Parallel Discourses

Parallel Discourses:
Religious Identity and HIV Prevention in Botswana

By

Kipton E. Jensen

CAMBRIDGE SCHOLARS

PUBLISHING

Parallel Discourses:
Religious Identity and HIV Prevention in Botswana,
by Kipton E. Jensen

This book first published 2012

Cambridge Scholars Publishing

12 Back Chapman Street, Newcastle upon Tyne, NE6 2XX, UK

British Library Cataloguing in Publication Data
A catalogue record for this book is available from the British Library

ISBN (10): 1-4438-3718-0, ISBN (13): 978-1-4438-3718-7

TO MARION, *MOSADI WA ME*,
MY FAVORITE SOCIAL SCIENTIST, AND MY COLLEAGUES
AT THE UNIVERSITY OF BOTSWANA, WHO DEMONSTRATED
THE MEANING OF *BAETELEDIPELE BA DITUMELO*.

We were taught, sometimes in a very positive way, to despise ourselves and our way of life. We were made to believe that we had no past to speak of, no history to boast of. The past, so far as we were concerned, was just a blank and nothing more. Only the present mattered and we had very little control over it. It seemed we were in for a definite period of foreign tutelage, without any hope of our ever again becoming our own masters. The end result of all this was that our self-pride and our self-confidence were badly undermined.

It should now be our intention to try to retrieve what we can of our past. We should write our own history books to prove that we did have a past, and that it was a past that was just as worth writing and learning about as any other. We must do this for the simple reason that a nation without a past is a lost nation, and a people without a past are a people without a soul.

—Sir Seretse Khama, 1970.

TABLE OF CONTENTS

List of Figures and Tables ix

Preamble xi

Acknowledgements xv

Introduction 1
Country Profile and Epidemic Response Timeline

Chapter One 11
Religious Identity in Botswana

Chapter Two 25
Disaggregating Faith-based Organization Responses to HIV
in Sub-Saharan Africa: African Independent Churches in Botswana

Chapter Three 39
Toward a Better Topology of Traditional Healing in Botswana

Chapter Four 53
On the Politics of HIV Prevention Programs

Chapter Five 73
African Communalism: On the Importance of Indigenous Concepts
of Personal Identity to HIV and AIDS Policies

Chapter Six 87
Applied Religious Studies Research and Public Health Objectives

Chapter Seven 95
Conclusion: *Botho ke therisanyo*

Appendix 103
The Theological Problem of Evil and the HIV Epidemic

Endnotes 111

Bibliography 123

LIST OF FIGURES AND TABLES

Figure 1: Map of Botswana xvi

Table 1: Distribution of Religious Identity..... 16
Table 2: Table of Disaggregated Responses to Selected Survey Items 34

PREAMBLE

The following chapters describe the role and involvement of faith-based organizations as well as traditional healers in HIV prevention and AIDS treatment in Botswana. Animated by the belief that public health programs in Botswana, or other parts of sub-Saharan Africa, would be more effective if those who designed and implemented them possessed a better understanding of existing ethno-medical as well as religious beliefs and cultural practices, this manuscript provides a revised topology of religious identity in Botswana and then shows why it is important to disaggregate or otherwise distinguish between diverse faith-based communities – from traditional African religions and African Independent Churches to mainline Christian denominations and Muslim communities – when designing or implementing faith-based HIV prevention programs. It also describes the identity politics at work within various faith communities as well as between the faith sector and public health officials. Though it may be true that there have existed *parallel if not competing discourses* on HIV and AIDS in Botswana, between the public health sector and the faith sector or between traditional healers and allopathic physicians, each with their own paradigms of authority and evidence, these spheres of discourse are, I suggest throughout, amenable to a dialogical rapprochement. I have borrowed the phrase "parallel discourses" from Suzette Heald, whose anthropological research in Botswana has certainly influenced the warp and woof of essays presented here. Interweaving or otherwise reweaving the varied strands of discourse on HIV and AIDS may well be instrumental to the implementation of more effective HIV prevention programs, enhanced HIV diagnostic capacities and better care for PLWHA (People Living with HIV and AIDS) in Botswana. Although the methods employed and research questions explored may strike some as extremely diverse, it is a diversity unified by their application to a complicated but urgent and shared public health objective.

Beyond the effort to provide a better topology of religious identity, especially as it relates to HIV prevention messages or attitudes and practices, I also explore – in a set of related essays – the bold hypothesis that the Tswana notion of self is significantly different from Western notions of personal identity, that this is a theoretical difference that also

makes a difference in terms of behavior change, that international health organizations design behavior change programs following a decidedly non-African model of human agency, and that interventions would be more effective if they were informed by indigenous models of behavior change. Though these essays sometimes focus on the many obstacles to collaboration between the faith sector, which includes traditional healers, and the public health sector in Botswana, they also suggest common ground for increasingly collaborative and effective faith-based HIV prevention interventions in the future. Throughout my analysis, I have tried to apply the results of my research to public health intervention objectives rather than theoretical or academic issues; and yet, as a philosopher by training and someone preoccupied with the meaning or function of belief systems as applied to a broad spectrum of human concerns, I attach intrinsic worth as well as instrumental value to the process of gaining a better understanding of indigenous belief systems. But the glimmering prospect that a better topology of indigenous health care systems, i.e., a better understanding of existing of religious or cultural or ethnomedical beliefs as well as attitudes and practices in Botswana, could lead to more effective public health programs is compelling.

In many ways, my manuscript is a animated by Green's suggestion, similar to Airhihenbuwa (1991), that "[p]ublic health programs in developing countries (and among minorities or foreign-born groups within developed countries) would be more effective if those who design and implement programs possessed an empirically based understanding of existing ethnomedical beliefs and practices and designed and implemented programs with these in mind" (*Indigenous Theories of Contagious Disease*, 1999: 217). Analogically, and amending "ethnomedical" with "religious," I am animated by the prospect that public health programs in Botswana – or elsewhere – would benefit also from "an empirically based understanding of existing [religious] beliefs and practices." It is in this sense, I think, that there are eminently practical reasons for enlisting scholars of religion to share their expertise and insights with those who design and implement public health programs.

The title selected for the present collection of essays alludes to a recurring theme: sometimes it refers to the parallel if not conflicting discourses between the public health community and the faith sector, or between allopathic physicians and traditional healers, or between what is espoused publicly and what one says in private about the epidemic, but it also points to parallel discourses within the scientific research community.

Even if each of these sectors or disciplines is working toward a common goal, namely, designing more effective interventions, as allies working in parallel trenches, it makes sense to suggest that these sectors or disciplines discover new ways to collaborate or otherwise efficiently coordinate their insights in service of a shared public health objective; but when these parallel discourses become politically charged, as they often are, these potential allies find themselves caught in a cycle of ineffectiveness. But collaboration is only possible if these various disciplines or sectors are committed to genuine cooperation, which means engaging in a shared or mutually informed discourse. Some scholars – e.g., Heald (2005) – concede that their role in shaping the discourse on how to design HIV prevention programs has been "largely a critical one"; but it does seem possible, perhaps even essential, for anthropologists and scholars of religion to shift their role from one that is largely critical to one that is increasingly constructive and collaborative.

ACKNOWLEDGEMENTS

Earlier versions of several chapters, or portions of chapters provided here, have appeared elsewhere: *African Identities* (2008), *WHO: Policies and Practices* (2007), *African Journal of AIDS Research* (2010), *Scriptura* (2005) and, most recently, in *The Faith Sector and HIV/AIDS in Botswana: Responses and Challenges* (ed., Togarasei et al, 2011). I wish to thank my research colleagues at the University of Botswana, in Gaborone, for their patience and cooperation as well as conviviality. In particular, I wish to thank Muhammed Haron and Joseph Gaie, who collaborated with me on earlier versions of the chapters on religious identity and African communalism, respectively, as well as Leila Katirayi for her contribution to the chapter on traditional healers in Botswana.

Figure 1: Map of Botswana (see http://www.mapsharing.org)

INTRODUCTION

Botswana has one of the highest levels of HIV prevalence in the world: the *2008 Botswana AIDS Impact Survey* (BAIS II) estimated that 17.6% of the population aged 18 months and above was HIV-positive; the corresponding figure in the 2004 BAIS was 17.1% (UNAIDS, 2010).[1] The *2009 HIV and AIDS Sentinel Surveillance* (Botswana Ministry of Health, 10) reports that HIV prevalence among pregnant women aged 15–49 has leveled off at 33% since 2005. The World Health Organization estimates that 320,000 Batswana are HIV positive. The nation has approximately 93,000 AIDS orphans. Across the spectrum of age groups, suggests the latest estimates (BAIS III), approximately 17% of the population is HIV positive. In the worst hit health districts, populations to the north and west, prevalence exceeds 40% for both men and women between 15 and 49. Infection is distributed unequally between men and women, of course, with women carrying more than their share of the burden, and the poor are hit hardest. Young women are at higher risk of HIV infection than their male counterparts: the prevalence among women aged 15-19 years was 9.8 percent versus 3.1 percent of men of the same age (CDC 2006); the 2008 BAIS II reported a prevalence disparity across age groups of 20.4% for females and 14.2% of males.

Because of the relatively early detection of HIV within Botswana, a quick national response (National Emergency Plan 1987) and committed leaders, early VCT (2000) and then routine ("opt-out") or provider-initiated testing and counseling (PICT) as well as free ART (2001) programs, dedicated international donors and a strong medical infrastructure, and all of this within a country that is both politically stable and economically strong, "one might have supposed that if western AIDS policies were capable of working anywhere in Africa they should have worked here [in Botswana]" (Heald 2005: 5). And while there are some who claim that western-based prevention strategies have been "in the main, signally ineffective"[2] in Africa, Botswana has achieved at least some success – arguably significant success – in its collaborative partnership with international health agencies, especially the US Government (PEPFAR)[3]: the percentage of HIV-positive pregnant women who received ART to reduce the risk of mother-to-child transmission rose from 34.4 in 2003 to 94.2 in 2010, 100 percent of all schools have been provided with life skills-based HIV education since 2003, the percentage of infants born to HIV positive mothers has dropped from 20.7 in 2003 to 3.8 in 2010, 89.8 % of adults and children with advanced HIV infection are receiving ART, relatively high levels of reported condom use with non-cohabiting partners (76%), and HIV prevalence among young people (15-24) has been declining consistently albeit modestly since 2001. Although Botswana is often cited as a best practice in sub-Saharan Africa, prevalence rates remain unacceptably high. How is one to explain the alleged success of prevention programs in Uganda, for example, to draw on a comparison often discussed in recent literature strategy (Epstein 2004, 2005; Halperin, et al 2004; Stoneburner and Low-Beer 2004; Hearst and Chen 2004; Green 2003, 2006; Shelton, 2005; Wilson 2004; Cohen 2004), a regional neighbor who lacked the structural advantages afforded to Botswana?

The following reflections on the divergent responses to HIV and AIDS by faith-based communities and traditional healers were empirically-informed by a series of collaborative studies conducted in Botswana between 2005 and 2008. The initial study, which was exploratory in character, was limited to 35 key informant interviews. In 2006/2007, a second study – the Ditumelo Study[4] – extended to 141 faith communities across seven health districts in Botswana: Gaborone, Ramotswe, Ghansi, Francistown, Kasane, Selibi-Phikwe and Serowe (see Map 1, p. 4). These seven health districts represent a geographical range from north, south, east and west of the country. The study sites also represent diverse population sizes as well as various cultural values as well as perceptions

held by people in rural and urban areas. Blending qualitative and quantitative methods, the key features of the assessment consisted in a basic mapping of faith-based organizations in seven health districts, a questionnaire, participatory research workshops, key informant interviews and site visits. The initial mapping exercise identified 572 distinct faith communities or faith-based organizations within the selected health districts. A random sample of 150 respondents was selected from the initial pool of identified communities; subsequently, quota sampling was used to insure that each sub-section of the religious sector was represented.[5] Approximately 75% of the faith community leaders surveyed were male, most of whom were between the ages of 30-45 (37%) and 46-60 (34%); less than 10% were younger than 30. Almost 30% of the questionnaire respondents had been with the faith community they represented for longer than 20 years.

The assessment focused primarily on the 'capacity,' both presently and potentially, of faith-based organizations for a very specific public health objective – namely, coordinated if not collaborative HIV prevention programs. Faith-based organizations are certainly exercising their collective capacity in other areas as well, many of them tightly interwoven with HIV prevention (e.g., hospice care, healing, psycho-social support, grassroots moral education, and social activism), and so the study attempted also to capture these other peripherally related activities in our assessment. Although our assessment focused on tangible "religious health assets,"[6] we were also cognizant of the vast array of "intangible religious health assets" (e.g., prayer, rituals, commitment levels) inherent in faith-based organizations and communities.

In general terms, one could say, but with a certain degree of trepidation, since the terms in question require conceptual analysis and the data cited needs to be denominationally disaggregated, faith-based communities in Botswana have been, and remain, actively involved – *usually by way of inspired sermons and impassioned prayers and life skills counseling and acts of compassion but sometimes also in the form of committees and HIV prevention programs* – in promoting, often with a deep sense of moral zeal but with varying degrees of knowledge about HIV and AIDS, the A – B – and sometimes C of the standard HIV prevention message. These communities of faith, as well as faith-based organizations, are burdened with the 'grass-roots' work of providing – often on a voluntary basis – psychosocial support (e.g., hospice care, home visits, prayer, encouraging ART adherence) to PLWHA. With respect to HIV prevention, our research

showed that the majority (82%) of faith leaders (i.e., *Baruti* or *Baporofeta*) across faith traditions had discussed the basic facts about HIV and AIDS in sermons and teachings in the six months prior to the assessment; an overwhelming majority (95%) had promoted sexual abstinence as well as faithfulness within marriage in sermons and teachings and 87% reported promoting sexual partner reduction or marital fidelity in sermons within the six months prior to the assessment. Many faith leaders were convinced that they have very little if any influence on policy formation related to HIV and AIDS in Botswana. Faith leaders recognized the need for greater access to HIV prevention 'information, education and communication' (IEC) materials, as well as training on how best to adapt those resources to their own faith communities. While progressive faith leaders [*Baeteledipele ba Ditumelo*] recognized the need for greater collaboration, both within the faith sector and between sectors (e.g., between public health agencies and faith-based organizations), collaboration remains rare. Approximately 50% of all faith communities surveyed – with 83% of mainline, 43% Pentecostal, and 36% of AICS – indicated that they provided direct services to orphans or vulnerable children.

Though it is often assumed that the faith sector serves as one of the primary sources of stigmatization against PLWHA, 83% of the respondents said that their leadership had discouraged stigma in sermons or teachings within six months prior to the assessment. The study also showed that almost 93 % claimed that their faith community leaders were either 'very strongly' or 'strongly' committed to discouraging stigma and discrimination. (The figures provided here are disaggregated and discussed in the following chapters.) The mentioned studies suffered from many limitations, certainly, waffling as they do between the overly narrow and the hopelessly broad, but they were merely exploratory; the initial research has, though, I think, cleared the way forward in the direction of better research questions and enhanced capacity for conducting collaborative research. Indeed, this has already happened: together with the University of Pennsylvania, the University of Botswana is presently conducting research on HIV prevention among adolescents (NIH, 2007-2012); and recent collection of essays, *HIV and the Faith Sector* (2011, Togarasei et al), many of which are based on the DITUMELO Study, is rich in its suggestiveness for improving faith-based HIV prevention interventions, encouraging inter-sectoral collaboration, mobilizing the faithful and informing public health policy in Botswana if not elsewhere in sub-Saharan Africa.

In Chapter One, "Religious Identity and Public Health in Botswana," I examine several rather conspicuous inconsistencies in the data available related to religious identity in Botswana and explore the possible importance of religious identity to issues of public health in general as well as HIV prevention and AIDS treatment policies in particular. This chapter begins with a concise introduction to the historical context of religious identity in Botswana, which I consider to be important to comprehending religious identity as it applies to the spread of HIV in Botswana. I then focus on the available demographic data related to Botswana's religious identity, and because the data suggests that more than 80% of Batswana are Christian, I give special attention to the subcategories of Christianity. It is also suggested that the influence of African traditional religion is far more significant than one might assume based on surveillance data. I then explore the alleged value or possible importance of the religious identity question to informing national development policies and HIV prevention programs. This chapter concludes with several recommendations on how the religious identity question, if retained, could be modified.

The Second Chapter, "Disaggregating Faith-based Responses to HIV and AIDS," focuses on divergent responses to HIV and AIDS within African Initiated Churches (AICS) in Botswana. Though faith-based organizations are increasingly recognized as significant if not decisive institutions as providers of care and support for people living with HIV and AIDS [PLWHA] as well as in HIV prevention in sub-Saharan Africa, the precise nature of their varied involvement remains in large part undocumented. In the absence of systematic research as opposed to anecdotal information on the role of faith-based organizations, public health policies that promote faith-based health initiatives are often well intentioned but misguided. It would be a mistake to make generalizations about the role and significance of faith-based organizations, either as assets or liabilities, since the nature of the response – as we shall show, using Botswana as a case in point – varies from one organization to the next. Responses to HIV and AIDS vary significantly not only *between as well as within* faith traditions in general (e.g., Christianity or African Traditional Religion or Islam) and denominational affiliations in particular (e.g., mainline or Pentecostal or African Independent churches) but also from one faith community to the next. This chapter, which draws on a recent study of 141 faith communities in seven health districts across Botswana, focuses on how the response of African Independent Churches to HIV and AIDS diverges from other forms of Christianity. Perhaps the

most conspicuous divergence is found in the area of condom promotion, but there are significant variations in other areas as well. By way of a modest conclusion, it is suggested that carefully documenting the often divergent responses between and within faith communities – i.e., disaggregating responses by faith-based organizations – is not unimportant to the development of responsible faith-based initiatives within public health.

Chapter Three, "Toward a Better Topology of Traditional Healing in Botswana," attempts to demonstrate the extreme diversity of indigenous healing traditions across Botswana. "Though within most nations there are usually a large number of medical sub-cultures, each with its own characteristics and structure," suggested Murray Last in 1999, "policy-makers often have in mind apparently a single, paradigmatic culture from which they generalize about traditional medicine." A better topology of indigenous health care systems, i.e., an empirically based understanding of existing ethno-medical beliefs as well as attitudes and practices, could well lead to more effective public health programs in Botswana. This chapter aims at providing a better topology of traditional healing methods and indigenous medical knowledge systems in Botswana. This chapter also provides a selection of the preliminary results of a study focused on traditional Tswana perceptions of HIV and AIDS (i.e., the etiology and origin of HIV, the effectiveness of anti-retroviral treatment and the limits of traditional medicine), present treatment practices, including referrals to allopathic clinics and psycho-social support, and explores the prospects – including inducements and obstacles – for collaboration between traditional and allopathic medical practitioners.

The Fourth Chapter, "On the Politics of HIV Prevention Programs," deals with several rather pernicious obstacles to multi-sectoral – both inter-sectoral and intra-sectoral – collaboration on HIV prevention programs, including faith-based initiatives, in Botswana. Although the global public health community has made significant advances in understanding the biology of the human immunodeficiency virus (HIV), as well as developing reliable diagnostic tests and effective drugs for prolonging the life of the infected, the rate of transmission and – in the case of Botswana – the prevalence rate remains alarmingly high. Part of the explanation for this alleged ineffectiveness, itself a point of contention, may have less to do with the attitudes or behaviors of Batswana than with the politics of public health prevention policies adopted by Botswana (Heald 2002, de Cock 2002, de Waal 2003, Allen and Heald 2004; Green,

Halperin, Nantulya and Hogle 2006). And while Botswana is often hailed as an exception to the rule in sub-Saharan Africa, what de Waal claims for Africa – namely, that "the AIDS industry is a prisoner of political circumstance" – is perhaps doubly true when applied to Botswana. This chapter explores the political circumstances that have haunted if not imprisoned HIV prevention programs in general and faith-based initiatives in particular. Unfortunately, there remain numerous hindrances to religious collaboration: e.g., the "identity politics" of HIV Prevention programs and policies in Botswana, including "international versus Indigenous systems of knowledge and discourse of power," the politics of religious identity, both theoretically and practically, the "faith politics" of HIV prevention programs, as well as theoretical and practical inducements against "inter-sectoral" and "intra-sectoral" collaboration.

The Fifth Chapter, on "African Communalism," explores the possible relevance of indigenous notions of personhood or agency to HIV and AIDS policies, which might be viewed as imperfect compromises between the moral mandate to attack the removable causes of disease and the ethical duty to protect individual human rights. Preoccupied with protecting individuals against HIV-related discrimination and threat of violence, advocates of an exceptionally vigilant human rights-based approach to HIV testing are opposed to the application of standard methods of disease control. Failure to apply these standard methods, it is argued, undermines society's ability and responsibility to control the epidemic. De Cock argues that the emphasis on human rights in HIV/AIDS prevention, which some Batswana policymakers tend to view as a burdensome rigmarole, has reduced the importance of public health and social justice. Beyond public health and social justice, there is also the very personal issue concerning the human rights of sero-negative husbands, wives, partners and neonates: these vulnerable people should be at the very heart of a sound human rights-based approach to HIV-testing policies and legislation. Using the human rights-based approach to routine HIV testing policies in Botswana as a litmus test, this chapter stresses the importance of indigenous concepts of personhood – as captured in the Setswana proverb "*motho ke motho ka batho*" [i.e., that a person is a person through persons, or alternatively, following Mbiti, "I am because we are; and since we are therefore I am"] – as relevant if not also decisive to our struggle to balance individual rights with the welfare of the community. Drawing on the pragmatic maxim that the meaning of a concept is what it makes us do, I wish to explore several possible applications of indigenous notions of personhood to HIV and AIDS

policies in Africa. Recovering past traditions, beyond mythology and distortion, is valuable not only for the purposes of self-identification but also in order to help us meet the challenges and problems of today.

The Sixth Chapter, entitled "Applied Religious Studies," explores the possible applications of religious studies to public health objectives, especially HIV prevention, in Botswana if not also other parts of sub-Saharan Africa. The use of "anthropological forms of understanding" and "potential insights" of local practitioners, claims Heald (2003), despite the sustained critique of individualistic intervention strategies (e.g., Farmer, Manderston & Whiteford, Seidel and Waterston), have been "neglected" by those involved in HIV prevention and treatment. Anthropologists, claims Heald, "have not been enlisted into the effort to combat HIV/AIDS in Botswana, nor have they achieved an established position elsewhere." (The same could be said, *a fortiori*, of many other academic or scientific sectors.) In view of the *alleged* lack of success of existing interventions, however, it is not too late for those who design HIV prevention programs to reach out to anthropologists and historians, as well as those studying religion in Africa, many of whom are keen to contribute their "potential insights." More specifically, this chapter examines the possible relevance of religious studies to modeling behavioral change and enhancing communication, capacity-building, health promotion and social welfare, including strategies for treatment and care, the development of institutional partnerships, informing HIV and AIDS policies, and providing inter-sectoral checks and balances. But collaboration is only possible if both sectors are committed to genuine cooperation. In 2005, wrote Heald, the role of anthropologists is "largely a critical one." But it does seem possible, perhaps even essential, that anthropologists or ethnologists and researchers in general – as well as public health officials and members of diverse communities of faith, including "diviners, healers, and churchmen" – change the role they play from one that is "largely critical" to another that is "largely constructive and increasingly collaborative."

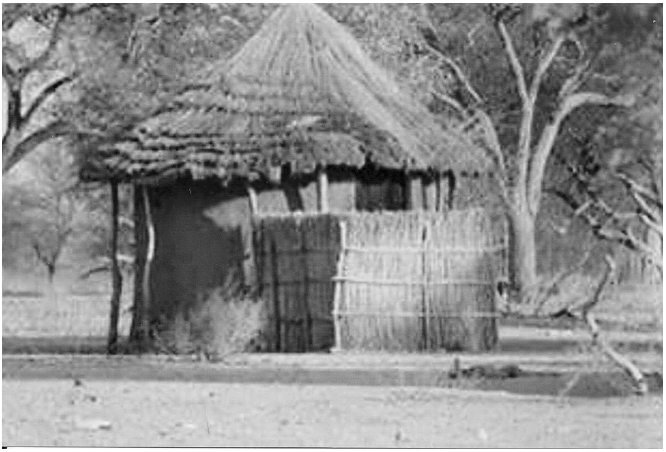
Although the following research was conducted in Botswana, the general thesis of the following chapters – namely, *that public health programs would be more effective if they were better informed by an understanding of religious beliefs and practices* – extends well beyond sub-Saharan Africa. The case of HIV prevention programs in Botswana is illustrative of a lesson to be applied elsewhere; though grounded in local research, and applied to a very specific public health objective (e.g., HIV prevention), the leading research questions are conceptualized from

diverse but related disciplinary perspectives. I have relied on social demography in the chapter on religious identity in Botswana, the history of religion and social scientific research in the second chapter on the importance disaggregating faith-based communities, ethno-medical anthropology in the chapters on African Initiated Churches and traditional healers, philosophy in the chapter on African notions of agency or personhood, as well as sociology and psychology on the chapter focused the politics of inter-faith or inter-sectoral collaboration. The concluding chapter argues for the benefit of this type of research, i.e., a multi-disciplinary if not also empirically-based understanding of religious beliefs and practices relevant to HIV prevention in Botswana, for those who design public health programs; this chapter also summarizes the common ground, i.e., shared goals as well as common commitments and overlapping fields of inquiry, available for enhanced collaboration between faith communities or faith-based organizations as well as scholars of religion or anthropologists and the public health community.

CHAPTER ONE

RELIGIOUS IDENTITY IN BOTSWANA

"The microbe is nothing, the terrain is everything."
—Louis Pasteur



In many ways, Botswana represents the exception that proves the rule in Africa: it is a middle income country, it has a stable democratic form of government, it has a well developed medical infrastructure as well as universal primary and secondary education, and it has been relatively free of military conflict throughout its history. It is also, according to fairly recent studies, a haven for religious tolerance and freedom (US State Department 2007; Hudson Institute Centre for Religious Freedom 2007). Despite this laudable record of religious freedom, the topology of religious identity and its impact on development and public health remains ambiguous. What, if anything, is the relevance of religious identity in Botswana to issues of public health in general as well as HIV prevention in particular?

To social demographers and behavioral scientists, at least, but also policy makers and public health officials, surveillance data is often considered to be indispensable to our collective effort to gain a better understanding of the epidemic and thus formulate more effective strategies for reducing the risk and impact of HIV and AIDS. Conventional census data serves, according to the Botswana Census Bureau (BCB), to "inform national development policies." The information provided by the BCB is perhaps doubly important in times of a national health crisis, e.g., the AIDS epidemic. Beyond the general census data in Botswana, the National AIDS Coordinating Agency (NACA) together with the Ministry of Health and various non-governmental health organizations have conducted numerous studies aimed at identifying individual behaviors as well as societal trends (for example, gender inequalities or alcohol abuse) that might be associated with HIV transmission. In this essay we attempt to examine the possible relevance of the religious identity question, which is included in both the 2001 Census and the *Botswana 2003 Second Generation HIV/AIDS Surveillance* (BAIS II), to HIV prevention policies and programs.

In Part I, I provide a concise introduction to the historical context of religious identity in Botswana. This historical context is important to comprehending religious identity as it applies to the spread of HIV in Botswana. Part II focuses on the various if not conflicting data related to religious identity in Botswana. Though the most recent data suggests that greater than 80% of religious Batswana identify themselves as Christian, variations within the category of Christianity are plentiful; the sub-categories of Christianity in Botswana are discussed in Part III. Part IV suggests that the influence of African traditional religion (ATR) in Botswana – especially when treated as the cosmology inherent in traditional African healing practices – is far more significant than one might assume based on this single-answer religious identity question. But in addition to drawing attention to what I consider to be rather conspicuous inconsistencies in the available data on religious identity in Botswana, Part V explores the alleged value or possible importance of the religious identity question to informing national development policies and HIV prevention programs. In the concluding section of this chapter, Part VI, I suggest that the religious identity question may well be less important than the question of religiosity as an indicator of behavior relevant to public health. If retained, the religious identity question should be modified in ways that would "transform facts and figures into effective programs for individuals, families, communities, and nations."[7]

I. Religious Identity in Context

> African Religion has been largely responsible for shaping the character and culture of African peoples throughout the centuries, Even if it has no sacred books, it is written everywhere in the life of the people. . . . It has been rightly said that 'Africans are notoriously religious' (Mbiti 1978: 27)

Although it may be true that, as Mbiti puts it, "Africans are notoriously religious," it is also true that the nature and influence of religion in Africa is notoriously difficult to capture in terms of conventional religious categories. And religions in Africa, not unlike religious traditions elsewhere, are constantly evolving. In addition to the complex difficulties associated with colonialism, post-colonial African nation-states continue to be affected by the interconnected processes of secularization, modernization and globalization.

Prior to the missionaries, who first arrived in 1812,[8] African Traditional Religion (ATR) was tightly interwoven into all aspects of Tswana life (see Comaroff 1997, Amanze 1998, Shapera 1970, Mkiti 1978 and Nkomazana 2001a). Political authority and spiritual authority were seated side by side, *Dingaka* [traditional healers] next to *Dikgosi* [chiefs] as mutually supportive loci of authority, and in some cases they were one and the same. According to Boschman, in The Conflict between New Religious Movements and the State in the Bechuanaland Protectorate prior to 1949 (1994: 12):

> Christianity arrived quite early in Bechuanaland but it was slow in taking root. . . . For the most part, the Batswana *Dikgosi* (chiefs/kings) welcomed the missionaries, but since they feared the schismatic effects of religious pluralism, they made it their fairly consistent policy to allow only one missionary society to work within their territories and this in most cases was the London Missionary Society. As a result, prior to World War II, the Roman Catholic and Anglican churches were allowed to work in only a few areas of the Protectorate, and the Zionist and Ethiopian churches were often banned completely.

Because LMS missionaries were political assets, especially in their role in assuring protectorate status for Botswana and from expansionists from both South Africans and Rhodesia between 1904 and 1924, these missionaries were often granted exclusive permission to evangelize on the condition that they offer medical care and education. The LMS was, at least *de facto*, the Church of the Tswana State. This is particularly true of Kgosi Khama III, who ruled the Bangwato, and Bathoen, who ruled the

Bangwaketse between 1889 -1910. Bathoen believed that his people owed their literacy and political independence to the LMS. Both Khama and Bathoen – similar to Khama III – even "banned certain Bangwaketse traditions, such as rain making and initiation rites, which he considered incompatible with Christianity" (Boschman 1994: 9). These chiefs also opposed, on religious grounds, polygamy, alcohol, and witchcraft. The most effective but by no means reliable missionary strategy consisted in converting the chief, who would subsequently order his people to join the church. Church membership, together with top hats, served as an indication of political prominence. During the colonial period, for perhaps shrewd political reasons, writes Ngwenya (2001: 287) "chiefs actively promoted Christianity and banned traditional African religions and African-initiated churches . . . which were perceived as posing a threat to central authority and social rank" (see also Landau 1995; Comaroff & Comaroff 1997; Elphick 1998; Ntloedibe-Kuswani 2003). From the outset, one could say, religious identity in Botswana has been politically charged. Freedom of religion was not granted until Botswana's Independence in 1966.

Contemporary national development strategies and goals, which are articulated Botswana's VISION 2016 document (Presidential Task Group 1997), express the ideal of creating a tolerant and respectful society. The document stresses the importance of *botho*, which expresses the African communalist ideal of humaneness. The principle of *botho*, suggests the VISION 2016 document, was inherited and traditionally re-enforced by the values inherent in various religious traditions. So while national policies endorse religious tolerance if not secularism, the document also draws on or harkens back to certain traditional religious values and suggests that "religious organizations must be assisted to play a full part in imparting sound moral and human rights education in schools and in the community" (1997: 16). This adoption of a secular democratic model of governance placed Batswana in a predicament that was, perhaps, not foreseen at the time when Botswana declared its independence. The difficulty of adopting the ideal of secularism, despite a long-standing appreciation of religious values, at the time of independence replaced – at least temporarily – the earlier dilemma of identifying with ATR as well as Christianity. Perhaps the missionaries were unaware of the influence of religious identity to cultural identity. Their evangelistic fervor, which brought an end to significant cultural practices (e.g., initiation rites) and reconfigured traditional structures of authority (e.g., away from traditional healers and toward churchmen and public officials), contributed not only a