learnt things I had not known before. For the same reason, the community finds it very good. As fieldworker I learnt so much. There were many programmes, in this one programme, which meant a great deal to us.

At first we found the wind blowing against us because the community did not understand what we were about. Together with the Project co-ordinator we were able to persuade them about what it was were busy with. Now they get impatient if we do not get to see them.

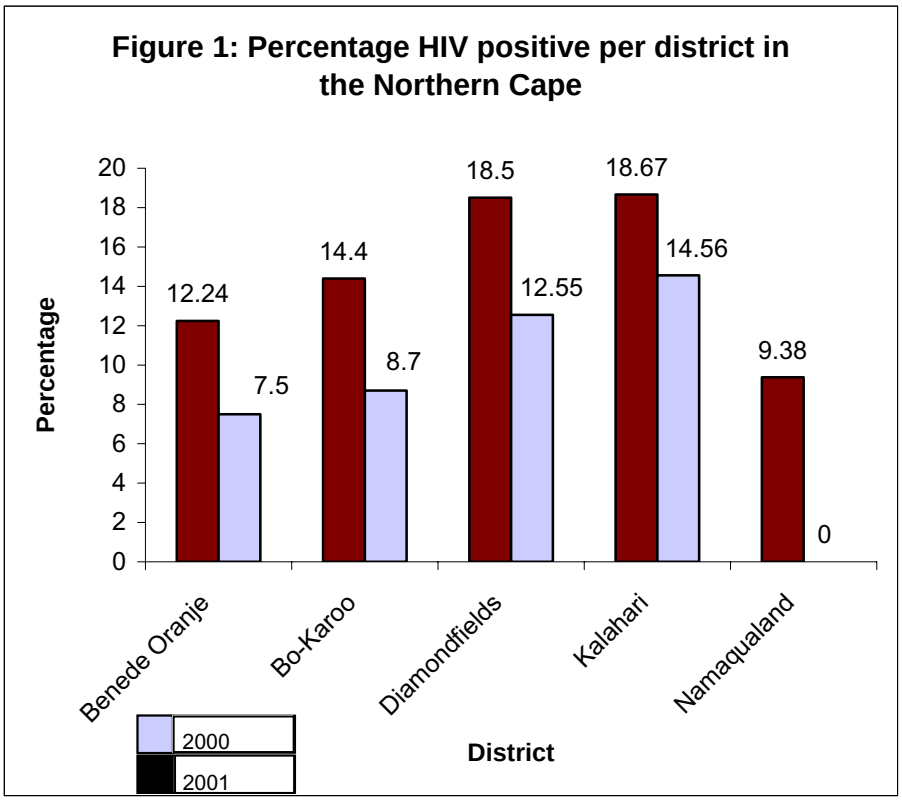
Now we have a problem. We have told the community that the project is about to end. They are very concerned about this. I personally am also disappointed because the programme was an advantage to me. We would like the programme to continue.

STATISTICS AND GRAPHS ON HIV INFECTION IN THE NORTHERN CAPE

1: HIV Percentage by district in the Northern Cape

2001			
District	Total samples	Total HIV	Percentage
Benede Oranje	98	12	12.24
Bo-Karoo	125	18	14.4
Diamondfields	200	37	18.5
Kalahari	75	14	18.67
Namaqualand	32	3	9.38
Northern Cape	530	84	0

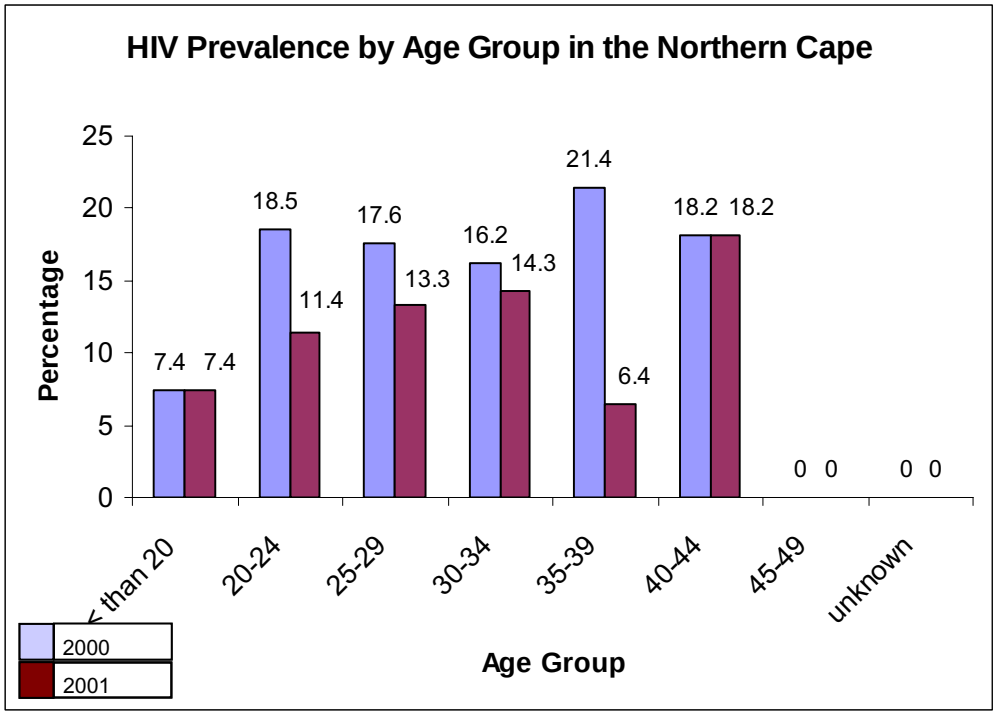
2000			
District	Total samples	Total HIV	Percentage
Benede Oranje	40	3	7.5
Bo-Karoo	69	6	8.7
Diamondfields	263	33	12.55
Kalahari	103	15	14.56
Namaqualand	34	0	0
Northern Cape	509	57	



2. Prevalence of HIV by Age Group for the Northen Cape

2001			
Age group	**Total samples**	**Total HIV**	**HIV Prevalence by Age Group**
< than 20	94	7	7.4
20-24	162	30	18.5
25-29	153	27	17.6
30-34	68	11	16.2
35-39	42	9	21.4
40-44	10		18.2
45-49			
unknown	1		
TOTAL	530	84	15.8

2000			
Age group	**Total samples**	**Total HIV**	**HIV Prevalence by Age Group**
< than 20	95	7	7.4
20-24	149	17	11.4
25-29	105	14	13.3
30-34	98	14	14.3
35-39	47	3	6.4
40-44	11	2	18.2
45-49	1		0
unknown	3		0
TOTAL	509	57	11.2



STATISTICS OF HSRC SALIVA SWAB TESTS ON HIV INFECTION AND RISK BEHAVIOUR IN THE NORTHERN CAPE

SAMPLE INTERVIEW

General Questionnaire

1. Have you heard of AIDS?
- Yes 72
- No 8

2. Is it a deadly disease?
- Yes 31
- No 36
- Uncertain 13

3. Has this disease been around for a long time or is it a new sickness?
- New 8
- Long time 12
- Uncertain 60

Comments:
"This disease has been around for a long time."
"People before were much healthier than now, so they didn't get it so seriously. People used to use herbal medicine and eat 'veld' plants so they lived longer."
"Herbal medicines can cure anything."

5 What do you know about this disease?
- Nothing 8
- Contagious disease 34
- Incurable 25

Comments:
" Just heard about it, don't know if it really exists".
" AIDS in the only disease which takes advantage of a person."
" Friends leave you."
" Have not had contact with this disease, maybe it doesn't exist".
"Spread from one person to another."

6 Where did you hear about HIV/AIDS?
- Clinic 31
- Workshop 1
- School 20
- Church 2
- Friends 1
- Radio 5

- TV 4
- Magazines 10
- Farm Africa 1

7 What are the symptoms of HIV/AIDS?

- Hair loss
- Destroys the nervous system
- Destroys appetite
- Become thin or fat
- Muscles weaken
- Body feels tired
- Causes body to waste away until death
- Become bedridden.

8 Are there people to don't get HIV/AIDS? If so, who are they?

- People who don't believe God have to punish them.
- People who know themselves and live correctly.
- Old people.
- People whose blood is clean.
- People who take care of themselves.
- People who are re-born. (i.e. accepted Charismatic Christianity)
- God gives it to people who are unhappy with God because he doesn't give them what they want.
- God alone cannot get it.
- People who have a correct life style.
- White People

9 How can one avoid getting this disease?

- Avoid dirty toilets
- Look after yourself, respect yourself
- Get your life in order
- Use correct medication
- Do not sleep with just anyone
- Practice safe sex
- Get tested every time you have sex
- Avoid promiscuous behaviour
- Beware of contaminated blood
- Avoid smelly open wounds
- Use condoms
- Use herbal medicines
- Don't have sex with someone who has it

10 How does one contract HIV/AIDS?

- If you have TB you will get it if you don't take your medication
- If you have sex with infected people
- If someone who has HIV/AIDS has sores on their lips or other parts of the body and you touch them
- Through blood transfusion
- Rape
- Dirty blood
- If a baby drinks from someone else's breast
- If someone spits in your face
- From a toothbrush

11. Is there medication that one can take which can cure you completely?

- Yes 36
- No 32
- Herbal medicines can cure you 30
- Doctors have medicines 8
- Don't know 12

12. Is there medication that allows an infected person to live longer?

- Yes 36
- No 32
- Don't know 10

13. If yes, which medicine is that?

- Herbal medicines. 60
- Medicines from the clinic 20

14. Can a person contract HIV/AIDS if they share the following with people who are infected?

- Kiss 32
- Sex 39
- Food 16
- Needles 70
- Breast milk 75
- Toilet 35
- Blood 65

15. Is it shameful to have this disease?

- Yes 34
- No 38
- Don't know 8

16. Please explain your answer.

Yes, it is shameful

- A sexually dissipated life is wrong.
- Because you have this disease
- If you look after yourself and have a faithful partner, you would not get it.
- You will always be alone if you have this disease.
- You cannot help your genetic make up.
- Because your blood has changed, it is not pure.
- People are ashamed because they are afraid people will say bad things about them.
- People will know that you have not taken care of yourself

No, it isn't shameful.

- Anybody can get it.
- You cannot judge anyone because it may happen to you.
- Everyone in the country knows about HIV/AIDS, how could you be ashamed?
- What if you thought your boyfriend was faithful and then he was not?
- You could take herbs as medication and get cured.
- God decides who should get it.
- When it is your turn it's your turn.
- If people think it is shameful, they are uninformed.

16. Are there things that one can do to make sure you have a healthy life?

- Yes 69
- No 0
- Don't know 11

17. How can one be sure to stay healthy and not contract HIV/AIDS?

- Have regular check-ups at the clinic or doctor.
- Learn about herbs.
- Give more information to the community.
- Bring God's word to people so that they understand what is right or wrong.
- Have a blood test every day.
- Look after yourself.
- Do not mix with strangers.
- Keep your body clean.
- Eat healthy food.
- Have one partner.

Comment: no mention of condoms.

18. Can alcohol or drugs play a part in contracting HIV/AIDS?

- Yes 67
- No 9
- Don't know 4

19. In what way do alcohol or drugs influence HIV/AIDS?

- Alcohol distracts your thoughts and takes you away from spiritual life
- Drugs change your behaviour and you don't care about yourself any more
- When you are drunk you can be stabbed by someone who has the sickness
- Alcohol can lead to murder
- You loose your sense of self-worth.
- Men rape when they are drunk.
- If a woman is drunk she doesn't know who she has sex with

20. Do you know the words the letters HIV/AIDS stand for?

- Yes 12
- No 47
- Unsure 21

21. Are HIV and AIDS the same disease?

- This virus is in everyone's blood.
- HIV is curable because you only have the virus.
- If you have HIV it doesn't mean you have AIDS.
- You get both through sex.
- AIDS destroys the body; you get thin and have no appetite.
- They are closely connected.

22. Is there anything that can be done to stop HIV/AIDS from spreading, individually or as a community?

- Create Sports facilities to occupy our time.
- Make people aware of traditional medicines.
- Put people who have this disease in quarantine.
- Community awareness campaign.
- Talk to each other.
- Council young people not to be promiscuous.
- Have programmes against alcohol and drug abuse.
- Herbalists could help with herbal medicines.
- Teach boys to respect girls and not force them to have sex

A comparative survey on completion of the HIV/AIDS Action Research Programme would show if the interventions have been effective.

AN INTERVIEW WITH A TRADITIONAL SAN ELDER: MR R.

This interview shows the type of interaction we had with open-ended interview techniques. A number of the team took time to speak with different adults and elders about their views of HIV /AIDS without using the formal questionnaire described above.

Mr 'R' is illiterate and an alcoholic. His wife has left him; their children live with their maternal grandfather 60kms away. He has not seen them for some time.

Q. Have you heard of HIV/AIDS?
A. Yes

Q. How do you think one acquires the disease?
A. If any little bit of blood from a person who is sick touches you, you will become ill too.

Q. Are there any other ways that one can pick it up? Have you heard of ways that you can get this sickness.
A. If a man sleeps with a woman who has it he will get it too. Then that man can pass it on to other women when he sleeps with them.
A mother can give it to her baby because if her breast milk is dirty the baby will get it.
If you use the same toilet, spoon, cups as people who have it you will get it. Also mosquitoes can give it to you if they bite someone who has this sickness and then they bite you.

Q. Do you think this is a deadly disease?
A. Not really.

Q. Do you know anyone who has died from this sickness?
A. No

Q. Where does this disease come from? Has it always been with us or is it a new thing?
A It has always been around.

Q. Was this sickness around in the time of your grand parents?
A. Yes.

Q. So they knew about this illness.

A. No, they did not know about this. Now people have got clever. The white people brought this cleverness with them. Nowadays people can read and learn about these things.

Q. So, would you say that this sickness was around at the time of your grand mother but has lately been named?
A. Yes.

Q. Are there any ways one can get better from this sickness?
A. Yes

Q. What would you say they are?
A. People should use the herbs from the '*veld'*. These herbs are very healthy and can make people well. These are herbs for any kind of illness. Sometimes a combination of herbs is better.
(Went on to describe various herbs and their healing qualities)

Q. Do you think that people who get this disease have behaved in a way that is wrong?
A. Yes.

Q. What is it that those people have done?
A. It is that they have sinned against God. They have not asked God to forgive them.

Q. What have these people done that needs God's forgiveness?
A. Their lives are rubbish. They are violent, drink, and swear. They don't care about themselves or live a good life. They don't go to church. Even you if go to church only now and then God may forgive you for not listening.

Q. In the time of the grand mothers and before, people did not know about church?
A. No, but now people have become clever.

Q. What is it that makes people so clever now?
A. They can read books and know things they didn't know before.

Q. What did people do before there was church?
A. In those times it was very different. People would go out into the '*veld'* and talk to God out there in nature.

Q. So people spoke directly with God?

A. Yes, anyone could go out there and talk to God. They could hear the reply. If someone has done something wrong they could talk to God and feel guidance within their body. They could ask the ancestors for guidance and help with any problem. The ancestors would come and tell you very quickly if you did something they did not like. Then you could do as they say and you could ask God for forgiveness, then you would not need to be punished and get sick or something.

Q. Do you ever hear God or the ancestors speak to you?
A. Yes, at times, such as when I am out walking in the 'veld'. When I'm out there I feel as though I am a strong person.

Q. Do you think that the old way was a good one?
A. Yes because it was easy to talk to God and get forgiveness.

Q. How come people changed their ways of speaking with God?
A. Well, it was the "*Boere*"[31]. They were the ones who are clever. When one had to work for the "*Boere*" to buy a few things, they were very hard. When I worked in the park (Kgalagadi Transfrontier Park) I would be sent to track lions that had disappeared. I would run. I ran all day for 2 or 3 days, sometimes with no food. Then when I had found the lions the "*Boere*" would come with a pickup. Then I would fun in front of the pickup doing the tracking. I had to keep up with the motor. If you did not do things as fast as they wanted they would hit you.
(Went on to tell of his father and grandfather's experiences).

Q. How come people had to work for the "*Boere*"?
A. We needed to buy things to eat.

Q. In the time of the ancestors, were things the same?
A. No in those days we had enough to eat from the '*veld*' [the bush / desert] and from hunting. Then our land was taken away, the animals became scarce and we got into trouble if we hunted them.

Q. Now that you have some of the land back to live on do you think you can talk to God and hear the ancestors speak to you more often?
A. I could do that. Maybe I should try to hear the ancestors more often because they could tell me what to do. – *Laughs*-. They can really tell you off if you have not listened to what they say you should do.

31 Boere is Afrikaans for the farmers but is generally only applied to the White settler farmers who took the land of the indigenous peoples and implemented the harsh system of apartheid.

Q. How about dances that were done for healing, were they still done when you were young?

A. Yes, when I was a child we used to dance a lot.

Q. How come there is not much dancing now?

A. I suppose people got too clever. I sometimes feel like dancing. The feeling does rise up in me but I don't think I could dance anymore my body is too weak. My lungs were ruined with all that running I did when I worked in the Park. I don't have the stamina anymore.

Q. When there was dancing for rain or healing and the animals were called in, who did that? Were there specific people who called the animals or was it any one of the dancers? Were particular people associated with specific animals?

A. No not all people can call the animals it is only me. I can talk to lions or any other animal.

Q. This is a very rare gift. How about talking to some of the other people and seeing if anyone is interested in dancing. Not for money but for healing and so on?

A. I suppose I could get fitter if I really tried and took '*veld'* medicines.

Q. Maybe you could teach your children what you know. If this knowledge dies out it will be sad.

A. You're probably right. But don't expect too much from me. I'll think about this and see what happens. I'd like to teach my children what I know just like my father taught me. I'm sure the ancestors would like me to do that, they always get annoyed when people don't take heed of how things used to be done.

The interview was concluded with HIV/AIDS information and the use of condoms in curbing the spread of HIV/AIDS and other STD's.

Two weeks after this interview this elder attended the men's workshop on violence against women. The workshop happened to include HIV/AIDS. The elder felt confident enough to explain HIV/AIDS and prevention to the people attending the workshop.

REPORT OF WORLD AIDS DAY 1.12.2002

Introduction: The ‡Khomani San HIV/AIDS Action Research Project was introduced and an explanation of the programme given.

October 2002 through March 2003, 6 fieldworkers were trained, 4 youth and two adults, 1 from Scotties Fort, 1 youth, 2 adults, Brosdoring, 1 youth Erin, 1 youth Uitkoms/Miershooppan.
The training encompassed HIV/AIDS prevention, information, care and counselling; research; interview techniques; substance abuse; violence against women; reproductive health; traditional herbal practices and attitudes.

***1 Hour information lecture**

The youth were advised of the nature of the disease.
The difference between HIV and AIDS, preventative measures i.e.: safe sex.
The ways in which the virus can and cannot be spread.
HIV/AIDS is not a punishment, a crime or something to be ashamed of changing attitudes towards a person living with HIV/AIDS.
This to go about having a test, the necessity of counselling before and after results.
Having the badiap of friends, family and medical staff.
The concept of the disease being one of mind, body and soul was explained.
Keeping a positive and look on life and enjoying what one can cut of everyday situations, care of before living with AIDS.

Discussion and feedback

Youth were given the opportunity to discuss what they had learnt and to have any areas of uncertainty cleared.

NOTES ON SYMBOLS

How to type special letters: you can pull down the insert menu, choose Symbol, go to Normal, and select the appropriate symbol. Or you can use your number pad (make sure your number pad is activated!):

‡ type ALT + 0135 (this looks better in Arial than Times New Roman)
â type ALT + 131
ê type ALT + 136
î type ALT + 140
ô type ALT + 147
õ can only be added by INSERT, or CTL+SHIFT+~, let go, type o or O
û type ALT + 150
| and || are now on most keyboards, usually in upper case only.