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It's never as easy as ABC: Understandings of AIDS in Botswana[1]

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This paper argues for the importance of examining the way the messages of Government AIDS educational campaigns in Africa are interpreted at the local level. One of the striking features of the HIV/AIDS epidemic in Botswana is that it is not universally seen as a 'new' disease syndrome but as an 'old' one. HIV/AIDS has been interpreted by traditional healers as a manifestation of old 'Tswana' diseases, acquiring new virulence because of the increasing disrespect for the mores of traditional culture, or as a result of 'old' diseases mutating as they have 'mixed together'. This alternative discourse of AIDS is set first in the context of official Health Education programmes and policy. It is argued that the fact that these programmes and policies have been couched exclusively in biomedical terms, and in apparent ignorance of other conceptualisations, has been detrimental to public education and understanding. Further, it has encouraged the development of a powerful and coherent counter discourse, based in the common understandings of Tswana society and cosmology. The main concern of this paper is to contextualise this counter discourse in order to understand why there has been a move to 'claim' the disease, turning it thus from a global problem into a local one. It is argued that it allows not only for a trenchant critique of current morality but also of the Government and the west. In turn, this raises a more general policy dilemma with regard to the dissemination of medical information in societies with plural health care systems, each operating on the basis of different truth claims. Where, as in southern Africa, these coincide with entrenched social divisions, educational interventions carry an inevitable political load, operating to locate the Government and its spokespeople on one or other side of the social (and epistemological) divide.

Keywords: AIDS, Botswana, traditional healers, indigenous knowledge

Introduction

Every month, new estimates are provided of the extent of the AIDS pandemic in Africa. In December 2000, UNAIDS estimated that 36.1 million people are living with HIV/AIDS of which 25.3 million live in sub-Saharan Africa. There seems no way of halting the current devastation and that which is to come. AIDS intervention strategies aimed at prevention, at curbing the pandemic, implemented through an increasingly well-organised AIDS industry, have had negligible effect. The reasons at an institutional level might be complex, the conditions and ability to implement such strategies in each of the countries in sub-Saharan Africa is different, but the issue of failure is no longer open to doubt. A prevailing view that AIDS is a disease of poverty ignores the fact that the same failure has occurred in wealthy states and well-organised polities as well as those driven by war and economic hardship. For this reason, the case of Botswana, a state which can be counted in African terms as both rich and well-organised, is particularly instructive. The Government here acted speedily in an attempt to avert the coming epidemic and launched its first mass awareness campaign in 1988. Yet, less than ten years later, it had the highest recorded prevalence of HIV in the world. In 2000, it was estimated that a 15 year-old in Botswana had more than a 50% chance of dying from an HIV/AIDS related condition.

This paper examines some of the reasons for this failure which relate to the model of intervention used in the educational effort. This was heavily reliant on western experiences and expertise and thus, to some extent, the reasons are generalisable. In particular, the lack of cultural sensitivity is an issue which is becoming increasingly recognised by those involved in the AIDS field. It is, however, an area which is not well documented, with relatively few anthropologists dealing with the differing cultural definitions of the disease and the responses of people to educational campaigns. By responses here I mean more than the formal knowledge of how the disease is spread for the campaigns have generally been considered 'successful' in this respect. Nor, do I refer to the evidence or lack of evidence for behaviour change. Rather, I refer to the interpretation of the message, of how it is worked and reworked in prevailing cultural idioms at the local level. The acceptance of biomedical models of the disease has been so much to the forefront that other understandings have been subdued even when not dismissed as the product of 'ignorance' or of outmoded traditional views by those primarily involved in the AIDS field, both by Government personnel and western AIDS specialists. It is here that anthropological approaches in contextualising these other discourses of AIDS and discerning lines of resistance to the messages of the campaigns are essential.[2]

One of the striking features of the AIDS epidemic in Botswana is that it is not universally seen as a 'new' disease syndrome but as an 'old' one. It has been interpreted by traditional healers as a manifestation of old 'Tswana' diseases, acquiring new virulence because of the increasing disrespect for the mores of traditional culture, or as a result of 'old' diseases mutating as they have 'mixed together'. The main purpose of this paper is to try to place this reaction, to contextualise this counter discourse, to understand why in Botswana there has been a move to 'claim' the disease, turning it thus from a global problem into a local one. I should make clear that this 'claiming' of the disease is not the kind of embracing of the problem that has been seen by the gay community in the West. Most emphatically not; AIDS remains such a highly stigmatised disease in Botswana that by August 1999 only seven people were said to have publicly 'come out' as HIV positive. It follows that people who are HIV positive are not involved in educational or community campaigns, as they are elsewhere in Africa. Again, the stigma relates in part to its construction as a Tswana disease. Nor has this shown much sign of lessening as infection and death rates have risen.

The spread of AIDS in Botswana

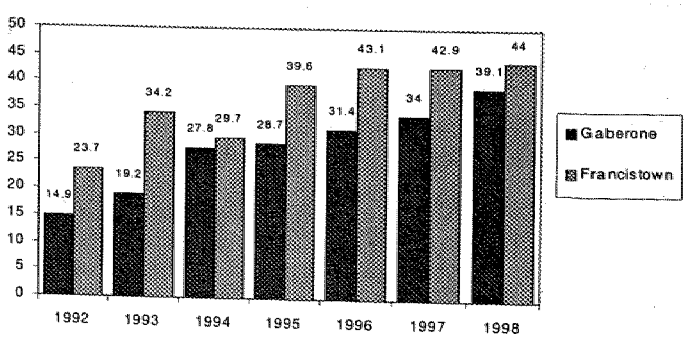
The first AIDS case in Botswana was reported in 1985. Government responses were at first reassuring to its population. The case involved a foreigner and it was a short step to seeing this as an 'outsiders problem'; indeed, as he was a white homosexual, to seeing it solely in those terms–terms which it was assumed did not affect the indigenous population. By 1987, the situation had changed and the Government, realising that there was a problem, set up the National AIDS Control Programme (NACP) and instituted a one-year emergency plan or Short Term Plan, followed by the first strategic plan, covering a period of five years. This has been followed by a series of others and a Second Medium Term Plan, 1997–2002 is now in force.[3] All have been framed in the accepted formulations of the international organisations, as multi-sectoral, integrated, and so on. The reality of putting such ambitious programmes into effect has proved rather less impressive.

In any event, none of these initiatives appear to have had any effect on halting the epidemic or modifying its devastating impact. The first Sentinel survey of 1992 picked up an already alarming figure of 23.7% of pregnant women infected with HIV in the industrial centre of Francistown (Figure 1). All women attending ante-natal clinics are tested every year in Francistown and Gaborone, and in four of another 10 selected sites.[4] There has been an exponential rise since 1992, with numbers infected doubling in five years and Botswana becoming known as the AIDS capital of the world in 1997. Then, between 34% and 43% of pregnant women were infected nationwide, rising in 1998 to 39% in the capital city, Gaborone, 44% in Francistown, and 50% (49.89%) in the mining and industrial centre of Selibwe Phikwe. No comfort is to be drawn here from the idea that rural rates may be lower than urban, for the mobility of the population almost certainly means that there is now little difference in infection rates. Nor, can any come from the idea that the statistics are inaccurate. Far from it, they are probably the most accurate statistics in the world. Botswana is a small country with a population of only 1.4 million and a well-resourced and effectively free modern health care system. Ninety five percent of pregnant women are estimated to attend ante-natal clinics at least once.[5]

A neutral message?

In considering the inexorable rise of HIV infection in Botswana, one place to start is with the nature of Government educational effort and its messages. It has been widely noted that the language of AIDS is the language of western science and policy. All the programmes in Africa, whether medical or social, have been dominated by the WHO, and more recently UNAIDS, as well as USAID and other western-based NGOs. Nowhere more so than in Botswana. All the research sponsored by Government through its AIDS/STD Control Unit is exclusively in these terms; to attempt to monitor the development of the disease, to conduct research into the sexual practices of the population, to put educational interventions into place, to supply condoms and so on. Further, the public discourse of AIDS is couched solely in these terms. Newspapers and English medium radio all preach the same story, with an emphasis on protection of the individual through the use of condoms. Indeed, as an English-speaking resident of the capital city, Gaborone, one would be unaware that there were any other messages about AIDS than the official line. This is neatly summarised in the billboard advert which reads 'Avoiding AIDS is as Easy as A (abstain), B (be faithful) C (condomise)' (Figure 2). When I first saw the billboard, I was impressed as it seemed a straightforward and clear message. It was only after living in Gaborone for half a year, that I began to see just how inappropriate, even ironic, it was. This was not just because it was in English in a country where the dominant language is Setswana.[6]

It is worth considering briefly the background and history of this message. The 'safe/r sex' model of prevention was initially developed and used in the West in the 1980s; indeed among a particular group of Westerners, that of homosexual men.[7] Its assumed universal relevance seems to rest on a further set of ideas, all of which can be located again in western ideas of the person. In the first place, it assumes a particular model of rational choice; that given the 'facts' and presented with alternatives, people will act with self-preser-



Source: Sentinel surveys, 1992 onwards

Figure 1: Percentage HIV positive in pregnant women in Botswana, 1992–98, attending ante-natal clinics

vation in mind. This theory, as we have all come to know, is deeply flawed: human choices are constrained and depend on who and where one is, especially in such an emotive and important an area as human sexuality. People cannot be assumed to be autonomous agents operating in a social vacuum. It has become increasingly clear that while some may have such choice, there are many others who have no such freedom, and the position of women in Africa, whether married, poor or young, has been a particular focus of concern. But, even if that complex area of human choice and behaviour is bracketed aside, there is still another issue which affects the universal validity of the message.

Aids has been a battle of ideas, as Justice Edwin Cameron commented at a recent AIDS conference in Johannesburg,[8] and such ideas are socially located. People have to first believe in the 'facts' presented and identify with the alternatives. In Botswana it seems that neither was the case. From the outset, that is in 1988, the AIDS awareness campaign was met with widespread scepticism (Ingstad, 1990; Ubomba-Jaswa, 1993). The silent nature of the disease, the slow-burn nature of the epidemic, poses immediate problems since campaigns, if they are to succeed, must bridge the initial credibility gap. This first campaign occurred at a time when there were so few cases of AIDS that its existence and its potential threat could easily be doubted. Ingstad (1990) reports the ironic naming of AIDS as the 'Radio disease' as most people then had experience of it only through radio programmes. The evidence of the senses failed to support the advice being given. It could be that this is always a decisive problem, leading to the dismal conclusion that there is no way of preventing the epidemic taking hold.[9] However, by 1995/96, the situation in Botswana had changed as most people then had direct experience of it through the deaths of family and friends.[10] Yet, resistance to the message continued and, while this might normally be attributed to 'denial', it must be understood as a very motivated form of denial.

The idea of the protection of the self through safe sex practices, with the condom a dominant element in the message, has been controversial even among religious groups in the west. It has proved even more so in Africa. In the first place, the sexual nature of the disease has run up against resistance to freely talk about the subject. The public nature of many of the campaigns, indeed, has breached every rule of kinship, riding roughshod over the respect rules that limit such intimate talk (see further, Heald 1995). Further, the advocation of barrier methods to prevent infection has set up the cry of immorality. Thus, the campaigns have been seen to encourage the very thing that they seek to discourage, inviting promiscuity through the use of the condom. Thus, they have met the resistance of churches, parents and population who see deeply held inhibitions breached. In Botswana, the suspicion of the condom runs even deeper as, it will be explained later, it is held not to be a prophylactic but to be a direct agent in the spread of the disease.

The message can be countered at every turn. At one level, we could say that what is being rejected are the ideological underpinnings of Western individualism. The message is read not as about a neutral scientific 'fact' but as a rejection of morality and of culture. The Government AIDS

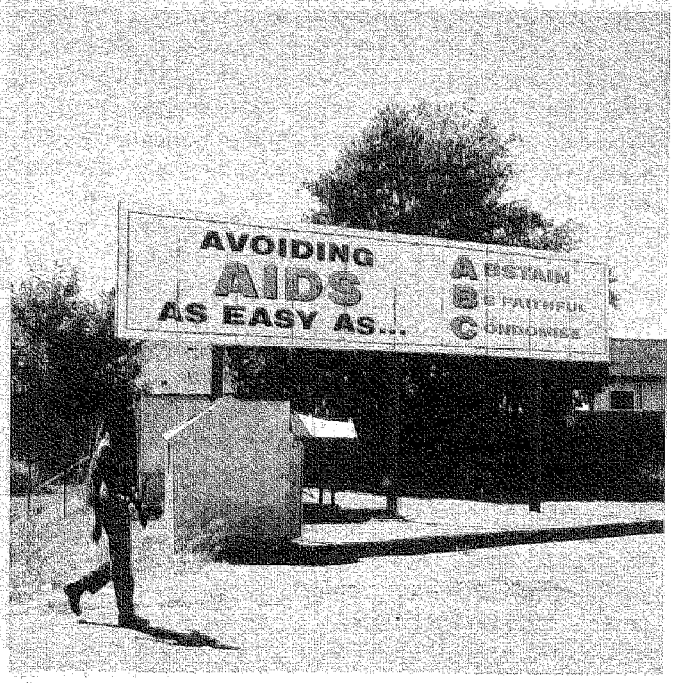


Figure 2: A message to the people of Gaborone

message then is seen as politically loaded: not promulgating a universal truth but a sectional Western (White) one. In Botswana there is another whole discourse about AIDS which is rooted in the local epistemology, in Tswana truth and medicine.

Medical alternatives

The Western medical system is particularly well developed in Botswana.[11] Delivery of health care thus does not pose the problem that it does in many of the countries of Africa. Further, the wealth of the state and the resources fed into the medical sector, uniquely in Africa, meant that anti-retro treatments such as AZT were available in the public hospitals in the late 1990s.[12] Nevertheless, it is not the only medical system on offer.

The basic situation is, as elsewhere in Africa, of a diversified health care system, with official provision of Western medicine supported by the State, and an informal sector consisting in Botswana of diviner/herbalists (*dingaka*) and the prophets of a growing multitude of independent spirit churches. The former represent a traditional form of power; the latter, a new one, but one which has as much to do with the local imagination, its problems and concerns as with Christianity. Such churches were originally introduced from South Africa and are led by prophet healers who are estimated to claim 65% of the church membership (Amanze, 1994).[13] These churches vary in size from a single local congregation with a membership of, say, 30, to large organisations with congregations in several different population centres, international links and a membership which runs into thousands. They differ markedly from the established denominations, most particularly in that most see healing as their major mission, with Jesus very often referred to as the

ngaka (diviner/healer). Healing is through prayer and water, the latter being used both for external and internal purification, by washing, drinking and enemas. Evil is washed out and away. For this reason, their leaders are sometimes referred to as 'Water doctors'. They are generally hostile to western medicine and also to the *dingaka* (diviner/herbalists or 'Tswana doctors') though herbal remedies may be used within the context of the church. Their antipathy to the *dingaka*, who practise privately from their homes, rests both on their method of divination–the throwing of bones–and on the nature of the power the diviners claim, which is the double-edged power to both harm and cure. In other words, they are seen as sorcerers as well as herbal healers. For this reason, there is a marked gender divide in the clientele. Christian church membership is (and has always been) predominantly female, whereas the clientele of the diviners is predominantly male, mainly because women are forbidden to consult them independently lest it be thought that they are soliciting sorcery substances.[14] It is women rather than men who are associated with witchcraft and sorcery in Botswana.

The Tswana thus have a wide range of avenues to explore in a search for remedies to illness and misfortune and they may be pursued simultaneously as well as consecutively. For many reasons, most especially in its free provision, biomedical care might be thought to be the first resort of many as the diviners require payment and the prophets demand allegiance to their particular communities of worship. Indeed, Tswana have proved inveterate users of 'modern medicine'. Staugard (1985) gives a figure for 1981 of 4.5 outpatient visits per person per year, roughly the same as attend doctors' surgeries in modern Britain.

But, there has always been a problem here, as Seeley (1973) notes. For all the use of modern sector medicine, the practice of the clinics, hospitals and doctors effectively offers people a remedy without a rationale. By contrast, the traditional system offers a thickly inscribed curative system, linking misfortune with moral infractions and with ancestral anger as well as with witchcraft and malevolence. Thus, even if remedies are sought from the modern sector, one might surmise that the reasons for many are still sought in the indigenous one. Indeed, there is no reason to suppose that fears of witchcraft — or its rumours — have declined. And, if this is so, the remedies offered by biomedicine are unlikely to be seen as absolute cures, which can be achieved only though more direct and active attempts to counter the source of the misfortune. This fact alone might counter the view that runs through the literature that the scientific view will eventually displace other traditions of healing because of its proven efficacy to heal. And, with AIDS, the adequacy of biomedicine fails not just in its lack of a satisfactory causal chain but in its pragmatic rationale. It has had to admit itself unable either to cure or to prevent the disease.

With this in mind, one can ask: has this fact given the indigenous sector, particularly the traditional doctors, the chance to stage a come back, or rather a fight back? While, as indicated above, Tswana doctors and Water doctors are opposed in many respects, they share a local moral vision. Thus, while competitors for influence at the local level, they unite in opposition to translocal forms of power and knowledge. Further, the legitimacy of their views rests on a widely accepted epistemology. The question is how far the AIDS crisis has created the space for them to make a bid to become once again powerful arbiters of public morality.

The view from below

I want here to give some direct quotations from interviews in Serowe in order to show some of the ways that people think, the range of opinion and their anger.[15]

Serowe is the capital of the Bangwato, in the Central District of Botswana, and of particular interest as the home of the first president, Sir Seretse Khama. It is a large. semi-urban village of over 30 000 people. As a district capital, it houses local authority offices, is well-served by schools and has a modern shopping centre, and is connected to the capital by tarred roads, some four to five hours drive from Gaborone. The extracts below come from interviews with three men: a leader of an established independent church, an *ngaka* or 'Tswana doctor' and the prophet/healer or of a small spirit church, who I will refer to, as he did himself, as the 'Water doctor'.

The first quote is from Meshack Selolwane, Bishop of St. Paul's Apostolic Faith Mission of Botswana. He had worked for many years as a mine clerk in Johannesburg and introduced the church on his return, later splitting from the parent church in South Africa to form a separate Botswana branch. This has also had its factional disputes and divisions — but at its height the church is reported to have had a membership of 6 000 or so (Amanze, 1994).

AIDS is a punishment sent by God, as Sodom and Gomorrah. Today we have all kinds of unnatural things–homosexuality, Satanist cults who practice cannibalism, ritual murders, bestiality. Christ is the one who said that those who do such things are cursed already. Unless we discover ourselves we are a lost people. The whole country should pray to God for deliverance.

This church leader prophesied a great apocalyptic war where the Christians would rise up to fight the Antichrists. His advocation of prayer alone — 'the whole country should pray together' — was very much a minority view and he admitted did not find a following even among other church leaders. However, in this case his faith did not preclude science; he believed that AIDS could be beaten by a partnership between medicine and God. No such compromising view was held by the other two.

The diviner or Tswana doctor was a young man, who operated his practice from a traditionally constructed rondavel, a stone's throw from a modern shopping mall. Though not educated he had a job as a security guard at the Post Office and practised after hours and at the weekend. He had originally been a member of the Zion Christian Church (as had his parents) but this was before he was called by his grandparents to become a diviner.

In traditional Tswana medicine we don't believe in the existence of AIDS. There is no AIDS and if it is there it is made by makgoa *(whites) because of the many things that they recommend to be used. These are pills, injections, condoms and the coil.*

Disease of the blankets can kill, even in the past, it killed. That is not surprising, it is only that the makgoa

refer to it as AIDS. They say that AIDS can even take 10 years to kill. But, in the past, if a man met a women who had had a miscarriage he will not go 5 days before he dies.

This doctor totally refused to believe in AIDS as a new disease. He said that all he saw were venereal diseases and the majority of his clients presented with such symptoms.

The third was the prophet of a small spirit Church, the New Salvation Freedom of God. He is uneducated and heals though water, specialising in the cleansing of women's wombs, due largely, he claims, to the use of the pill and promiscuity.

The disease of AIDS is very much related to tonono *(result of sleeping with a woman who is menstruating). AIDS is* megare *(germs) which has been sowed by modern ways (*sesha*) but some of these germs have been there in the past, as gonorrhoea,* tonono *and* thibamo *(breach or other abnormal birth).*

But for AIDS, I blame the Government and this is not the first time that I blame the Government because it is the Government which has caused the problem. It has spread it. It has spread it through condoms. Now, if you take a plastic bag and you tie the top, there will be some air left inside. I am trying to show that makgoa *have led us into trouble because even the oil in the condom we don't know where it comes from. Again, God did not make a person to be in contact with this oil. And again this plastic — if, as the two are in the sexual act, it will blow out and retract and now that air will get inside the man and it kills his channels. God didn't create things that way and again the* makgoa *have killed us because they want to reduce us because it had been reported that the number of people in Botswana is too high.*

There is a lot here that needs to be unpacked. Firstly, it is clear that this is not a coherent set of discourses; the moral crusade advocated by the first independent church leader, based on Christianity, is close to the Established denominations and differs from both that of the Tswana doctor and the Water doctor. Yet, even here there are large areas of overlap, with all locating the fault in the 'loss of culture', in the contaminating effects of the west which have led the youth astray. The first Church leader used a Biblical idiom, the 'tree of knowledge' and blamed moral decline on western education. The other two, more militantly, seem to evidence a total refusal to have any truck with modernity, medical science or the government — on all of which the disaster can be blamed. At its base is the charge that the Government in alliance with the West has destroyed the culture by introducing unnatural things such as birth control. As the Tswana doctor put it:

God didn't make things that way. AIDS is made by tholego *(nature) which we have deserted,* meila *(pollution / taboos) and* ngwao *(culture and tradition) which we have deserted.*

The only way back and through is to return to their culture. And, Whites are blamed for introducing the disease in some cases through a definite conspiracy — 'they sowed the germs', with genocidal intent. Again from the water healer:

The makgoa *say that the disease does not have any cure because they know that they 'sowed' it, even the amount of poison that they have sowed. When it was discovered, even before a month had passed, they immediately said that it was AIDS and it has no cure. This was before it was tried out by a private (medical doctor), before it was tried out by a Tswana doctor and before it was tried out by a water doctor. They denied a cure right from the beginning because they knew what they had done.*

Lest one dismisses this as simply a paranoid projection, some of the background to the AIDS prevention programme in Botswana needs to be filled in. Conspiracy theories have commonly been reported from Africa (and indeed are a common response historically to epidemics) — and never without some reason. In the case of AIDS the most significant, apart from the fact that it came from the outside, is probably the running together of most AIDS prevention measures with existing birth control programmes. The most influential organisation here is USAID which continues to be explicit in its line that birth control measures are still required in Africa; that is, that AIDS mortality will not produce, by itself, the desired decline in fertility and population growth (see further, Turshen, 1997). This line was clearly accepted by the Botswana Government, with USAID being the largest donor in the field and responsible for the social marketing of the 'Lovers Plus' condom. Government Ministers very frequently seem to have dropped into their speeches the need for population control together with AIDS/HIV prevention measures. This is repeated even in the 1997 Botswana Human Development Report. Added to which, the same outlets and clinics which had been developed in the 1980s to deliver family planning advice were also charged with AIDS education. Given the historical correlation between the use of birth control, particularly the condom, and the rise in morbidity, it is hardly surprising that many read malign intent.

Yet the traditional healers have a further motive for their suspicion. The exclusive Government support of biomedicine has effectively marginalised them, divorcing them from state power, finance and legitimacy. Their history is indeed the story of displacement, as descendants of the powerful priest/diviners of the old Tswana kingdoms in the 19th century, who worked in concert with the chiefs and rulers, to the essentially private practitioners of today, deprived of a public role.[16] Nor, with the AIDS crisis has there been any attempt to use or incorporate them into the Government programmes, in marked contrast to the situation in Zimbabwe. Though previous commentators (Ulin, 1979; Staugard, 1985) seem to have seen the relationship between biomedicine and traditional medicine as complementary, any *modus vivendi* here would appear to have broken down under the impact of the crisis created by AIDS. In the process the two world views — that of the Whites and that of the Batswana — seems to have come much more to the fore.

Medicine — as so many other areas in Botswana — is extremely well-researched and recorded (Seeley, 1973; Ulin, 1979; Comaroff, 1980; Staugard, 1985; Ingstad, 1990; Comaroff & Comaroff, 1997). The same themes come out, particularly, the survival of the indigenous nosology, standing opposed to Western classifications and ontology. In the history of the relationship, as Western medicine became increasingly 'scientific' in its justification, the divide between

the two, the Comaroffs (1997) argue, has widened rather than lessened.[17] The discourses actually appear to differ little from Livingstone's famous conversation of Rain Doctor and Medical Doctor. This reveals that both used a shared concept, an all-powerful God to whom both attributed their powers, but they did so from radically different vantage points, neither of which could be effectively challenged by the other. The same feature holds today. Where there is apparent coincidence there is also the greatest possibility for divergence.

A clear example here is with the idea of 'sexually transmitted' diseases. This is a cultural area which has traditionally recognised such diseases, a factor which has proved equivocal in the understanding of AIDS because it is linked to a divide between diseases seen as indigenous, *Setswana*, and those seen as new or treatable by biomedicine, *Sekgoa*. It should be noted here that, historically, it seems that the venereal diseases, even where initially recognised as foreign, have been incorporated into the Tswana categories.[18]

However, even here, *Setswana* categories do not provide a perfect overlap with Western ones. In the first place, *Setswana* classifications of venereal disease do not map precisely onto medical ones. In the second, many fall outside the range that Western medicine would classify as venereal at all. And, in the third — and most important — they are not necessarily thought to be spread through sex per se but rather sex with the wrong people at the wrong times. That is, they are seen to be due to the pollution incurred through breaking of sexual taboos — *meila*. These diseases are thus perversions: they link the physical and moral, with 'White ways' providing a reservoir of contaminating influences.

In the light of this, I propose to use the term 'venereal disease' to refer specifically to those conditions recognised by Western medicine to be sexually transmitted. For example, two of the most serious sexually transmitted diseases for the Tswana are *thibamo* and *mopakwane*. The symptoms of *thibamo* overlap with tuberculosis but it is believed to be caused by the polluted state of a woman's womb after an abnormal delivery. This pollution can be passed on to others if sexual intercourse takes place without the prerequisite cleansing. Another is *mopakwane* — a complicated category — which affects small children, bringing weakness, disability or even death. Here the fault is located with sexual intercourse on the part of the parents within the three month period of abstinence following birth. Again this pollution may be carried to third parties through intercourse.

As is clear from the above examples, such *meila* are strongly linked to the regulation of female sexuality and the possibility of the transmission of disease from women to men. In conversation, it is always this aspect which is stressed, despite the fact that men's actions can in some cases cause the pollution and transmit it from woman to woman through intercourse. It is given further emphasis in the idea that many diseases run a longer course in women than in men. Thus, the Tswana doctor told us that *rasephiphi* (gonorrhoea) could change into *lebusa* (sores), which might develop into *thosola* (syphilus), which may take 25 years or more to reveal itself in a woman, though if she infects a man the disease will run only a short course before he dies. By such modes of reasoning, women can always be seen as the source of infection.

Yet disease is not just linked to moral fault, it also rests on a coherent and elaborate theory of the body and its workings. The belief is that blood and the state of the blood is the key to physical well-being and lack of disease. Ulin (1979) writes that 'for the most part, the body is conceptualised as a cavity containing 'good' blood, which is bright red and flows freely, and 'bad' blood which they described as dark, hot, and thick' (p. 245). Both the healers I quoted earlier gave a more sophisticated version of this, relating the circulation of the blood to *ditshika* (veins, arteries, channels), a term which also implies the continuity of life, as the word is also used for kin and kinship connection. Thus diseases occurred when these life-given channels were blocked, causing morbid states in the blood of the sufferer and typical pains at the point of constriction.

The key idea here is that of connection, of a flow both within the body and between bodies. Thus sexual intercourse, the mixing of bloods of a man and a woman, is attributed with particular efficacy, promoting health and relatedness in its proper form. The bloods indeed must mix for procreation: the blood of the man (semen) mixing with that of the woman to form the foetus.[19] And the procreative act promotes too a further connectedness of the partners, with the blood of husband and wife seen as needing each other, becoming interdependent. Following the death of a spouse, particular dangers are posed for the bereaved partner, whose blood is said to 'stop' to become 'hot' and 'heavy', without its partner. Not only might this cause illness in the bereaved but it poses a particular danger for any other person in contact with him or her, especially in sexual contact to whom the disease can be transmitted. This morbid state known as *boswagadi*.[20]

To summarise, sexual life is ideally regulated by a set of *meila* (taboos) whose infraction brings disease, sometimes to the offender, sometimes to the partner and sometimes to 'innocent' parties. Yet, as it is clear, the onus of responsibility here lies with women. It is women who must avoid intercourse during menstruation, for three months after birth (even longer after a miscarriage) and for a year after the death of a husband. This, by itself, gives only a very slight glimpse into the force of these taboos and the inherent danger attributed to women who can, at certain points in their reproductive life, harm others (particularly children, crops, cattle) by their presence alone. AIDS is attributed by many to the breaking of such taboos. But, it is not a question of one cause rather than another. All or any infractions of purity rules might be involved. The water healer used the image of sowing seeds. There is a particular Setswana technique of sowing a mixed bowl of seeds, pumpkin, maize, millet, beans etc. (Molebatsi, 1999). In the same way, AIDS is a mixture of many diseases, or a result of many causes, something which accords well with its variant symptomatology.

We are faced here with an old anthropological conundrum: these beliefs would seem to make sex dangerous enough to deter everyone, yet they apparently deter no one. But, to look at things this way, would be to dehistoricise the

process. Certainly, ideas of female impurity and danger are deeply embedded — and some beliefs today are reported as in the time of Schapera (1940, 1979) 60 years ago. Yet, now they might be thought to be compelling not just because of this, but because of the way they link to the nightmare world of hidden connections, which is AIDS, to the secret paths which women with hot blood have traversed, 'deceiving innocent men' whom they fail to inform about their polluted state. It is interesting to note in this context, how many of the AIDS control programmes in Southern Africa nicely reinforce this view, in targeting commercial sex workers, for example, seen as the source of contagion, infecting men. In Botswana, there has been little targeting of this kind, but the idea of women who 'hide' is an image of the subversive power of women, linking their dangerous fertility to their real exclusion from the public arenas of decision-making and politics.

As Mary Douglas (1966) would maintain, pollution beliefs have not only an expressive function, they carry a political load; as much tactics as concepts. In spelling out a universe of risk, they provide the criteria for the allocation of blame and responsibility. Thus, if such views — among a certain older stratum of the population — can be read as a backlash against women, it is equally a backlash against the youth more generally and against the Government, the West and the conditions of modern life. As Farmer (1992, 1999) has demonstrated in his work on Haiti, the discourses of AIDS link local moral worlds with the political and economic fault lines of the global system.

The National context

From the outside, Botswana is a success story, economically, politically and socially. At the time of Independence in 1966, Botswana was an impoverished country, with one of the lowest GNPs in the world. Its scattered population eked out a living of farming and cattle rearing on desiccated land, and a large percentage of its adult male population sought employment as migrants in the mines and industrial centres of South Africa. In the late 1960s, with the discovery of minerals, particularly diamonds, a radical change in the economy of the country began.[21] It had the highest annual recorded rate economic growth in the world of 9.2% between 1965–1997 (World Bank), and by 1992 its GNP was the highest in sub-Saharan Africa.

Further, it has had a stable democracy with regular elections, and the nearest thing to a welfare state in Africa. In addition to free education, and a universal and effectively free health care system, the Government has recently introduced an old age pension scheme. There are also regular programmes for drought relief and to feed destitutes. But, despite the success of these modernising measures, and the safety nets in place for the very poor, it is also a society in which inequalities are most glaring. In the early nineties, the degree of income inequality in Botswana was said to be second only to Brazil.[22]

From the point of view of many Tswana, the society has unravelled; it is at the tail end of an historical process that has seen, firstly, the loss of control of elders and chiefs over the young men in the first half of the century as these went for migrant labour to the mines of South Africa and, at an increasing pace, male loss of control over women as they have entered the labour force and, today, everyone's loss of control over the 'youth'.[23] Accompanying this, 'there has been a recurring juxtaposition of themes in popular Tswana commentary on historical change: fear of moral chaos and its destruction of the health of society set against a nostalgic past where a clear moral order protected individual and community vitality for the common good' (Livingston, 2000).

Today, with education which takes people out of their home villages to often distant community schools, and on to tertiary education in Francistown or Gaborone, there is the constant movement of people for both education and work.[24] The close knit ties of the small-scale society, with its village-living and authoritarian structures, have in good measure been dissolved due to the increasing mobility — both geographic and social — of the population. On the one hand, there is a burgeoning, consumer-orientated, urban middle class. On the other, there are the people disenfranchised from this success, through their age or infirmity or lack of education. Added to which, marriage ties are seen to have weakened, with rising rates of divorce and many women, who are central today in both formal and informal sectors of employment, remaining unmarried throughout their lives, and in charge of their own households (47.1% of households are classified as female headed). With the rapidity of the changes, particularly in the last twenty years, it is not surprising that the people of Botswana have seen their society as beset with problems, from teenage pregnancies to the increasing virulence of witchcraft due to envy, and, as ever, the perennial ones of drought. And now AIDS. In all this, the position of women is highlighted. Not only are the old regulations controlling sexuality, deference etc., fast dying out or being ignored, even when not directly challenged, but, the conditions of urban living and modern sector employment impose other disciplines which simply do not allow practises such as long periods of seclusion after births, miscarriages and deaths.

To move towards a conclusion, to cast AIDS as a Tswana disease allows people to prosecute an internal debate about morality. This may be said to be a counter discourse, forged in opposition to the official line, to modernity, but it also has an unbroken lineage to the past, rooted as it is in a very different ontology. As I have sought to show, it provides an elaborate and potentially extendible biomoral model, in which the state of the body is related to morality, to one's own behaviour and to that of others; some of whom one is in direct contact, and some more distant. Whites are seen both as a source of contagion and of maleficent influence with which their own Government concurs and conspires, with its advocation of unnatural practices, such as those involved in birth control.

This, in turn, allows of a strong critique of the Government and its educated elite. Gulbrandson (2000) has argued that suspicion of the Government at all levels has become widespread over the last 15 years, 'grounded in a pervasive popular mode of perceiving the use and abuse of power' (p. 4). Where once the activities of leaders could be closely monitored through the institution of the *kgotla*, the councils led by chiefs and headmen at all levels of village

life, power has been increasingly invested in the officials of the modern state. Bureaucratised, located in distant centres, orientated to the needs of the global economy and transnational corporations, power has become to a large extent hidden and freed from the old ascriptive relationships. The characters of their leaders can no longer be scrutinised on a daily basis and rumbling suspicion, always a feature of the Tswana polities, has no ready counter for those distant from the sources of power. As this paper has illustrated, the gulf between centre and periphery, rulers and ruled, global and local, Western and Tswana has taken yet another turn in the discourses of AIDS which not only set up an absolute opposition between two worldviews but impute malignant intent.

Though the battle lines between the two sectors are clearly drawn, it is a battle without direct confrontation. The Government, in pursuing the biomedical line, has eschewed any direct contact with the practitioners of informal medicine from the beginning. Its messages tell just one story. Thus, there have been no direct and public forms of dialogue between the two ideologies, each purveying their own construction of the disease. One can only now wonder if the Government had attempted to use the traditional healers in the AIDS education effort whether the results might have been different. In that they discourage promiscuity, much of what they preach coincides with safe sex practices. Their abhorrence of the condom and indeed birth control of all kinds might be considered the central objection. However, in this context, it is worth remembering that the only sub-Saharan country which has shown a decrease in infectivity over time is Uganda (albeit after the experience of a massive death rate) and here the central message has not been condom use but responsible sexual conduct. The appeal has been made to morality, not to barrier methods of self-protection. I return to the points made at the beginning of this article about the assumption of universality (and neutrality) in the 'safe sex' message. The dangers of following an exclusive biomedical line seem all too evident. Nevertheless, there is no evidence of any change in policy on the part of the Government and its advisors.[25] The Government has now entered into a new international private partnership involving the pharmaceutical industry Merck, the Bill and Melinda Gates Foundation, as well as academic institutions such as the Harvard AIDS Institute and other development agencies. Through this, it aims to provide anti-retro treatment to all HIV infected patients for the next five years.[26] Whether this programme will manage to overcome the stigma associated with the disease which has meant that many up to now have preferred to 'die in ignorance' despite the availability of AZT in the public sector hospitals, remains to be seen.

Final thoughts

While Tswana discourses of AIDS can be read as a conservative backlash, a fight for the older moral orders of the village and/or an attempt to construct a barrier to the encroachment of the global, it is one which may well carry more radical implications. In Southern Africa, the epidemic has come later than elsewhere in Africa but it has come with particular virulence. The deaths have only just begun. As conditions deteriorate, as the suffering increases, the critique of the Government and the West may well come more to the fore. AIDS, Barnett & Blackie (1992) write, is an unprecedented disaster — the responses to it may also be unexpected, especially so if the West fails to provide the promised magic 'shot' in the arm. This possibility seems to have been recognised in 2000 by the USA, with the fear that the pandemic may pose a security crisis in Africa.

In this context, I have to say, it seems unlikely at the moment in Botswana that the AIDS crisis will undermine the legitimacy of the state — the ill, the dying and their carers will hardly have the energy, let alone the political wherewithal. But, this is not to say that it will not happen elsewhere. Rather, what seems likely is that more and more will seek alternative forms of empowerment and solace in churches of one kind or another. The terrain will shift even more from a battle for bodies to a battle for souls. And, if some of this operates to counter the prevailing fatalism, then it can only be counted a good thing. The danger may well be that it lends itself easily also to new forms of millenarianism, of a time we are now witnessing in East Africa. Life will be sought in an afterlife. It may be that recent events in Southern Uganda where an entire congregation of an independent church was incinerated are a unique perversion, but there has been an enormous growth in independent Christian churches throughout Eastern and Southern African regions in recent years.

To return to the situation in southern Africa, by way of conclusion, I would highlight the political dilemmas of getting the Western AIDS message across in societies with different health care systems resting on different truth claims. Where, as in southern Africa, these coincide with entrenched social divisions, most signally of black/white, these carry a political load, operating to locate the Government and its spokespeople on one or other side of the social and epistemological divide. I would suggest that it is possibly in this context that we can begin to understand Mbeki's stance on AIDS. Thabo Mbeki, South Africa's President, in siding with the so-called 'AIDS dissidents' questioned the causal connection between HIV and AIDS arguing that 'for Africans there had to be found African solutions' (Dilger, 2001). While this opinion has called forth expected opposition from educated South Africans and many involved in the campaigns against the disease, this paper, I hope, points to the importance of research into the unheard voices of the rural hinterland and their responses to the messages of AIDS.

Notes

[1] The research on which this article is based was done while I taught at the University of Botswana from 1997 to 1999 and, in particular, while supervising two undergraduate students, Thato Jenzen and Keamogetse Molebatsi, on their final year dissertations. In addition, I am particularly grateful to Julie Livingston and Roy Williams for their very helpful comments on an earlier version of this article.

[2] This is not, of course, to imply that they will be heard by those involved in HIV/AIDS work and education. Indeed, in the case of Botswana, Benedicte Ingstad (1990) wrote warning of the likelihood of the messages being reinterpreted in Tswana idioms. This paper documents her predictions which were unfortunately totally ignored by those responsible for HIV/AIDS policy in Botswana.

[3] The first strategic plan identified key areas on which prevention

activities were to focus: blood screening, information, education and communication; surveillance; and clinical management of HIV/AIDS. This has been followed by a series of other Government initiatives, though a national policy was not formulated until 1993 (following a Presidential Directive) and the National AIDS Council, formed to coordinate and monitor the activities and effectiveness of various bodies involved in prevention, was not formed until 1996.

[4] Each year, Sentinel surveillance is conducted at six sites for a period of eight weeks. These sites always include Gaborone and Francistown and the others vary from year to year. Unfortunately, the statistics available through UNAIDS for Botswana are now presented in terms of general estimated prevalence and I thus have no access to the Sentinel surveillance figures after 1998.

[5] *Botswana HIV and AIDS: Second Medium Term Plan, 1997–2002*, p. 10. This plan also reports for 1997 a doubling time for infection rates of two years (p. 8).

[6] The sub-text of this and other advertisements in English may also be seen as implying that AIDS, as first reported to be in Botswana in 1986 (Ingstad, 1990), is a disease of the educated and foreigners. This initial information about the disease has been difficult to dispel (Ubomba-Jaswa, 1993) and a small survey among drivers at the Central Transport Depot in Gaborone in 1998 found that a few of them still regarded AIDS as a disease of homosexuals which thus had no implications for them (Jenzen, 1999).

[7] This had further ramifications in that it went along with the identification and targeting of specific 'risk' groups, a factor which again might be thought of as less useful in the African situation, where the disease is spread primarily through heterosexual contact and other vectors, whether injecting drug use or other medical practices, both modern and traditional have been shown to be very much more marginal.

[8] AIDS in Context: Explaining the social, cultural and historical roots of the pandemic in Southern Africa, University of the Witwatersrand, Johannesburg, 4–7 April 2001.

[9] The case of Uganda, now quoted as the one success story in Africa, offers little comfort here as it would appear that HIV infection rates have only fallen following excessive mortality due to AIDS.

[10] The same small survey in Gaborone among drivers and office workers at the Central Transport Depot (see Note 6), found that most respondents only saw it as a 'problem' for them following deaths among family and friends, and thus not until 1995 and 1996 (Jenzen, 1999).

[11] Currently, Botswana has 33 general and primary hospitals in addition to a large number of clinics, health posts and 'mobile stop' facilities. Despite the size and scattered nature of some of its population, it is estimated that no one is more than 30km from a health facility.

[12] This drug, as with all treatment in Government facilities, was available free to patients after payment of the initial 2 pula registration fee — which amounts to rather less than the cost of a coca cola.

[13] Amanze (1994) classified the churches in Botswana into three main divisions: the Mission Churches (7 denominations), the Pentecostal Churches (13) and the great mass of Independent spirit churches (200 plus). These were initially introduced to Botswana through returning migrant labourers but have proliferated in the recent past. Only Seven independent churches were formed in 1940s, in face of fierce opposition from the established denominations, but in the current situation, new local congregations emerge constantly.

[14] Julie Livingston (private communication) thinks that this marked gender distinction is less marked today in the areas around Gaborone, where women also commonly seek the services of *dingaka*.

[15] Interviews were conducted in Serowe in August 1998, with Molebatsi acting as translator. I later asked him to return to tape further interviews covering the same ground. The quotations come partly from my original notes and also from the tapes which he translated at my request.

[16] Their political role was broken following the Witchcraft Act of 1927, though even before this the medical missionaries had usurped their role in many of the Tswana kingdoms, a factor that was particularly notable in Bangwato (Landau, 1995) and see Comaroff & Comaroff (1997).

[17] This should be set in the context of the assumption which runs through the history of Missionary and Government medicine that the scientific view point will eventually win out. This assumption is usually based on the efficacy of cures. Yet the area is very grey here and admits of a variety of interpretations. If one takes venereal disease, for example, both sides can claim that the other gives only a temporary palliative (neglecting the real underlying source of the disease) due to the normal remission of symptoms for a time.

[18] Schapera (1979) reports for the 1940s that a disease complex resembling gonorrhoea was recognised and treated by Tswana healers as a Tswana disease, though syphilis, also widespread, was distinguished by a separate name (*thosola*) and not regarded as Setswana. Both diseases were prevalent in the 1940s, encouraged by the circumstances of widespread labour migration which gathered increasing momentum in the early years of the century. In the 1970s, the situation was still largely the same (Seeley, 1973; Ulin, 1979) but, by the 1990s, syphilis seems to have been incorporated into the Setswana category (Molebatsi, 1999).

[19] Again, in sex, the flow and mixing of bloods is good and is seen as cleansing for a man; he is believed to take in a little female blood which mixes with his own and then through ejaculation to discharge and cleanse the body. (Thus, the fear of the mixing with the air in a condom.) For a woman, the cleansing is seen to take place at menstruation, when the dirty blood is discharged, as it does again following miscarriages and birth. Nevertheless, these beliefs also stress the dangers of sexuality, for too much mixing, or wrong mixing, brings disease, just as it locates the source of much impurity in female discharges of blood and reproductive disorders.

[20] For a woman, this is generally said to last a year, when the blood must then be purified by a traditional doctor and, where necessary, a ritual to unite her blood with that of a new partner also performed. For many in Botswana, *boswagadi* and AIDS are the same thing. The restrictions last a shorter time for men, generally around six months.

[21] 30% of the world's diamonds by value are produced by Botswana and the proceeds account for a third of GNP and more than half of Government revenue.

[22] In 1993/94, 47% of the population were said to live in poverty while the 20% richest have 60% of income (Botswana Government, 1996).

[23] Historically, this occurred as a result of women being left behind to manage home and farm during the years of migration. The more recent trend, gathering pace since the 1970s, is women themselves taking to migrant labour in the growing cities of Botswana (Izzard, 1985; Botswana Government, 1982). There has been a huge growth in female headed households, and in some women remaining unmarried throughout their lives, as well as in marital instability (Van Driel & Thu, 1994). The development of the educational system has meant that many better-educated women can run and manage households independently of their menfolk and may prefer to do so. At the other end of the social scale, many of the poorest members of society are women, especially old women, who have missed out both on the opportunities

of the old system and of the new (Wantanabe & Muller, 1984; Botswana Institute for Development Policy, 1997).

[24] No one, to my knowledge, has investigated the role of Tirelo Sechaba in the spread of AIDS. This youth service programme, initiated in the early 1980s, sent all school leavers aspiring to higher education off for a year's service, generally in Government departments all, over the country. This programme was not abolished until 2000, with the last intake in 1999.

[25] In replying to Linda Chalker at a meeting in London hosted by the Royal Institute of International Affairs, the Royal Commonwealth Society and the Royal African Society on 29 March 2001, Festus Mogae, the President of Botswana, on the subject of traditional healers said that 'we consider them...a nuisance and a distraction'. Given the demographic situation in Botswana with over half its population under the age of 20, he seemed convinced that that would spell the end of what influence they had. This might seem to ignore the fact that many of these children would be brought up by grandmothers — a normal feature of Tswana life but one which is likely to increase given that AIDS mortality will hit the intervening parental generation.

[26] President Mogae at the meeting above.

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