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# LANGUAGE AND HIV/AIDS HEALTH PROMOTION IN SMALL SCALE MARGINALIZED COMMUNITIES

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**Abstract**

The continual cases of new HIV/AIDS infections in San communities is an issue of grave concern. Given that the information aimed at sensitizing these communities was disseminated in English and Setswana and most of San people spoke only San languages, it was hypothesized that languagebarrier could be contributing to inadequate knowledge about HIV/AIDS in San communities.Based on this problem, this paper examines how failure to use the San and other languages spoken by the San could have contributed to resistance to HIV/AIDS health promotion by some San people in the Central District. Using a semi-structured interview withrandomly selected four San couples at Moitshopari cattle-post, this paper examines the San couples' behaviors and their response towards HIV/AIDS campaigns. The findings indicated that the Sanwere living in a different and peculiar communication environment which did not accord with the communication processes of HIV/AIDS health promoters. Data were interpreted and analyzed through a careful consideration of the cultural context of the San where it wasproduced. The conclusion is that despite all the efforts made to sensitize Botswana populationon HIV/AIDS health, failure to address HIV/AIDS issues in the languages spoken by alltarget audiencesmade the campaigns ineffectual.

**Key words: San, HIV/AIDS, language, campaign, health promotion**

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## 1. Background Information

Ever since the beginning of the HIV/AIDS era, Botswana just like the rest of the world, embarked on robust and rigorous campaigns. This was inevitable given the threat HIV/AIDS was posing to people's lives across cultures (Health Promotion International, 2003). The HIV/AIDS campaigns were intended to reduce the risks and spread of HIV/AIDS. Using various approaches, media and methods of communication, campaign messages revolved around the underlying causes of HIV/AIDS and what people could do to circumventfurtherspread of the disease or to evade being infected all together. Sixteen years after the inception of HIV/AIDS educational campaigns in Botswana, it wasevident that the Ministry of Health was not able to reach all segments of the Botswana society with HIV/AIDS campaign messages.Precisely, HIV/AIDS campaigns in Botswana started in 1999. The whole idea was to facilitate a closer interaction and dialogue with the general public on HIV/AIDSand to help them adopt safer alternatives of sexual behaviorsso as to reduce the risks of being infected or being re-infected.

The Ministry of Health officials used Setswana (Botswana's native language) and English to spreadcampaign messages. However, the English language seemed to be dominant as evidenced by its use in many written documents, advertising materials, radio and television messages. Research has shown that despite Setswana and English being common and spoken by the majority of Batswana (Botswana citizens) there are some ethnic minority groups which do not understand nor speak Setswana (Bolaane and Saugestad, 2006). Those ethic minority groups speak different home languages (Mokibelo and Moumakwa, 2006).

Research has also shown that when these two languages are used as languages of instruction in the classrooms in those ethic minority groups, they tend to become major hindrances to the understanding of instructions (le Roux, 1999; Nyati-Ramahobo, 1999, 2000; Pansiri, 2008; Motshabi, 2006). In fact, the use of these two languages in schools contributed significantly to driving students away from school at the initial stages of learning. Apparently, Sanlearners did not find any reason to sit in the classrooms without meaningful learning ((Motshabi, 2006; Mokibelo, 2014; Nguluka and 2012). Based on this problem, it was hypothesized that the San ethnic minority groups were not able to conceptualize and understand HIV/AIDS campaign messages which were communicated to them in either English or Setswana.

The hypothesis that San communities could have been unable to relate with and conceptualize HIV/AIDS messages was borne of previous related studies that had been done. The San from the Central District had been previously researched on their reading skills 2004-2005 (Mokibelo & Moumakwa 2006) and it was found that language barrier impacted on their ability to read. Also, a tracer study was conducted in some selected Primary and Junior Schools in 2008 to find outhow English and Setswana, the two languages of instructions, affected San learners at higher levels of education. It was found that these languages presented inequalities and a barrier to learning which resulted in disengagement from school (Mokibelo, 2009). In 2011, another study was conducted on why the San drop out of school by the same researchers.This study was therefore a follow up on the San after leaving school to see how the languages used in formal education impacted on their understanding of HIV/AIDS health promotion messages.In the light of the findings of these researches; it was concluded that if the two languages caused San children to drop out of school, it was possible that the same languages could create a barrier to the San's understanding of HIV/AIDS campaign messages who incidentally spoke different home languages.

As Nyati-Ramahobo (2004) notes, the Ministry of Health is an agency that deals with issues that affect the whole populationespecially within the framework of HIV/AIDS pandemic. Given that communication with the people about health matters is vital and inevitable, it is expected that it should be done through languages that would be understood by all segments of the society. Thus, while it was apt to use Setswana and English to communicate HIV/AIDS campaign messages to people who understood them, it was inappropriate to use them to communicate to ethnic minority groups such as the San. Communication of HIV/AIDS campaign messages to San communities had to be done in their own native languages. Even though data from the Ministry of Health indicated that only 42% of the documents were written in either English or Setswana; it was not unusual to find posters in primary schools and health centres in the remotest areas of Botswana written in English. This meant that, notwithstanding the fact that some ethnic groups did not understand Setswana and English, the Ministry of Health principally spread HIV/AIDS information in English and Setswana. This was in contravention to the basic understanding that in the field of communication that; information has to be communicated using means and media of communication that target audiences are familiar with and use in their daily interactions.

Below are some of the examples of the messages that were used by the Ministry of Health to reach all segments of Botswana society with information about HIV/AIDS during the campaigns.

**Abstain, Be faithful, Condomise,**


Fig 1

This message was common in billboards across the country at the initial stages of HIV/AIDS campaigns and it conveyed the message that avoiding HIV/AIDS was as easy as A.B. and C. The message required the population to avoid having sexual activities all together; stick to one partner and be faithful to that only one partner; and or to use condoms whenever they had sex. This message was written in either English or Setswana.

**Prevention from Mother to Child Transmission (PMTCT)**

The Prevention of Mother to Child Transmission (PMTCT) programme's primary goal was to prevent transmission of HIV to unborn babies from infected mothers, a process usually referred to as vertical transmission. Through this programme, the Ministry of Health sought to advise HIV/AIDS positive pregnant mothers to receive at least two Tetanus Toxoid vaccines during pregnancy to prevent the transfer of the HIV virus to their unborn children. This message was communicated through the radio and television in either English or Setswana (Botswana Daily News, Friday December 14, 2012: 238: 19).

**Cut the chain – Networking (NACA)**

This message was used by NACA (National Aids Coordinating Agency) to appeal to Batswana to be faithful to their partners and reduce the number of sexual partners. Just like the rest, this message was also written in either English or Setswana.

**Male Circumcision**

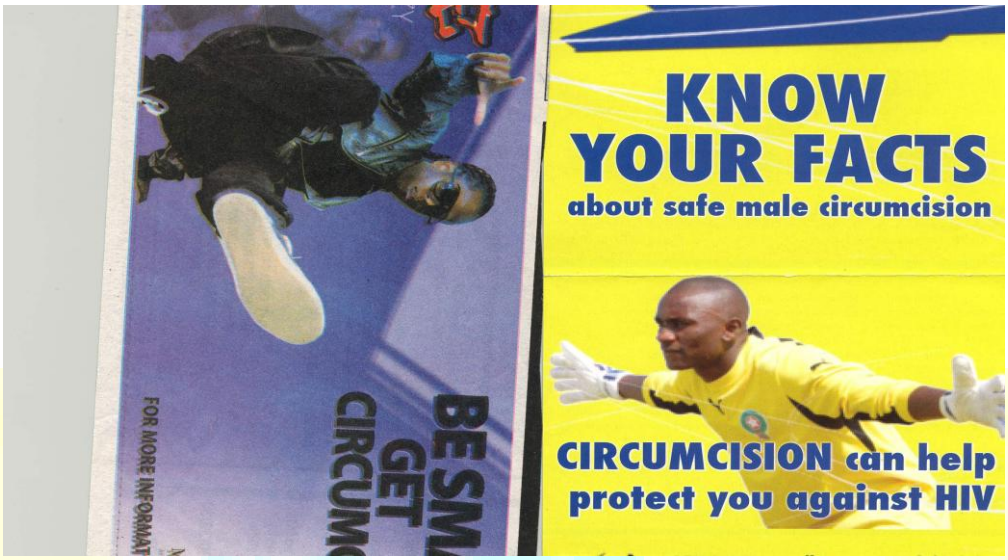


Fig 2

The male circumcision message was communicated on television and radio by local music and soccer celebrities in both Setswana and English. The music celebrity emphasized that circumcision reduced the risk of being infected with HIV/AIDS by 60%. As the picture below shows, the soccer celebrity (football goal keeper) is running with his arms spread wide, enjoying purported success after saving a goal with the caption "**Know Your Facts: Circumcision Can Prevent HIV."** While some of the advertisements included a line that says "**even a goal keeper needs his defenders**" some did not have this follow up line. This message was written in English.

Given this problem of language biasness, this study aimed to find out how San ethic minority groups related with HIV/AIDS campaign messages which were not written in their languages but were meant for them to read and understand. Thus, this study was driven by the following research questions:

1. How do the use of Setswana and English in HIV/AIDS campaigns impact on the reception and understanding of the messages by San ethnic groups?
2. What is the relationship between HIV/AIDS advertising materials and the San ethic group's socio-cultural contexts?

HIV/AIDS promotion was of profound interest becausethe AIDS pandemic was threateningto wipe out the entire polities in Botswana just as was the case in many other African countries. As shown by the research questions above, this study did not intend to interrogate scientific HIV/AIDS issues. It was solely concerned about the languages used for the campaigns

against HIV/AIDS which incidentally werenot the languages spoken and well understood by the San people.

## 3. Theoretical Perspectives

### i). Statistical Exposition of HIV/AIDS Prevalence

The literature on the status of HIV/AIDS in the world indicates that HIV/AIDS is still a major global problem. It is estimated that about 33.3 million people in the world are living with HIV/AIDS (Ayiga, 2012). It is also estimated that in Sub-Saharan Africa alone, about 26.6 million people live with HIV/AIDS while approximately 3.2 million new infections occurred in 2003 (Pilane, Mokganya, Magowe and Tsheko, 2005). Pilane et al (2005) also point out that in 2005, the infection in Africa catapulted to 38.6 million people worldwide with 4.1 million new infections and 2.8 million deaths.The literature further shows that about ten million young people aged between 14 and 24 and almost 3 million children under 15 years of age are living with HIV ((Pilane, Mokganya, Magowe and Tsheko, 2005). An estimated eleven million children have been orphaned by AIDS in Sub-Saharan Africa.

According to UNAIDSReport (2006), Botswana has one of the highest HIV prevalence rates in Sub-Saharan Africa. This prompted the Botswana government to rigorously embarked on sensitize the nation about the need to prevent further infections through campaigns. The need to prevent getting infected was also emphasized by former Botswana State PresidentDr Festus Mogae. He stated in 2006 that in the absence of a vaccine or cure, and given the intensity and expense incurred in the treatment of the often-devastating HIV/AIDS related diseases, prevention was the most important focus of attention. Manson (2002) observed that HIV/AIDS is spread through unprotected sex with an infected person, being born to an infected mother, and being in contact with infected blood and body fluids.

The call for prevention of further infections was encouraged by the Ugandan experience. Uganda had reduced HIV/AIDS prevalence to about 6% in 2002 and had made significant strides in expanding access to antiretroviral treatment(Ayiga, 2012). Addressing himself to antiretroviral treatment, Ayiga (2012) fears that antiretroviral treatment could impede consistent use of condoms among the general population. However, the Ugandan study does not show any correlation between antiretroviral treatment and a decline in condom use.

Another success story of HIV/AIDS prevention that can inform HIV/AIDS campaigns is Rwanda. Binagwabo et al (2012) note that Rwanda has a comparatively low HIV prevalence of 3% and it has decreased the disease's prevalence through a decade long comprehensive approach. Binagwabo et al (2012) further point out that HIV has major implications for the individual, family, social and economic stability and that the vulnerable segment of the population is the adolescent group. They argue that HIV/AIDS impact more on adolescents because they lack many socio-economic protections to mitigate the effects of the disease. However, there has been a shift of events where older people too are affected by the HIV/AIDS epidemic. For instance, it has become common to find women and men aged 50 years and older infected with HIV/AIDS virus (Scholten et al 2011).

Disclosure of HIV status has been repeatedly described by other studies as an essential element in the prevention, treatment, care and support of people living with HIV/AIDS (Ncama, 2007; WHO, 2004).Ncama (2007) reports that people who do not disclose their HIV status deprive themselves of family and social support and they burden themselves with guilt and secrecy of non-disclosure. Paxton (2002) also posits that suppression of one's feelings results in stress, which affects physical health and well-being. The reluctance to disclose HIV/AIDS status has been widely documented and is often attributed to fears of loss of economic support, abandonment, blame, physical and emotional abuse, and disruption of family relationships, discrimination and other forms of reprisal (WHO 2004).

To try and reduce infection rates and the spread of HIV/AIDS a conference was organized by the Red Cross AIDS Information and Voluntary Testing Centre and DITSHWANELO in Kasane, Botswana, in 1995. One of the outcomes of that conference was a charter document on HIV/AIDS. Conference participants sought to make that charter document an advocacy tool for the whole nation. One of the pillars of the charter document was an emphasis on behavioral change. The Charter Document (1995) calls on all Batswana, the government, and the private sector, to collaborate and share the responsibility of mitigating the spread of HIV/AIDS. According to the Charter Document(1995) all persons, irrespective of their HIV status, should act responsibly towards themselves and towards others. Further, the charter document emphasizes that all those who are sexually active should practice safer sex to avoid infections or re-infections. Although the message put across from the charter document carries such important messages of acting responsibly towards themselves and others, the

messages can only be understood by those who can read and understand English and Setswana. As explicitly shown in the background section, documents and other HIV/AIDS advertising materials written in English and Setswanaform the crux of this study.

**ii). Embedding HIV/AIDS Messages within Socio-Cultural Context of Target Groups**

Contrary to practice in Botswana where HIV/AIDS documents are written only in English and Setswana, the theory of social constructionism suggests otherwise. This theory suggests andemphasizes that the communication of messages should accord with popular means through which target audiences communicate and generate knowledge which sustain and constitute them (Loustaunau & Sobo 1997: Lupton 2003). It must be noted that in advocating for the consideration of people's communicative interactions and social practices when communicating messages to them, the social constructionist approach is suggesting that the knowledge and interpretation of HIV/AIDS messages and behaviors and patterns of interactions of the San were influenced by their social context. This means that for the San to meaningfully and intelligently generate knowledge about HIV/AIDS prevention, campaign messages have to be written and verbally communicated in their languages. This validates the hypothesis made in the background section that the San were probably unable to conceptualize and fully understand HIV/AIDS campaign messages.

Furthermore, social constructionism perceives reality as being socially created and viewed from a particular cultural standpoint (Gergen and Gergen 2004). It also views realities as being outcomes of communicative actions rather than simply being objective entities (Ford and Yep 2003; Griffin 2009). Gergen and Gergen (2004) clarify and emphasize that social constructionism does not deny the existence of "reality". They posit that whenever people define what "reality" is, they speak from the ambit of their cultural traditions and orientations.This means that the San's perceptions, attitudes and knowledge about HIV/AIDS messages are directly influenced by their cultural traditions and orientations, and can only be observed through their communicative actions. This latter statement does not only verify the suggestion that given the multilingualism and multiculturalism status of Botswana, the use of only Setswana and English in HIV/AIDS advertising materials could be marginalizing ethnic minority groups. It also informs the methodology for this study. Given that knowledge about any particular phenomenon can only be observed through communicative actions, it means that the knowledge and attitudes of the San about HIV/AIDS campaign messages could only

be observed through talking to them; hence the decision to use a semi-structured interviewing method to collect data from the San.

Allied to the issue of reality, Gergen and Gergen (2004) further assert that as people communicatively interact and engage in dialogues on different issues, they cross a threshold into new worlds of meanings. In a broader sense, social constructionism recognizes that as people communicate with each other, they construct the world in which they live (Lorber and Moore 2002; Gergen and Gergen 2004). This resonates well with Tan and Tan (2006) who in demonstrating the relevance of social constructionism as a framework for studying communication processes posit that communication interactions are conduits through which "identities of participants involved in interactions are formed, shaped, affirmed or denied and cultures in which interactions take place are also renewed and modified". This explains why this study purported to unearth the interplay between HIV/AIDS messages and the socio-cultural context of the San.In other words,the concerns of social constructionism indicated the need to investigate whether or not HIV/AIDS health communication was embedded within the San's cultural orientations and practices.

As repeatedly alluded to above, it was on the strength of the concerns of the social constructionist paradigm that the authors of this paper developed a hypothesis that the experiences of and communication of information about HIV/AIDS had to be connected with the San's varied socio-cultural identities, especially their popular means and media of communication. Based on this hypothesis, it was presumed that the Ministry of Health was not using the existing popular forms of communication and media through which the San communicated and acquired knowledge.

## 4. Methodology

This study adopted a case study approach to investigate the impact of using English and Setswana to communicate HIV/AIDS campaign messages to the San who spoke different languages.

The Semi structured interview method was used with four San coupleswho were purposively selected. The interviews ran for a period of six weeks at Moitshopari cattle-post. The participants' age ranged between 18 and 35 years. The ages of the couples were important to

this study given age has a bearing on people's thinking, behaviors and actions, and these would influence their perspective and understanding of campaign messages. As shown in the section below, the couples were referred to as cases 1, 2, 3 and 4 respectively. The participants lived at a cattle-post (a place where farmers keep their cattle and livestock) and they worked as cattle herders.The participants' literacy levels were low. For instance, some disengaged from school at Grade One, Two and three and four, while others did not attend school at all.

The Semi-structured interview method was chosen because it would enablethe researchers to haveface to face interactions with participants and record them verbatim for accuracy and preciseness. The idea was to capture and hear what the participants said about HIV/AIDS health promotion and how they understood HIV/AIDS health promotion messages. Interviews would also assist in observance of non-verbal communication of the respondents. The interviews were conducted on individual basis for privacy and to avoid a situation where partners would intimidate each other.In this regard, the participants expressed their views openly and without fear.

Data for this study was produced in the form of narratives of subjects' opinions. As a result, data analysis was largely interpretative, analytical and descriptive. To put it differently, data was analyzed using Corbin and Strauss's (2008) idea of grounded theory. Grounded theory is an approach which is characterized by systematic processes of collecting, coding, analyzing and sub-dividing data into categories based on themes that emerged from the data itself (Corbin and Strauss 1990; Corbin and Strauss 2008). It is one of the most rigorous, popular and widely recognized approaches to qualitative research (Jeff and Taylor 2014). Using the grounded theory approach, the coding enabled division and sub-division of data into common themes and sub-themes embedded in the data.

The analytic notes were accomplished through the questioning of data and making comparisons as suggested by Corbin and Strauss (2008). The questioning of datainvolved exploring opinions expressed by interviewees, in order to determine the extent to which they answered research questions and confirmed or disconfirmed hypotheses developed at the initial stage of the study.

## 5. Findings on the Knowledge about HIV/AIDS by the San

The results of this study unearthed a profound lacunae in the dissemination of HIV/AIDS information to the San. This has resulted in lack of knowledge about HIV/AIDS by the San. It has also led to a heavy reliance on cultural and traditional practices in intimate relationships; reluctance to take anti-retroviral (ARV)medication and general indifference about HIV/AIDS related issues. Below, the results are discussed case by case in order to demonstrate these claims.

**Case 1**

Participants in this case comprised an illiteratewoman aged 33 and her 35 years partner who was also illiterate. The woman's responses to interview questions explicitly demonstrated that despite HIV/AIDS campaigns having been in force for years, she had not changed her casual sexual behaviors. She had multiple sexual partners which astonishingly included her boyfriend (the one who was part of this study), her father and uncle. According to the participant her father believed that if his daughters got married outside their kinship, they would be abused by their husbands. As a result he kept his daughters and their partners in his home and slept with his daughters despite them having their partners. He called this "looking after the family". Having father and uncle as the participant's sexual partners, was a clear demonstration of the encroachment of culture and traditional practices into the San's intimate relationships. In the past Batswana married their close relatives. However, the girls could not marry or even sleep with their biological brothers, uncles or fathers.

By seemingly not being perturbed by keeping three sexual partners, thewoman indicated limited knowledge about HIV/AIDS. Her behaviors poseda danger to herself and her sexual partners because she continued to sleep with them interchangeably despite being aware that there was HIV/AIDS and that they had been infected. Also, consequent to having tested HIV positive and started taking ARV's,the participant did not take the medication as prescribed. She indicated that she decided not to take the treatment because it made her sick.As a result she lost four of her children who were born infected. Asked about whether or not she used condoms during sexual intercourse the young woman stated: 'my partner does not want to use a condom because he believes that it reduces pleasure. Again, he thinks I may sleep around with other men who may make me pregnant". When asked about his father, the young woman said, "My father is selfish. He wants to sleep with everybody in the compound and

we did not know that he does that until we discussed this when we went to collect firewood. We were a group of girls from the same compound."

On the issue of HIV/AIDS, the participant said, "I know about HIV/AIDS but I do not really understand what it entails. I hearthat people are dying and four of my babes died but I am not sure that it was the disease. My father has a skin problem too. His skin is very rough and it's like the skin of an elephant. Blood oozesout in some of the sores on the skin and where there are skin cracks. So I am not really sure it is AIDS."

The participant's babies died before they were born. If she knew about the PMTCT programme, she could have enrolled at the clinic to prevent her babies from dying. When asked about some of the relatives she had sexual contact with especially the uncle with whom she had a child she said: "at times he gets sick too, but in most cases he suffers from flu and splitting headaches or develop sores under his feet". When asked if these could be signs of HIV/AIDS the participant indicated that she did not know.

The male partner on the one hand, indicated that he was aware that his partner had multiple sexualpartners during the interview. However, he was unequivocally adamant that there was no problem with her partnerhaving sexual relationships with other men. He narrated that: "I am married in the family that does not accept me. In my absence, some of my partner's relatives sleep with her. But what can I do? Out of the eight children this woman had (this includes the four that died), only one is mine". When asked if he used a condom he stated: "if I sleep with this woman using a condom, she will sleep with others without using it, so I will be the one missing out on unprotected sex while others are enjoying".

Answering the question on what he knew about HIV/AIDS, the man said:"aah! People around me do not talk about the disease. I do not fully understand where the disease is coming from. All that I know is that there is such a disease. Again, I can't read and write." When asked if he was infected with HIV/AIDS, he said: "I do not know, it is my partner who has been diagnosed with the disease. I never go to the clinic and therefore I do not really know. But I am not sick so far. I have been with my partner for eight years now. But, I have had other partners as well".

Participants' responses in this case revealed that there was inadequate to no knowledge about HIV/AIDS pandemic. This begs the question: how has the information about HIV/AIDS which had been robustly communicated through various media evaded this San couple?It is evident from the responses that: the cut the chain, be faithful, abstain and condomise messages had not reached them. The participants indulged in risky sexual behaviorswilly-nilly because they had very limited information about HIV/AIDS. It suffices to say that the respondentsdid the opposite of what HIV/AIDS campaign messages demanded.

**Case 2**

Participants in this case were a woman aged 18 years and a young man aged 19 years. The couple haddropped out of school at grade four and three respectively. The female participant indicated that she was abandoned by the father of her child and she had many sexual partners. She also indicated that she had sex without any form of protection. When asked about the knowledge she had about HIV/AIDS virus, she said:"I know about the disease and I know people are dying from the disease. But I am not sure whether one can contract it through sex alone. Otherwise I could have died a long time ago". Such an answer suggested that the participant had limited knowledge about the transmission of HIV/AIDS. When asked why she had multiple partners after being abandoned by the father of her child, the respondent stated that: "They ask me to have sex with them and I agree. Again, I do not have a stable partner and therefore I might find one that satisfies me. Also, some of my partners give me money".Asked if she was aware that she risked her life by sleeping with many men she responded by saying: "they want to use me and I want to use them too". She went on to say: "famonna a ntenakemokgwisa lebele (meaning if a man annoys me, I dump him and go for another one". These kind of responses showed that the respondent was not accountable for her own life and others as well. Asked where she leant about the HIV/AIDS disease she said:"Nowhere. we are in the bush and nobody comes here. In the clinics they write the information in English but we do not understand English. Some of us ran away from school at a tender age before we could learn English".

The young man in this case also admitted to having had many multiple partners in his life and having sex without using condoms. He was also aware that his partner had many sexual partners before him. Heindicated that some of them had died. Asked whether or not he knew about the disease he responded: "Yes, they used to talk about it at primary school when I was

a student, but I did not understand some of the information because it was in English. Again, I did not complete my primary education. But I used to see scary pictures of people infected with HIV/AIDS. But now I do not hear about the disease anymore".

**Case 3**

This case also involved a young couple both of whom dropped from school at grade two. The woman was 22 years and the man was 24 years. This couple alsoseemed to have little knowledge about HIV/AIDS. They too indulged in unprotected sex with multiple partners. When asked about what she knew about HIV/AIDS, the woman claimed that she sometimes heard people talking about the disease when she went to the clinic for regular antenatal classes. But she did not fully understand how the disease was spread and what caused it. Asked if she had seen a patient suffering from HIV/AIDS, she was uncertain. She said:"The ones that I saw were not really sick. Although they were on treatment, it did not show that they were sick. There are sick people around, but I am not sure whether they are suffering from HIV." When the respondent was asked about where she heard about the disease she said:"From the clinics, but there people talk in Setswana and they speak so fast that we can't figure out what they are saying. I do not ask them questions because they might think that I have the disease". When asked if she thought she had the disease she said:"No, I do not suffer from HIV. I know my partner had a woman who was suffering from it, but I do not have it myself".

The male partner confirmed that before he met his current live-in partner, he had a woman who had contracted the disease.But the man indicated that he was not sick then. That notwithstanding, it was inconceivablethat this woman could think that she did not have the disease while she was in an affair with a person whose previous partner died of the same disease and she was having unprotected sex with that same man.

It can be discerned from the responses that information about HIV/AIDS was lacking from the couple. They knew about the disease, but it was not clear how the disease was transmitted such that even if they were at risk, they did not make any effort to go for HIV testing.

**Case 4** The participants in this case were a man aged 30 and a woman aged 26. The couple were visibly sick and showed signs of being infected with the HIV/AIDS virus. They had

sores all over their bodies, worryingly thin and they indicated that they sometimes fell critically ill. They also indicated that one of their children died at infancy. The couple went to traditional doctors and not the clinic to seek medical help. The man gavepretexts for his suffering and ailment. He claimed that the sores that developed from his feet were caused by the fact that he stepped on the hole made by spiders on the ground. He indicated that to cure them he had to look for the same hole and get the soil from that holeto wash his feet with. This was a typical case of encroachment of cultural beliefs and practices in the man's conceptualization of ill-health. Surprisingly, the man admitted to having had multiple sex partners some of whom had died from symptoms associated with HIV/AIDS such as: loss of weight, coughing, and developing sores. He knew about this but kept on denying that he had contracted the disease.

When the man was asked about HIV/AIDS he said: "this is a disease I hear people talking about. We hear the disease affect people in towns and cities only." Surely, the respondent was distancing himself from the possibility of being infected. For him the disease was for people in the cities and could not affect those who are at the cattle-posts. This kind of response would not help the man to seek medical attention because he believed in witchcraft. Asked whether or not he was able to read the posters about HIV/AIDS in clinics and hospitals, he said: "I do not go to the clinic or the hospital; they might ask me to undress. I am an old man. How can I undress in front of small boys and girls? I do not want to be insulted".

This kind of response demonstrated the man's stereotypical attributes which could notbe circumvented through provision of information about HIV/AIDS.Further asked if he ever considered getting circumcised, the man responded by saying: "What will I use if I cut the very important part small? How will I approach women? God gave me my private parts and how do I start cutting them?" Surely, the participant did not fully understand what circumcision was about. The information about the significance of circumcision in curbing the spread of HIV/AIDS was lacking.

Unlike the man, the woman showed a measure of understanding about the disease. During the interview, she admitted that that she and her partner could be infected. She shyly said, "My partner sleeps around with other women. Sometimes people come to tell me the women he goes out with, and some of them are HIV/AIDS positive. Again, my husband refuses to go

and test for HIV/AIDS and he believes he is bewitched. Who would bewitch such a poor man? My own mother changed partners after my father died and she died too. I think they were HIV/AIDS positive. I can see the signs and symptoms they had in us. So I think we are infected". When asked where she learnt about the disease she said:"some of our family members died from the disease. We used to talk about it with our cousins, but we do not have full information about the disease.

It was gratifying to note that at least the woman in this case study admitted that she and her partner could be suffering from the disease. Unfortunately, she seemed helpless and surrendered her fate to her husband who had multiple sex partners.

The results of the four cases above indicate that the San ethnic group had very little to no knowledge about HIV/AIDS despite the campaigns having been in force since 1999 (fifteen to sixteen years back). The question then was: where does the problem lie? Participants' responses indicated that there were flaws in the way information about HIV/AIDS was disseminated to the San. These flaws are discussed in the following section.

**5. Flaws in the Communication of HIV/AIDS Health Promotion Messages and Implications.**

As already alluded to, despite HIV/AIDS country wide campaigns having been going on since 1999, the San were still not reached by the campaign information about HIV/AIDS. Two issues that precipitated the lack of adequate information about HIV/AIDS emerged from participants' responses captured in the section above. Those issues are: languages usedand cultural beliefs and orientations.

**i) Languages Used for health Promotion**

It has emerged from the findings that the languages that were used to disseminate messages about HIV/AIDS did not accord with the socio-cultural context of the San. In all the four cases described above, the issue of language was raised by the participants. It can therefore be generalized that language barrier prevented access to HIV/AIDS information by the San.The use of Setswana and English to communicate HIV/AIDS messages inhibitedthe San's accessto full information and have their awareness on HIV/AIDS raised.The language barrier issue is a common phenomenon in the communication of messages in African

countries. Lesch (2007) acknowledges the language barrier between English and Afrikaans-speaking doctors and their patients, most of whom speak African vernacular languages. Similarly, in Kenya, the Central Intelligence Agency stated that providers may not speak a particular client's vernacular when they are fluent in the national languages: Swahili and English (Odine, 2015).

The implication of this to HIV/AIDS health promotion is that health organizations and agencies should devise community specific messages which will address the peculiar linguistic and socio-cultural contexts of all target communities. For example, the Ministry of health should use a San language when communicating HIV/AIDS messages to the San. As proven by the findings of this study, using English and Setswana to communicate messages about HIV/AIDS to the San or any other community that does not speak these languages would be a nonstarter. The use of community specific languages can be achieved by using community opinion leaders who have an understanding about the health issue being promoted to communicate to their communities.

Allied to language is the issue of pictorial messages. Taking the message about male circumcision (figure 2) as an example, it is not a given that the San, given their high illiteracy levels, would correctly interpret the picture. They might fail to contextualize the message to HIV/AIDS because of the goalkeeper who is running spreading his hands. They might think the message is about football. To start with, the terminologies used might be difficult for the participants to understand owing to the language used. Second, they might not even know the soccer celebrity used to promote male circumcision.Given that the San principally shared and acquired information through interpersonal communication, it would be apt for the Ministry of Health to use interpersonal communication to reach out to them.

As many of the participants indicated, they knew very little Setswana. As such, the commonly used Setswana terms in HIV/AIDS promotion could be ambiguous to them.Those terms can be better understood by native speakers of Setswana. For example, the most common vocabulary that is used to spread HIV/AIDS messageswere:

- Sekausu (literally meaning a sock in English)–(the use of a condom is being likened to wearing a sock on a foot)
- Diritibatsi (meaning suppressant in English) – antiretroviral medication

- Tlhakanelodikobo (meaning to share blankets in English) – sexual intercourse
- Go itseeladikobo ( meaning to take another's blankets in English) - rape.

**ii). Cultural Beliefs and Practices**

The findings further unearthed that there were deep rooted cultural beliefs that influenced the San's health and sexual behaviors. As shown in case 4, the male participant did not visit the clinic when he was ailing. He thought that he was bewitched and only hoped that traditional doctors would protect and cure him. Furthermore, most of the participants in this study believed in having multiple sex partners. Having many sexual partners was accepted and tolerated.Such cultural beliefs acted as obstacles to changing sexual behaviors. It would therefore help if the Ministry of Health could train and use traditional doctors to disseminate information about HIV/AIDS. They could also use victims of multiple sex partners to teach their brethren about the dangers of having multiple sex partners.Culture should not be perceived as a problem to health promotion. Rather, it has to be embraced by contextualizing some of the information to target ethnic minority groups such as the San.

## 6. Conclusion and Limitation

This study has shown that a number of communication and educational strategies have been used in Botswana to disseminate information about HIV/AIDS. However, these strategies only accorded with the socio-cultural attributes of literate and educatedelites in mainstream ethnic groups. Even though the messages were meant for all Batswana, the languages and media used left out the illiterate and disadvantaged rural and remote area communities. As the findings show, thenegative impact of the language barrier could have long term suffering for individuals and families. The realities of not abandoningmultiple relationships, unprotected sex and casual sexual relations that emerged from thisstudyare a testimony that the languages and approachesusedin disseminating information on HIV/AIDS did not reach other Batswana who did not speak and understand the languages used.

Despite helping in discovery of such a "rich" and "thick" data on HIV/AIDS health promotion, this study had limitations. The sample for this study was limited to a small number of participants; four males and four females who came from the same ethnic group. As a result, the results could not be generalized to other ethnic minority groups who were not part of this study. It is possible that the results could vary across other districts, regions and

cultures. However, this study was significant in that; it demonstratedthat language barrier was a problem in the communication of HIV/AIDS messages across the country. With this discovery, the authors of this study, can share ideas with other language researchers on the importance of language and how it can impact on health promotion if used with people who cannot understand it.

**References**


- Ayiga, N. (2012). "Rates and predictors of consistent condom-use by people living with HIV/AIDS on Antiretroviral Treatment in Uganda". .International Centre for Diarrheal Disease Research: 30 (3), 270 – 280.
- Boerna, T. Chatterji, S.&Grosskurth, H. (2011). "Health and functional Status Among older People with HIV/AIDS in Uganda": BMC Public Health: 11, 886-897.
- Bolaane, M. and Saugestad, S, ( 2006). "Mother tongue : Old Debates and New Initiatives in San education":Indigenous Affairs: 46-54.
- Botswana Centre for Human Rights, (2008).Botswana HIV and AIDS and Human Rights Charter: Gaborone.
- Corbin, J and Strauss, A (2008).Basics of Qualitative Research: Techniques and procedures for Developing Grounded Theory: Sage Publications: Los Angeles.
- Corbin, J and Strauss, A (1990) "Grounded Theory Research: Procedures, Canon, and Evaluative Criteria", Qualitative Sociology: Vol 13, Issue 1, pp 3-21.
- Ford, LA & Yep, G.A, (2003). "Working along the Margins: Developing Community-Based Strategies for Communicating about health with Marginalized Groups", in Thompson, TL Dorsey, AM Miller, KI & Parrot, R (eds), Handbook of Health Communication: Lawrence Erlbaum Associates: New Jersey.
- Gergen, KJ & Gergen, M (2004). "Social Construction: Entering the Dialogue, Taos Institute Publications", Health Promotion. International:(2003). 18, (2), 85-87.
- Jeff, A &Taylor, C (2014). "Ward Nurses' Experience of Enhanced Recovery after Surgery: A Grounded Theory Approach":Gastrointestinal Nursing: Vol 12, No 4, pp 23-31.
- Le Roux, W. (1999). Torn Apart: San children as Change Agents in a Process of Acculturation. Commissioned: Kuru Development Trust and WIMSA.
- Lorber, J. and Moore, L.J (2002).Gender and the Social Construction of illness: Altamira Press: Oxford.

- Loustaunau, M.O, and Sobo, E.J, (1997).The Cultural Context of Health, Illness, and Medicine: Bergin and Garvey: London.
- Lupton, D.(2003).Medicine as Culture: Sage publications: New Delhi.
- Mokibelo, E. B, and Moumakwa, T.V, (2006). "Social factors that Contribute to the Reading Incompetence of Khoe Learners at Motshegaletau Primary School":PULA: Botswana Journal of African Studies:20 (2), 106 – 113.
- Mokibelo, E.B, (2008). A tracer study: Learners' ability to read English texts at Junior Secondaryschool. Unpublished Report.
- Motshabi, K. W, (2006). "English language and learning achievement in the Remote\AreaDweller Settlements and Rural Setswana medium of schools in Botswana":
- PULA:Botswana Journal of African Studies: 20 (1), 18-31.
- Republic of Botswana, (1994). Revised National Policy on Education. Gaborone. Government Printers.
- Nguluka, S, and Gunnestad, P, (2011). San children – In or Out of school. Impression House. Gaborone.
- Pansiri, N.O, (2008). "Improving commitment to basic education for the minorities in Botswana: A challenge for Policy and Practice":International Journal of Educational Developemnt: (28), 446-459.
- Pilane, C.N, Mokganya, L, Magowe, M, and Tsheko, G. N, (2005). "Occupational Exposure to HIV Infection and the Use of Universal Precautions: The Situation of Obstetric and Gynecological Units in One Referral Hospital in Botswana": Mosenodi: 13 (1 & 2), 77 – 88.
- Nyati-Ramahobo, L. (2004). "The language situation in Botswana": Language Planning and Policy in Africa:, Botswana, Malawi, Mozambique and South Africa: (eds). Richard Baldauf and Kaplan R: 1, 21-78.
- Republic of Botswana, (1994). Revised National Policy on Education: Gaborone:Government Printer.
- Republic of Botswana, (2011). Analytical Report: Population and Housing Census. Gaborone: Government Printers.