An exploratory study of the factors affecting the provision of church-based HIV and AIDS-related services and activities in Gaborone, Botswana

by
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ABSTRACT

This exploratory, qualitative study focused on one sector of civil society (organized religion) and sought to document Christian church-based HIV and AIDS-related services and activities in Gaborone, Botswana and to determine the principal factors that affect the churches' ability to provide these services. Overall, this study was meant to further the understanding of the role of Christian churches in HIV and AIDS mitigation efforts; to contribute to the body of church-based health promotion literature in countries of the South, and to generate recommendations to facilitate the ability of Christian churches to assist more fully and efficiently in the country's coordinated HIV and AIDS mitigation efforts.

Qualitative data were collected through one-on-one in-depth semi-structured interviews with 13 Christian church leaders and 3 key community informants. The results of this study revealed that churches provide a variety of HIV and AIDS programs, services and activities, yet the varying degree of perceived or actual support available to churches through internal and external social relations had a significant impact on their ability to provide effective HIV and AIDS-related services.

January 26, 2011

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Sala sentle!

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Definition of terms

Badimo- Ancestors (in Setswana)

Batswana/Motswana- Singular and plural form of a noun used to denote a citizen of Botswana

HIV incidence rate- The number of new HIV cases per specific population over given time period (CSO, 2009a)

HIV prevalence rate- A measure of the total number of new and old infections per population (CSOa, 2009a)

Modimo- God (in Setswana)

Setswana- National language of Botswana

Glossary of abbreviations

ABC	Abstinence, Be faithful or Condomize (ABC)
AICs	African Independent Churches
AIDS	Acquired Immune Deficiency Syndrome
ARHAP	African Religious Health Assets Programme
ARVs	Antiretrovirals
BAIS	Botswana AIDS Impact Survey
CBOs	Community based organizations
CBHP	Church-based health promotion
CBHPP	Church-based health promotion program
CHMs	Congregational health ministries
CSOs	Civil Society Organizations
CSO	Central Statistics Office
DMSACs	District Multi-Sectoral AIDS Committees
HIV	Human Immunodeficiency Virus
FBOs	Faith Based Organizations
MISA	Media Institute of Southern Africa
MOH	Ministry of Health
NACA	National HIV and AIDS Coordinating Agency
NCS	National Congregation Study
NGOs	Non-governmental organizations
NSF	National Strategic Framework
PEPFAR	President's Emergency Plan for AIDS Relief
PLWHA	People living with HIV/AIDS

RCCG	Redeemed Christian Church of God
STIs	Sexually transmitted infections
WB	The World Bank
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
US	United States

HIV/AIDS has now become the single most important obstacle to social and economic progress in many countries in Africa. AIDS is no longer a health problem. It is a development problem with potentially ominous consequences.

(1999 ILO-UNAIDS Conference on HIV/AIDS in Namibia)

CHAPTER I: INTRODUCTION

Faith based organizations (FBOs), and organized religion in particular, have played an increasingly important, yet unappreciated, role in the development efforts of countries in the South. As one of the most important social institutions in many developing countries, the church has served as a community center, school for morals and behaviour, social meeting place and refuge in times of distress. Some churches have also provided physical, mental and medical support to resource limited communities, and in doing so they became contributors to the community's development. Despite the documented ability of church-based programs to motivate, support and act as centers of change, research on the church as a resource in health promotion and disease prevention in sub-Saharan African countries such as Botswana remains under-documented and underexplored.

Within Botswana, HIV and AIDS is one of the most pressing threats to the social and economic development of the country; HIV has retarded gains in the area of health and welfare and diminished the country's labour force. Presently, the government of Botswana has adopted a multi-sectoral approach to HIV and AIDS mitigation with varying degrees of success at each level including that of civil society to which churches belong. This thesis will report on a qualitative research study conducted with a group of

church leaders in Gaborone, Botswana to discover the unique challenges and factors that influence their church-based HIV and AIDS mitigation efforts.

This chapter briefly introduces the HIV and AIDS epidemic in sub-Saharan Africa and Botswana, addresses the main drivers of the epidemic in Botswana and explains the government's response. Then, the purpose of this study is explained in greater detail, the research design is described, the chapter development is presented, and the study's limitations are outlined.

1.1 HIV AND AIDS IN SUB-SAHARAN AFRICA AND BOTSWANA

Since the acquired immune deficiency syndrome (AIDS) was first identified in the United States in 1981, 25 million[1] people have perished from AIDS, or health complications due to AIDS, while globally 7400 people[2] per day are diagnosed with HIV (UNAIDS, 2010). Of all the regions to experience the effects of HIV and AIDS, none has been affected quite as severally as sub-Saharan Africa (Van Niekerk and Kopelman, 2005; Whiteside, 2008). Home to 10% of the world's population (Zewdie, 2005), sub-Saharan Africa accounts for two thirds of the people living with HIV and AIDS (Whiteside, 2008) and 71% of all new HIV infections in 2008 (UNAIDS, 2010).

Though differences can be found 'between and within the countries in terms of the size, timing, and location of the epidemics' (Whiteside, 2008: 12), they are ultimately united by the fact that to date, HIV remains the leading threat to human and economic development in that region (Zewdie, 2005). A United Nations Department of Economic and Social Affairs (n.d) report found that AIDS has had a tremendous effect on the

[1] 2008 figure from avert.org
[2] This figure is based on 2008 statistics as published in the UNAIDS 2009 annual report

epidemiological[3] transition in developing countries such as Botswana, further retarding the longterm health and mortality improvements estimated. For instance, life expectancy in Botswana fell from 65 years of age in 1990-1995 to 39.7 years of age in 2000-2005; an estimated 28 years lower than would have been estimated had AIDS not existed (ibid). The increase in mortality as a result of the AIDS epidemic has already led to a decline in the rate of population growth, and by 2025, it is estimated that AIDS will have lowered Botswana's population to 40% of its expected size (United Nations Department of Economic and Social Affairs, n.d). The impact of such projections leaves the development planning of countries such as Botswana in limbo. Because the virus tends to strike people during their most productive years (Barnett and Grellier 2003; MISA, 1999), countries which rely primarily on human capital as their most valuable resources face a strained future as HIV/AIDS threatens to shrink the workforce and lead to declines in economic growth and household incomes (Ministry of Finance and Development Planning, 1997; Zewdie, 2005).

The increase in mortality alters not only the structure of the population but also the dependency ratios within that population (Whiteside, 2008). As the proportion of the society's most productive members succumb to the epidemic increases, the care of those they have left behind -namely grandparents and children- will be transferred to the government and the remaining members of the society (Whiteside, 2008). Due in large part to the AIDS epidemic, at present time, Botswana has the peak rate of orphaning in the region at 20% and this rate is expected to increase (Whiteside, 2008).

[3] The first epidemiological stage is the one in which the country passes from 'high to low mortality as infectious diseases are brought under control and are no longer the major cause of death' (United Nations Department of Economic and Social Affairs, n.d:11)

1.1.1 Main drivers of the HIV and AIDS epidemic in Botswana

With a prevalence rate of 17.6% (CSO, 2009a), Botswana, a politically and economically stable sub-Saharan African country of some 1.7 million people, has one of the highest prevalence rates in the world (Lush, Darkoh and Ramotlhwa, 2006; Phaladze and Tlou, 2006) second only to Swaziland. While the main mode of transmission of the epidemic may vary by country, within Botswana the virus is generally spread through sexual activity and is fuelled by fundamental elements of Batswana culture and social structure (Lush, Darkoh and Ramotlhwa, 2006). As identified in the 2nd National Strategic Framework for HIV and AIDS (NSF II) these elements include multiple and concurrent sexual partnerships, adolescent and intergenerational sex, alcohol and high-risk sex, stigma and discrimination and gender violence and sexual abuse (NACA, 2009).

Multiple and concurrent partnerships

More often than not Batswana were found to have more than one sexual partner thereby exposing any given individual to a larger sexual network of unknown partners (NACA, 2009). This linkage coupled to the relaxation of condom use between partners once a sense of trust has been established further increases the risk of STIs (and HIV in particular) within the context of multiple concurrent sexual partnerships (NACA, 2009).

Adolescent and intergenerational sex

The risk of contracting sexually transmitted infections was found to be high among populations exposed to sex at an early age (Ministry of Finance and Development Planning, 1997). The reasons for this vary. Presently, transactional

sex in the form of older men with longer sexual histories offering material and monetary support to younger and/or poorer women in exchange for sexual favors has been cited as a major driver of Botswana's AIDS epidemic. Within these intergenerational relationships, the females possess little bargaining power and therefore are unable to negotiate the terms of the relationship and find themselves exposed to a myriad of health risks including HIV (Phaladze and Tlou, 2006). A 2006 study lends further evidence to support this claim of power imbalance within intergenerational couples, reporting that among Batswana girls aged 18-22 who had reported having sex with older men, only half had reported using condoms compared to ¾ of those who had had sex with their age mates (NACA, 2008a; Nkosana, 2006). Whitside (2008) explains that biological reasons also play a role. The younger a woman begins to have penetrative sex, the higher are her chances of contracting HIV due to the heightened chance of vaginal tearing.

Botswana is a youthful country with youth aged 18 and under accounting for more than half of the population (Campbell and Shastri, 1994). Given the numerical strength of youth and their impending role of importance in the development of the country the current trend and its consequences pose a problem not only for the individual but also the society and country as a whole both now and in the future.

Alcohol and high-risk sex

The misuse of alcohol was found to increase the chances of participating in high risk activities such as casual, unprotected sex and was also linked to non-adherence to AIDS treatment regimes (NACA, 2009).

Stigma and discrimination

Former President of Botswana Mr. Festus Mogae stated that, "The stigma surrounding [HIV and AIDS] remains one of the greatest barriers to the implementation of various care and prevention strategies" (UN, 2004: 53). Stigma related to HIV keeps people from responding to prevention, care and treatment interventions for HIV (NACA, 2008a) and prevents people from seeking out their status (UN, 2004: 53). The most important social consequences are suspicion and prejudice among the local community when women opt not to breastfeed their children (NACA, 2008a).

The prejudice of HIV and AIDS is not so much attached to the disease itself but to the way people usually assume it to be transmitted (Snidle and Yeoman, 1997). First, because HIV in Botswana is transmitted primarily through sexual intercourse, the illness is at times perceived as punishment for the violation of a sacred law such as no sex before marriage or infidelity (Nkomazana, 2007). Second, some Batswana believe that HIV and AIDS was sent as a punishment by the ancestors for failing to keep traditional culture and to honour them. As a result only the ancestors are seen as being able to cure HIV and AIDS.

Gender violence and sexual abuse

Botswana is a patriarchal society (UN, 2004) where the lives of men as well as women are still bound by traditional beliefs and expectations (Nkomazana, 2007). Due to customary law, Batswana women are said to be under a form of guardianship throughout their life (Phaladze and Tlou, 2006) being passed from their father to their husband. Within Botswana the productive and reproductive roles and activities of women are said to be influenced by a myriad of social, cultural, economic and political factors (Ministry of Finance and Development Planning, 1997). Phaladze and Tlou (2006) state that a Motswana woman's lack of 'the right to sexual and reproductive autonomy' (26) influence her likelihood of contracting HIV. Men usually play a deciding role in the production and reproduction decisions of woman and direct many important areas in the woman's life including the size of families and the use of contraceptives (Ministry of Finance and Development Planning, 1997). Because of a woman's limited decision-making power coupled with her economic dependency on the male as a bread winner and laws which seem to support this gender imbalance, most women are accorded a lower socio-economic status and this leaves them vulnerable to gender violence and sexual abuse with little recourse (Ministry of Finance and Development Planning, 1997; Phaladze and Tlou, 2006; UN, 2004).

The UN (2004) notes that almost as worrisome as the growing violence against women is the fact that there does not appear to be a database of statistics which would facilitate the process of measuring the severity of gender-based violence against women.

1.1.2 The government of Botswana's approach to the epidemic

Health is as an important factor in development and productivity. Over the years the government of Botswana has been increasing the per capita health expenditure and access to health services in a bid to achieve adequate health care for all (Ministry of Finance and Development Planning, 1997). And since Botswana's first HIV positive case was identified in 1985 (Ministry of Finance and Development Planning, 1997), the country has seen more and more human, financial and physical resources diverted from other primary health care activities towards the struggle with HIV and AIDS (Campbell and Shastri, 1994). While this compromise has resulted in many difficulties and shortages of resources in the area of primary health care, it has also facilitated a series of firsts for Botswana. Botswana was the first African country to make HIV testing a routine part of all patient care and was also the first country in Africa to implement widespread distribution of antiretrovirals (ARVs) through its public health system (NACA, 2008a). Known as MASA, meaning "new dawn" or a symbol of hope for those infected, the program provides free ARVs and counseling at more than 32 sites across Botswana and as of 2007 had serviced more than 90 973 people (NACA, 2008a; MOH, 2007).

Though the government's handling of the country's epidemic has been credited with being successful in confronting HIV and AIDS on a clinical level, it has also been criticized for the lack of a 'comprehensive, coordinated communication strategy' (NACA, 2008a: 12). Critics also singled out the 'generic imports of one-size-fits-all variety [campaigns]' (NACA, 2008a: 23) conducted 'sporadically in different places on various topics with little continuity or impact... and communities... treated as an audience for

top-down messages from Government or as implementers of Government programs' (NACA, 2008a: 12-13).

Currently, the government's efforts for HIV mitigation are channeled through its multi-sectored National Strategic Framework for HIV/AIDS 2010-2016 which aims to prevent HIV infection, provide care and support, strengthen management of the National response to HIV/AIDS, mitigate the psycho-social and economic impact of HIV and AIDS and strengthen the country's legal and ethical environment (NACA, 2008b). Though it was recognized that there was not one particular prevention effort capable of stemming HIV infection, and the interventions with the greatest potential for impact were those that 'addressed cultural, structural and institutional determinants of vulnerability' (NACA, 2009: 11), behaviour change was singled out as the only long term solution to the prevention of HIV and AIDS epidemic within the context of Botswana's AIDS epidemic.

The mid-term review of Botswana's first National Strategic Framework (NSF I) identified 'overcoming personal barriers to behavior change through intensified focus on underlying socio-economic factors, gender equalities and cultural norms; and through comprehensive, scaled up behavior change interventions and communications and community outreach' (NACA 2008a: 1) as being a critical area of focus. However, government programme development was found to rely largely on simple demographic categories while specific groups and their specialized needs had not been identified. Hence there remained a gap in the diversification of prevention approaches to cater for multiple wide-ranging needs and insufficient targeting of prevention. The prevention response was further hampered by the "limited generation and use of appropriate socio-

cultural research to inform the development of prevention approaches tailored to specific needs and circumstances of various target groups" (NACA, 2009: 14). Existent research was often 'not widely disseminated, analyzed, or applied within the framework of prevention programming' (ibid).

Engagement of civil society -denoted as community, religious and non-governmental organizations- had previously been highlighted as an appropriate partner to assist with HIV and AIDS mitigation and was credited with offering 'alternative mechanisms to assist the country to increase the scope and coverage of critical HIV/AIDS programmes' (NACA, 2009: 70). Church communities were said to be comprised of organizations capable of preventing the spread of HIV and AIDS 'through community education and outreach programmes, and to mitigate the impact of HIV/AIDS on individuals and communities through counseling and orphan care' (NACA, 2002: 70). Together with other faith-based organizations, churches were tasked with the following roles and responsibilities under the NSF I (NACA, 2002: 71):

- Provide community leadership and guidance
- Mobilize resources for HIV/AIDS interventions
- Undertake advocacy initiatives
- Provide counseling, care and support to orphans and PLWHAs
- Work closely with District Multi-Sectoral AIDS Committees (DMSACs)
- Promote abstinence amongst the youth and delaying sexual debut

Though the programmes offered by such groups were well received by their target populations (NACA, 2009), the subsequent NSF II cited weak community ownership and

participation as an existent challenge[4] to the country's national response. The NSF II concluded that civil society organizations had failed to participate as widely as had been anticipated in the planning and implementation of HIV prevention initiatives in line with NSF objectives and needed to be 'further enabled to address the growing needs of the National Response' (NACA, 2009: 70):

> Insufficient local level ownership and participation contributes significantly to the present limited capacity for the development and implementation of response programmes...it has been observed that community structures in Botswana have tended to play a rather minor role in the current response to the epidemic ... the overall level of community ownership and participation is not at the level to maximize impact. Research in this area is an important gap that must be filled to enhance large scale, sustainable prevention efforts" (NACA, 2009: 13).

1.2 STATEMENT OF PURPOSE

The purpose of this thesis is to address the NSF II's claim of weak community ownership and participation of civil society by exploring the current state of mitigation efforts of one of the most influential civil society actors in Botswana: the Christian church. Within Botswana organized religion (the Christian church in particular) remains a powerful figure. An estimated 83% of Batswana identify with the Christian religion, and 60% report attending church at least once a week. Christian churches in general have had a well documented history of addressing health service needs in many parts of the world with studies showing promising results. Some studies have correlated spirituality and religion with improved health and greater longevity. And because the health of a

[4] Other challenges cited include underfunding of HIV prevention, insufficient targeting of prevention, inadequate generation and utilization of local research, limited capacities for prevention, competing communication strategies, safe male circumcision, prevention with positives, inadequate capacity for implementation and management and strategic information management

country's population impacts its development, the past decade has seen a general resurgence of interest in the connections between health and religion.

While much research and study has gone into developing a better understanding of religion and its effect on health, further work remains to be done when it comes to understanding the factors affecting the delivery of church-based health interventions centered on HIV and AIDS. The need for such inquiry remains greatest in countries of the developing world such as Botswana where both HIV and AIDS and religion feature prominently in the lives of the country's citizens. Specifically, the main objectives of this thesis are:

- to document the experiences of Christian churches with church-based HIV and AIDS related services and activities in Gaborone, Botswana,
- to further the understanding of the needs of Christian churches with regard to HIV and AIDS and how these needs may have shaped the churches' involvement in Botswana's HIV and AIDS mitigation efforts,
- to generate recommendations that will facilitate the capacity of Christian churches to assist more fully and efficiently in the country's coordinated HIV and AIDS mitigation efforts.

This study will answer two research questions

- What HIV and AIDS-related programs, services and activities are churches in Gaborone, Botswana providing?
- What are the factors that have affected the churches' provisioning of HIV and AIDS programs?

This thesis will contribute to the broader scholarship on the intersection of development, religion and health, as well as to church-based health promotion literature in general. The identification of factors that can impact church-based health programs will be of use to scholars in the field of public health, as well as governmental and development practitioners who wish to gain a better understanding of the church as a partner in community health and development.

1.3 RESEARCH DESIGN

This thesis is intended to be exploratory in nature. Through it, the characteristics and experiences of Christian churches with church-based HIV and AIDS-related programs, services and activities will be described. Qualitative methods have been employed to collect data for this research. Research design begins with the formulation of a research question. Next, the questionnaires are administered to 13 Christian church leaders to ascertain the following:

- HIV and AIDS-related services offered by the church;
- demographic factors related to the church;
- HIV and AIDS-related program structure and coordination;
- sources of financial support.

Following administration of the questionnaires, the church leaders are engaged in one-on-one interviews about their opinion of the AIDS epidemic within their community and within the country, their experience with church-based HIV and AIDS-related programs, and their relationship with other churches. Church leaders are also permitted to share their insight or opinions on any other factors that might not have been covered.

In addition, key informants from faith-based umbrella organizations are also interviewed. These methods were used to identify areas of critical concern, to develop a sense of common experience and repeating themes, and to inform the research design.

1.4 THESIS DEVELOPMENT

This thesis is divided into five chapters. This present chapter provides a brief history of HIV and AIDS, its impact on Batswana society and the government response and lays out the structure of the thesis. Chapter two provides an overview of health promotion, church-based health promotion (CBHP), presents evidence-based CBHP studies conducted in North Americas and Africa and concludes with an examination of the factors affecting provision of CBHPP. Chapter three details the methodology used to obtain data for this thesis, explains procedures used, indicates the characteristics of the population sampled for survey purposes and explains the method of data analysis followed in this study. Chapter four discusses the results obtained, indicating the results gathered for each research question. Lastly, a discussion of the results occurs in chapter five. Recommendations and implications for future research are stated and conclusions are made.

1.5 THESIS LIMITATIONS

Limitations of this thesis are as follows:

1. *Not all Christian churches in Gaborone are represented in this thesis:* It was not possible to interview every church leader in Gaborone.

2. *Generalizability is not possible:* As the study population was limited to 13 church leaders generalizability of data to all churches in Botswana is not possible and was never intended as an outcome of this study.

3. *Responses from church leaders were limited to the field research time frame:* Information was gathered from only those church leaders who agreed to participate and responded within the timeframe specified.

4. *The sensitive nature of the topic might make some participants hesitant to contribute truthfully:* The information obtained was dependent on the participants' accuracy and honesty.

5. *Study findings were based on self-reported data from participants:* The results are based on the self-reported perceptions, recall and interpretation of the participants.

6. *The absence of other published studies on a similar topic limits comparison with other populations.*

Faith-based organizations probably provide the best social and physical infrastructure in the poorest communities...[because] churches, temples, mosques, and other places of worship [are] focal points for the communities they serve.

Kumi Naidoo, former general secretary of CIVICUS (as cited in Thomas, 2004)

CHAPTER II: LITERATURE REVIEW

The question of how and to what extent varying ideas and cultural dimensions found within a given society should be accommodated and integrated into the planning efforts directed at that society has been long in debate. Marshall (2001) contends that often times the disappointing outcomes of development efforts stem from 'experience ignored, a piece of perspective missing in analysis, design, or implementation' (4) with development actors acting in ignorance of the actions or varying perspectives of others. As a defining component of culture, religion falls into the category of perspectives overlooked.

Religion has been a molding force and driving fixture in the political and social movements of many countries of the developed and developing world for some time. Yet for nearly just as long it has been noticeably absent from, or at best marginalized in, development discourse prior to the new millennium (Clarke, 2006; Marshall, 2001; Selinger, 2004) because the worlds of religion and development were often thought to be at opposite ends of the spectrum. Religion was perceived as belonging to the 'private sphere', which focused on the 'moral or spiritual regulation of the individual' (Clarke, 2006: 838; Marshall, 2001), while development was 'very much in the material world' (Marshall, 2001: 5).

Marshall (2001) contends that far from being worlds apart, religion and development are closer in goals, aims and missions than previously thought because the issues central to development, namely 'social justice, welfare, and the meaning of progress', are also issues which have been important and central to religion for centuries. Where development aims to alleviate the plight of the poor, so too do religion and religious institutions; where development is concerned with the care and worsening condition of the world's nature resources, an early area of concern within faiths was concerned with 'planet earth and man's failures of stewardship' (Marshall, 2001).

Despite these similar aims and longstanding concerns, religion failed to hold a prominent place in development discourse for some time. That religion and development were vital and important components of one another and therefore each should be included in discussion about the other was not a view that was universally held (Marshall, 2001). Hence, the relationship between religion and development, or more specifically, the role of religion in development, has been termed by some scholars as an uneasy one (Selinger, 2004).

In Selinger's (2004) article on the relationship between religion and development she contends that religion has been sidelined by the sea of modernization and secularization theories which centered on economic growth. She points to earlier dismissals of religion as 'increasingly less significant socially' (526) in a modernizing society in the 1920s as the starting point of the institutional and academic sidelining of religion in development

discourse[5] but notes that, 'the fact that religion remains a highly prevalent factor in a globalized and 'modern' world serves to disprove the theory as it stands' (527). Selinger (2004) argues that the absence of culture, and religion in particular, from development theory is important to recognize when examining the failure of the past international development efforts, and she asserts that effective sustainable development will not be brought about until religion is recognized as an inseparable part of a country's economic and political sphere. Selinger (2004) reasons that in light of the many ways in which religion impacts various facets of society around the globe[6], there is a need for a shift in the way religion is regarded if we are ever to apply it to development efforts (strategies or theory). She states that the literature examining religion and development was limited and often avoided the use of religion in the 'construction and critique of development strategy' (525). Furthermore, Selinger found that more often than not religion as examined in the literature was viewed through the lens of development and seen as a structural tool to be used to achieve development goals and was rarely associated with development as a positive force. Of all the points raised by Selinger (2004), one of the most important arose during her examination of religion in the post-development era. She reasons:

> Culture, and the way religion has fed into it, are highly significant for the successful development to take place, and while it is by no means wrong

[5] Emile Durkheim and Max Weber found that an inverse relationship between modernity and religion with sacredness declining in significance as a modernization increases. Science or rationality is seen to replace religion and is used to describe events witnessed in everyday life such as the rise and fall of the sun. A decline in church attendance was thought to correlate with religion's decreasing importance in society (Deneulin, 2009).

[6] Selinger (2004) explains that in Latin America and parts of Africa, religion has been used as a vehicle to help people make sense of the "post-developed world" they are now in.

> to see religion as a spiritual force, in the context of development strategy and in seeking to influence its agencies we must focus on the social and structural side of religion (ibid: 538)

Moreover, the growing body of literature on religion and development seems to point to a change in sentiments towards the importance of religion within development. Notably, the literature on, and interest in, the relationship between religion and health has grown steadily, especially over the past fifteen years, with particular focus on the effect of religious participation on risk-related behaviors (see Brown and Gary, 1994; Chatters, 2000; Goldscheider and Mosher, 1991; Heath et al., 1999; Luczak et al., 2002; Miller and Gur, 2002); clinical effects of religious and spiritual practices (see Baetz and Bowen, 2008; D'Souza, 2007; Harrison et al., 2005; Lee and Newberg, 2005; Mosher, Williams and Johnson, 1992; Rippentrop et al., 2005); and church-based health promotion initiatives, including those related to HIV and AIDS, of which this study is concerned (see Berkley-Patton et al., 2010; Griffith et al., 2010; Khosrovani, Poudeh and Parks-Yancy, 2008).

The purpose of this literature review will be to provide a review of the literature necessary to understand the present day situation of church-based health services with a focus on HIV and AIDS. First, the concept of health promotion will be introduced. Second, literature on the church-based health promotion programs will be presented. Third, evidence-based church-based health promotion within a developed and developing country context will be examined, and, lastly, factors affecting the provision of church-based health programs will be explored.

2.1 HEALTH PROMOTION

Historically, the concept of health promotion was linked to disease prevention (Lundy and Janes, 2009), but because there are many ways to conceptualize health, there are just as many ways to define 'health promotion.' To begin, the way that one defines health will have bearing on the action taken to preserve it via health promotion (Lundy and Janes, 2009). For instance, if health were defined in terms of prevention (see Leavell and Clark, 1965), as in the absence of disease, then the health promotion programs would involve a component of disease prevention. Program objectives could focus on primary prevention (programs are designed to increase awareness of the disease), secondary prevention (programs focus on risk reduction or early detection) and/or tertiary prevention (programs focus on minimizing the loss of function as a result of the disease) (DeHaven et al., 2004; Lundy and Janes, 2009, Leavell and Clark, 1965). Yet if health were viewed as achieving self-actualization (see Maslow, 1965) or defined as 'a concept that expresses the positiveness of a full and joyful life' (Lundy and Janes, 2009: 304) then health programs would focus on ways to assist individuals with the expansion of their consciousness or personal transformation so that they could achieve maximum health. Program objectives in that case would not focus on disease prevention. Regardless of how one defines health, health promotion's goal is to provide individuals with the tools needed to achieve a 'high level wellness'; a state of being built on the concept that recognizes that 'every individual, regardless of personal challenges, has a potential for wellness within the limits placed by that challenge' (Lundy and Janes, 2009: 305). Or in other words, high level wellness refers to the highest level of well-being possible for that individual given their circumstances.

When health promotion in relation to lifestyle came to prominence[7], health care delivery was generally focused on treatment of illness as opposed to the prevention of the illness through promotion of lifestyle change. With the realization that at the root of most chronic illnesses was the practice of health-depleting behaviors in conjunction with social and environmental barriers, the need to look for ways to avert illness by encouraging preferred behavior using appropriate methods and venues was developed.

2.2 CHURCH-BASED HEALTH PROMOTION PROGRAMS

In the article *Keeping your temple clean: Health promotion and religious function,* Kelly and Huddy (1999) examine the ways in which churches can encourage congregants to adopt health-enhancing behaviors. They assert that religious institutions have a responsibility to 'encourage stewardship of the human body by providing...environments that enable and promote health-enhancing behavior and discourage health endangering behavior' (334). And indeed, faith-based organizations have a documented history of independently and collaboratively providing the essentials of life to the communities in which they serve in the form of social services. Churches in particular, have a well-known history of functioning as 'healing institutions' (Ransdell and Rehling, 1996), providing parishioners with multi-level support and guidance as they 'struggle together with basic theological issues on a deeply personal level' (Clinebell, 1984). Thomas et al.'s (1994) summary of Mays and Nicholson's 1933 publication *The Negro's Church* concludes that the community outreach of 609 urban churches and 185 churches included programs to feed the unemployed, free health clinics, recreational programs and child care services.

[7] Lundy and Janes (2009) mention mid-1960s as the time when the relationship between health promotion and wellness to lifestyle began to be researched and appear in the media in North America.

And over the years churches have continued to take on greater responsibilities to provide the programs necessary to respond to, and care for, not only the mental and spiritual health needs of their congregants and their immediate communities, but also the physical health needs through formal or informal church-based health promotion initiatives (Ransdell and Rehling, 1996).

In sum, church-based health promotion (CBHP) can be described as 'a large-scale effort by the church community to improve the health of its members through any combination of education, screening, referral, treatment, and group support' (Ransdell, 1995; Ransdell and Rehling, 1996: 195). CBHP can offer congregants *specific protection, health promotion*, or both. In their guide to preventative medicine, Leavell and Clark (1965) define *specific protection* as preventative 'measures applicable to a particular disease or group of diseases in order to intercept the cause of disease before they involve man' while they define *health promotion* as measures employed in promoting health which 'are not directed at any particular disease or disorder but serve to further general health and well-being' (ibid: 20). Ransdell and Rehling's (1996) review of church-based health promotion literature characterizes health promotion programs as, '[preventing] illness and disability rather than [treating] it after it is too late' (ibid: 202). These church-based programs are said to provide a holistic approach to health in which mind, body, and soul are equally valued (Peterson, Atwood, and Yates, 2002) and may involve a series of stages meant to ease the participant towards the behavior or practice necessary to achieve the program goal (Kelly and Huddy, 1999).

While similar programs may be available in non-church settings, the advantage of church-based programs is that they allow the participants to partake knowing that the services provided are tailored to their faith in a culturally and spiritually sensitive way. Campbell et al. (2007)'s review of church-based health programs maintains that churches provide an ideal location to conduct community-based interventions given that churches already have access to groups convening for ongoing church-related activities (e.g.- Sunday school, prayer groups, weekly service) and possess the resources (such as meeting rooms) necessary to host programs. In addition, they are available to people of varying socioeconomic status and provide cost-effective approaches to resolve various issues (Ransdell and Rehling, 1996). Advocates of religious organizations as social service providers assert that religious organizations with a good standing in the community come established with the desired faith, trust and respect which would otherwise take government and newly arrived NGOs years to establish. And because members are likely to live in the same neighborhood as the church they attend (Lasater, 1986), the benefits of such services (especially those centered around primary prevention) may be spread to the rest of the community through the member's various social networks. Church-based health programs that document positive outcomes are deemed to be of 'value as a community health resource' (Timmons, 2010).

2.3 EVIDENCE-BASED CBHP LITERATURE

The majority of CBHP literature can be divided into two groups each of which focus on distinct health concerns in distinct regions of the world, namely North America and sub-Saharan Africa. The literature on church-based health promotion from/on North America tends to center on issues of drug prevention, health education, mental health, nutrition and

cardiovascular disease in particular (Taylor et al., 2000), while a small fraction of the literature places emphasis on church-based health related initiatives conducted in sub-Saharan Africa with an almost exclusive focus on HIV and AIDS.

In general, the literature originating from North America stems from the United States, and, falls into three categories: program elements and implementation; pre- to post- health behaviour and/or changes resulting from CBHP; and descriptions of characteristics of programs (Ransdell and Rehling, 1996). Ransdell and Rehling (1996) found that a wide diversity exists in religious orientation, geographic location, and type of program offered, with most programs focusing on education or the provisioning of services. The literature confirms that a significant number of Christian churches in the United States offer some form of CBHP and the church may indeed provide an effective delivery method for health programs. The majority of the research seems to indicate positive results in terms of reaching program goals and overall effect of the program on the health of the participants (Ransdell and Rehling, 1996).

A substantial proportion of the comprehensive church-based health interventions explored in the North American literature center on the African-American community (Campbell et al., 2007; Eke, Wilkes and Gaiter, 2010; Levin, 1984; Markens et al., 2002; Sutherland, Hale, and Harris, 1995; Taylor et al., 2000; Thomas et al., 1994; Watson et al., 2003; Yanek, 2001). While support can be found to attest to the importance of the Christian church within other ethnic communities in North America, the church, and religion in general, seems to have been a particularly important source of resilience for members of the African-American community. The church often served as a base for political

unification and broached and encouraged examination of a broad range of civic, economic and political concerns held by the African-American community during periods of social change such as abolition, emancipation, the great migration and the civil rights movement (Eke, Wilkes and Gaiter, 2010; Giggie, 2005; Mellowes, 2010; Moore et al., 2010; PBS, 2010). Studies have found that the church still holds a prominent place in the lives of African-Americans and remains a positive and influential institution (Taylor, Thornton and Chatters, 1987). Such echoed statements, coupled with the high religiosity exemplified within the African-American community (Eke, Wilkes and Gaiter, 2010; Taylor, 1988a; Taylor, 1988b), and a documented history of religious involvement of the church in health initiatives affecting African-Americans, makes the Black church[8] and African-Americans ideal foci for church-based health research.

While past CBHP research within African-American churches has investigated issues of cardiovascular disease, substance abuse and mental health, there is a growing body of literature on HIV and AIDS (see Aholou, Gale, and Slater, 2009; Baker, 1999; Berkley-Patton et al., 2010; Eke, Wilkes and Gaiter, 2010; Griffith et al., 2010; Khosrovani, Poudeh and Parks-Yancy, 2008; Moore et al., 2010; Smith, Simmons, and Mayer, 2005). This interest in HIV and AIDS and the black church reflects present day concern over the increasing HIV incidence among African-Americans. As explained by a Craig Cobb, a HIV+ Black church member of the AIDS ministry at the Abyssinian Church, "Every social movement that's been significant in black culture has been sparked or strongly supported by the Black church. ... AIDS happens to be our current struggle" (Jones,

[8] Aholou, Gale, and Slater (2009) and Eke, Wilkes and Gaiter (2010) define the Black church as a church in which the majority of members are African-American.

2007). Current studies on HIV and AIDS and the Black church have examined the capacity of black churches to facilitate HIV prevention programs; explored levels of stigma within, and perpetuated by, black churches; and monitored participatory exercises geared towards involving black churches in HIV prevention.

HIV and AIDS continues to be a pressing concern in the sub-Saharan region of Africa and most existing studies that address church-based health promotion literature in Africa have centered on the epidemic. Unlike the North American church-based literature which consisted of descriptive, quantitative or qualitative explorations of actual church-based initiatives, a number of the studies addressing HIV and religion in Africa have primarily addressed issues of religiosity and HIV and AIDS, or religious nonprofits involvement in HIV and AIDS issues (Agadjanian and Sen, 2007) while the work of, and within, congregations is at times overlooked in the literature (Adogame, 2007; Trinitapoli, 2006). And, in the earlier years of the epidemic when sub-Saharan African churches are mentioned in mainstream press they are often portrayed in a negative light so as to show how their actions, or inaction, have contributed to stigmatization of people living with HIV/AIDS (PLWHA); perpetuated misinformation surrounding HIV; or serve as barriers to the acceptance of safe-sex initiatives promoted by Western sources (Regnerus and Salinas, 2007).

While studies to document the strengths, achievements, or challenges of these programs is not on a scale comparable to that of the African-American CBHP experience, in recent years projects such as the African Religious Health Assets Programme (ARHAP) based in South Africa have emerged to fill the void. With an aim of conducting research on the

interface between religion and health in Africa, the ARHAP also places special emphasis on religion and HIV and AIDS within a number of countries in sub-Saharan Africa including Malawi, Kenya, South Africa and the Democratic Republic of Congo.

What is generally known about HIV and AIDS in sub-Saharan Africa is that in some communities, faith institutions (including churches) remain the key providers of HIV and AIDS-related services including prevention education, counseling and care (Liebowitz, 2002; Marshall, 2001); religious institutions have helped shape the national climate of AIDS response in many sub-Saharan countries (Davis, 2008; Epstein, 2005); and denominations vary in the way that they address HIV and AIDS within their churches (Darroch, Bankole, and Singh, 2003; Duff, 2006; Garner, 2000; Human Rights Watch, 2005; Trinitapoli, 2006; Ucheaga and Hartwig, 2010).

The following five studies offer some evidence that churches in sub-Saharan Africa are facilitating some form of church-based HIV and AIDS-related service, activity or program to their members and, in many some cases, their communities. Documenting the responses of religious leaders in Cross River State, Nigeria, Ucheaga and Hartwig (2010) interviewed 48 key informants from various denominations. The study found that abstinence before marriage and faithfulness during marriage was highly favored by the churches and all churches required engaged couples to undergo an HIV test prior to marriage. All churches felt a responsibility to address HIV and AIDS though only a minority of the churches, mainly mainstream urban churches, had formal programs in place to address the epidemic. Programs were usually oriented towards prevention rather than direct clinical care, counseling or social support for PLWHA. Messages about HIV

and AIDS were usually delivered by way of sermons in the participating churches. The Catholic Church as well as the Redeemed Christian Church of God (RCCG) had formal HIV and AIDS policies to facilitate the care and prevention education of leaders at various levels within the church while churches lacking formal policies felt comfortable coordinating their programs in the absence of guidelines. The Anglican Church occasionally facilitated programs through gender segregated seminars, workshops, and women's or youth conferences and meetings. National churches, such as that of the RCCG and the Assemblies of God, were said to have structured HIV and AIDS programs in place, yet Ucheaga and Hartwig (2010) found little evidence to indicate that such programs had made their way down to the local churches.

One of the goals of Trinitapoli's (2006) study on the religious response to AIDS in the religiously diverse but predominantly Christian country of Malawi was to document the AIDS-related activities of religious congregations. Her study was drawn from interviews with leaders from 85 congregations in the Balaka and Rumphi districts. At the time of her study, the HIV prevalence rate for Malawi was 15%. Trinitapoli (2006) found that church-based AIDS-related services consisted mainly of caring for the sick, widows and orphans through home visits. Home visits were made to the ill in general. Regular home visits by a congregation-based committee involved gifts, assistance with household tasks, prayers and songs at the house of the ill church member. On the side of prevention, most religious leaders in the two districts regularly mentioned AIDS by name within their churches. And as was found in Ucheaga and Hartwig (2010)'s study, abstinence and fidelity, were regularly discussed in sermons, second only to messages about repentance and salvation. Also, as in other places, Trinitapoli (2006), found that many churches in

Malawi encouraged -or required- that engaged couples be tested for HIV prior to marriage. Church-based youth programs encouraged youth to engage in "nongenital friendships" and view members of the opposite sex as potential friends rather than potential sexual partners. Though most matters in society remained sex-segregated, including seating during most church services, church-based youth programs aimed to provide youth with a space in which they could learn to interact "platonically" with each other.

Agadjanian and Sen's (2007) study on faith-based HIV-related care and support in the predominantly Christian southern region of Mozambique revealed that involvement of churches in the provision of HIV and AIDS-related care and support remained infrequent. Their study focused on Christian churches in Maputo and Chibuto, two areas with an estimated HIV prevalence level of 20%, 4% higher than the national average. They rationalized that because issues of treatment and care were increasingly at the forefront of the AIDS epidemic and institutional resources of religious organizations had potential to assist with both national and community-level prevention efforts, it was necessary to conduct an 'impartial assessment of the achievements and problems in the provision of HIV/AIDS-related assistance by religious organizations' to address the gaps in knowledge (Agadjanian and Sen, 2007: 362). Only 10% of the study's 677 respondents confirmed that they knew of, or suspected a church member of having, HIV or AIDS. 4% on average stated that their church had assisted a member with HIV or AIDS and 17.1% explained that their church had helped a non-member with HIV or AIDS. Activities were usually not pastor-organized and mainly included psychological support in the form of prayer and advice, and, to a lesser extent, instrumental support through the provision of

money, food or other such items. Higher engagement in these activities from mainline churches than healing churches was reported overall. Interfaith friction or church rivalries made outreach problematic especially if finances are involved.

A limitation of Agadjanian and Sen's (2007) study was that because one of their aims was to identify '[actual] assistance provided by the congregation to HIV/AIDS patients or their families' (Agadjanian and Sen, 2007: 363) such instances where care was provided to PLWHA who remained undiagnosed or failed to acknowledge their status would not be recognized by the respondents. Because a great deal of stigma and shame is still associated with HIV and AIDS, members may not always identify themselves to their church or their community as being HIV positive or may not acknowledge having PLWHA in their family. In the early years of the epidemic churches often augmented the shame associated with AIDS by teaching that HIV was a punishment for sin such as extramarital relations. Therefore, people were 'reluctant to disclose that any of their relatives bear such witness' (Caldwell, 2000: 127). Furthermore, people also remained silent for fear of isolation or ostracism within their communities. Although respondents in Agadjanian and Sen's study were asked to include known or suspected PLWHA when answering questions, the fact that so few of the respondents admitted knowing a church member with HIV or AIDS, or any PLWHA, would lead one to question their ability to include suspected cases in their answers.

It is difficult to draw too many conclusions from the study by Mukuka and Slonim-Nevo (2006). Their qualitative study on the role of the church in HIV and AIDS mitigation efforts in Zambia drew upon interviews with seven Christian churches, collectively

referred to as "the Church" throughout the study. No one region of Zambia was specified, the religious makeup of the country was never presented, in one case the HIV prevalence level offered was quite old when compared to publication date and the results were generalized across all denominations. The authors refrained from providing details about any specific church-based initiative, but mentioned that "the Church" provided counseling services to PLWHA and ran a home for those orphaned by the epidemic. Protein supplements were provided to PLWHA and parents were encouraged to discuss sexuality with their children. Most programs directed towards youth and orphans were generally joint ventures with NGOs and other government departments.

Other studies on faith-based HIV and AIDS programs such as that of Togarasei et al. (2008) indicated that while FBOs were indeed engaged in prevention activities, the level of commitment to these activities could vary greatly by activity. Stemming from the University of Botswana's Department of Theology and Religious Studies, Togarasei et al.'s (2008) quantitative study investigated faith-based organizations' potential to mount HIV prevention activities in Botswana. The study involved 141 faith-based organizations from all denominations and religious institutions in seven districts in Botswana including Francistown, Gaborone, Ghanzi, Kasane, Ramotswa, Selibe-Phikwe and Serowe.

The findings of the study revealed that the most common HIV prevention activities that faith institutions engaged in, were (Togarasei et al., 2008: 8):

- Preaching abstinence and fidelity
- Encouraging condom use primarily amongst married partners
- Counseling

- Youth empowerment
- Prayers
- HIV testing
- Stigma mitigation

Because FBOs were asked to indicate their participation in a predetermined listing of HIV and AIDS-related activities, it is possible that respondents may be involved in further activities above and beyond those which were put forth as options. In addition, involvement in these activities varied by faith for reasons left unexplored. For instance, it was noted that the primary prevention activity conducted by mainline churches was promotion of HIV testing in sermons/teaching followed by prayer while Pentecostal churches preferred prayer followed by stigma mitigation efforts in sermons, and African Independent churches primarily engaged in stigma mitigation through sermons followed by prayer. Across all faiths, respondents noted that they felt most committed to activities that involved the promotion of faithfulness, abstinence and stigma mitigation and least committed to activities that involved the volunteering of time, teaching non-members, promotion of condom use by married and unmarried partners, and the development of faith-based materials (Togarasei et al., 2008: 38).

Of all the studies church-based HIV and AIDS-related activities, Togarasei et al.'s (2008) 79-page study is the most comprehensive and detailed report. Because it was not distributed beyond the local level, it is also the least accessible of the studies presented in this chapter. Although the study is an excellent asset to the country in that it is the first in-depth study of its kind in Botswana and serves as a good starting point for future research

on the topic, the quantitative nature of the study meant that questions were close ended and participants were not given a chance to voice opinions that may not have coincided entirely with those presented as options. In addition to the questionnaire, data were also collected through a participatory district workshop attended by 156 FBO leaders or representatives. This workshop was held to 'complement and confirm data gathered through the use of a survey questionnaire and to provide an opportunity for...face-to-face discussion with participants" (Togarasei, 2008: 22). However, the participants who attended the workshop were not necessarily the same ones who completed the questionnaires. Furthermore, feedback by some workshop participants seemed to indicate that private interviews might have been a more appropriate avenue (Personal communications with church leaders, Gaborone, Botswana, 2010).

A final interesting fact revealed by Togarasei et al.'s (2008) study was the difficult nature of this type of research. Togarasei et al. (2008) noted that the lack of cooperation or interest espoused by FBOs with HIV and AIDS at their core was greater than they had predicted. This posed unexpected challenges to fieldwork and data collection.

In each of the five principal studies presented, the researchers found evidence that churches were engaged in HIV and AIDS education, prevention or care. While the messages of church-based HIV and AIDS programs were in general conservative and not comprehensive in comparison to secular emphasis on safer sex, Trinitapoli (2006) summarizes the African context best:

> Such discomfort with conservative messages should not, however, be a basis for dismissing or excluding church movements from AIDS-related

> scientific inquiry. What matters is whether conservative messages resonate with rural Malawians at risk of AIDS...With regard to prevention, [religious leaders] are preaching about abstinence and fidelity regularly, and this is exactly the area in which they are likely to be the most effective (ibid: 267).

Overall, these studies confirm that churches have become communicators of a wider health promotion and protection message in developing countries and are engaged to varying degrees in the mitigation efforts within their respective countries. Though Garner (2000) asserts in his exploration of the dynamics of religion and AIDS in South Africa that there is nothing distinctive about the role of the Church in such communication campaigns because the same effect could be achieved through other social networks, these studies have shown that it could be argued that religious organizations have comparative advantages because of the grounded influential position that they have held, and continue to hold, in their respective communities. Churches have a well documented history of engagement in health and social provision, especially in resource-poor regions and these studies demonstrate that this tradition has carried on in the era of AIDS.

2.4 FACTORS AFFECTING THE PROVISION OF CHURCH-BASED HEALTH SERVICES IN CHRISTIAN CHURCHES

There have been a handful of both quantitative and qualitative studies on the factors associated with church-based health services. In sum, the factors associated with Christian churches that facilitate church-based health services or activities are interconnected and may contribute to the church's ability to successfully facilitate and sustain their programs. The most recurrent factors identified include congregation size,

congregational resources, clergy characteristics, theological orientation and collaborations.

Congregation size

A number of empirical studies have found a link between church size and provisioning of church-based services with larger churches offering more programs, and, in some cases, a wider range of services, than smaller churches (Chaves and Tsitsos, 2001; Olson, 1988; Lincoln and Mamiya, 1990; Trinitapoli, 2005; Trinitapoli, Ellison and Boardman, 2009). In a 2007 quantitative study on Christian congregational health ministries (CHMs) in the United States, Catanzaro et al. found of the 349 churches sampled, the proportion of CHMs increased as congregation size increased. For instance, the proportion of the 349 churches facilitating some kind of health service or program increased from 3.6% → 33.3% → 23.4% → 39.6% as the congregation size of the churches rose from <100 → (100-499) → (500-999) → >1000 respectively. Catanzaro et al. (2007) concluded that 'there was a significant negative association between small congregations (<100 active members) and CHM involvement' (13). Thomas et al.'s (1994) quantitative study of the characteristics of Northern Black Churches with community health programs also found church size to be one of the 'strongest predictors of church-sponsored community outreach' (575). Of a sample of 635 Christian churches in America with predominantly black membership, the number of churches with health programs rose as the membership size increased. 88.3% of the larger churches (>401 church members) had health programs compared with only 39.7% of the smaller churches (1-70 members). Even as univariate and multivariate statistical procedures identified eight characteristics overall (congregation size, denomination, church age, economic class of membership, ownership

of church, number of paid clergy, presence of paid staff, and education level of the minister) a logistical regression model found educational level of the minister and church size to be most significant as indicators of church-based health programs.

A few reasons exist to explain why church size may be positively correlated with the sponsoring, facilitating or provisioning of church-based health programs. These reasons are interconnected with other factors including access to financial, physical and human resources (Eng and Hatch, 1991; Taylor et al., 2000).

Congregational resources

The decision of any congregation to facilitate health programs may be constrained or enabled by the availability of helpful resources. These helpful resources are also known as social support, a 'multidimensional construct that refers to three aspects of social relations, quantity, structure, and function' (Peterson et al., 2002: 407). Social support is most often defined in terms of its function that includes informational support, emotional support, instrumental support, and self-esteem (Cohen et al., 1985a; Peterson et al., 2002). Most relevant to this study are informational support and instrumental support. Informational support can be defined as assistance in understanding and coping with problematic events, and is also called advice, appraisal support or cognitive guidance (Cohen and Wills, 1985). Instrumental support, also known as aid, material support or tangible support, is the rendering of the financial aid, material resources or other required resources (Cohen and Wills, 1985).

Deficiencies in either informational support or instrumental support have been cited as factors affecting the provision of church-based health programs. For example, Smith,

Simmons, and Mayer's (2005) study of 18 Christian church leaders and their church-based health programs reported that financial resources were the largest barrier cited by ministers when asked about their reasons for not providing church-based HIV and AIDS related programs in black churches. They stressed that, 'it is unlikely that these prevention programs will be initiated without additional [financial] support' (ibid: 1683). Similarly, a respondent in Agadjanian and Sen's (2007) previously mentioned study on faith-based care and support in Mozambique cited transportation costs as a major barrier to the expansion of an interchurch HIV/AIDS support initiative run by a dozen churches in the Chibuto region. Established through a grant awarded from United States Agency for International Development to World Relief, virtually no further finances were available to the group to support activities beyond basic training of volunteers and the purchase of pamphlets and gloves. These financial constraints affected the church group's ability to offer more complex home-based support, nutritional supplements or transport PLWHA to specialized clinics when necessary.

In Togarasei et al.'s (2008) previously presented study on the capacity of FBOs for HIV prevention in Botswana, inadequate financial resources, inadequate facilities, inadequate technical skills and training among members and lack of staff to implement HIV prevention programmes (9) were identified as the largest obstacles to the implementation of HIV prevention in Botswana in order of importance. While all of these obstacles could be seen as having significance on their own, instrumental support in the form of funding stands centre stage when participants' comments are taken into account:

> Churches are not able to pay full time counselors. This leaves the pastor with many responsibilities (Togarasei et al., 2008: 41)
>
> The church should have money to purchase land to put up permanent shelters from which they can serve the community (Togarasei et al., 2008: 41)
>
> The leaders of AICs require training, but they do not have funds (Togarasei et al., 2008: 41)

Taylor et al. (2000) reason that because funding issues are central to the success of programs, larger churches are in a preferable position. Larger churches have more financial resources due to their larger donor pool. Another consequence of this larger donor pool and greater financial resources is an increased number of physical resources such as meeting halls and materials. Larger churches generally have a greater number of physical facilities in which to host their church-based activities and generally have access to other resources such as buses and vehicles (Taylor et al., 2000). While lack of access to these resources are legitimate concerns, Taylor et al. (2000) reason that the financial advantage of larger churches could potentially be offset for smaller churches through the acquisition of private and government funding while Agate et al. (2005) saw partnership of smaller 'storefront' churches with public health agencies as a way to resolve this resource deficit. Likewise, because lack of financial resources was found to be one of the primary reasons cited by the smaller churches without CHMs, Catanzaro et al. (2007) suggest that smaller churches with inadequate financial resources partner with 'other small congregations or with larger more affluent congregations to share financial and personal resources.' (15)

Finally, in order to run programs, churches require a reliable pool of labor. For this reason, the availability of the human resources can be seen as important to a church's ability to facilitate health initiatives. Volunteers from church members often serve as support systems to church programs by shouldering responsibilities and acting as assistants or coordinators. In addition, because churches may not always have the budgets required to compensate personnel with specialized knowledge, the use of volunteers presents a way to engage professionals whom the church might not otherwise have been able to afford. Catanzaro et al. (2007) found that health ministry committees coordinated 53% of the CHMs. And because the budgets needed to run these programs were often limited ($2000 annually), the involvement of volunteers on the committee was invaluable. 55.2% of the committee members volunteered their time while the remainder was paid 'with budgeted congregational funds' (ibid: 10). The volunteers who made up the health committees included nurses, as well as other health care professionals. Similarly, in a review of church-based health promotion programs, Ransdell and Rehling (1996) concluded that volunteers were an essential component of all successful programs. Volunteers received training of two hours on average and were given pre-prepared materials such as overheads and lessons plans to use (Ibid). Eng and Hatch (1991) reported that larger churches find themselves at an advantage because they possess a larger pool of congregants from which to seek volunteers to train as leaders for their church-based health programs.

While the involvement of volunteers is likely important to the success of church-based health programs, Thomas et al. (1994) stress that the role of paid staff should not be overlooked. In their study, they found that Christian churches with 2 or more paid clergy

(or other paid staff) tended to have more church-based programs. Thomas et al. (1994) explain,

> Although the institution of the Black church has traditionally been sustained largely by volunteers, this study suggests that the availability of paid clergy and other paid staff to provide consistent leadership to various programs is a necessary factor that will determine the extent to which the church can continue the provision of community outreach programs (ibid: 578)

Given that a lack of time to devote to further programs was cited by some church leaders as their reason for not facilitating programs, the involvement of volunteers or paid staff takes on even greater importance. Several studies have found that church leaders with their many responsibilities and obligations inside and outside of the church may feel stretched thin without further time to devote to new programs. Campbell et al. (2007) found that when questioning church leaders about their decision not to participate in programs, church leaders more often than not cited that a full calendar with competing priorities made it difficult for them to take on new activities. Similarly, Markens et al. (2002) reported that a theme that emerged from a discussion with 16 black ministers, who were asked to discuss their jobs, was that of not having enough time to do everything that needed to be done. In addition, Taylor et al. (2000) explain that ministers with other obligations (such as additional jobs) might not be able to commit the time required to coordinate church-based health programs. The statements made in these studies provide

further support to studies which established that an increase in volunteers and paid staff coincided with an increase in health related programs.

Therefore, the availability of congregational resources such as labor in its many forms, as well as physical resources and instrumental and informational support may impact the likelihood of adoption of church-based health programs.

Clergy characteristics

Church leaders are instrumental elements of any church. They are said to wear many hats (Taylor et al., 2000) because of the many functions and roles they occupy. These functions and roles have been well-documented in a small body of literature. In highlighting the traditional role of church leaders, scholars point to their ability to provide spiritual guidance, reinforce social and cultural norms and provide comfort in times of need (Strickland et al., 1998). They may serve as liaisons between hospitalized patients and families, counselors to the troubled, and program developers within their churches and communities (Levin, 1986) and they offer social support in the form of information, advice, tangible aid and referrals to external resources. They command a good deal of respect and trust from their communities as they carry with them a form of 'spiritual legitimacy' which puts them in a great place to influence the behaviour and actions of their congregants (Bazant and Boulay, 2007; Liebowitz, 2002). Their leadership and direction are critical to understanding the types of programs organized in the church and the church's relationship with formal service agencies in the broader community (Taylor et al., 2000).

Within the realm of health, Bruder (1971) emphasizes that clergy also fill the role of social change agent. They encourage members to 'get involved in promoting and insuring their own health, and at levels beyond their own individual well-being' (Levin, 1986: 99). In his Diffusion of Innovation theory, Rogers (1983) points to the role of the leader in insuring the rapid acceptance and dissemination of new ideas within a society. Leadership is also outlined as one of the seven outcome indicators for social change proposed in the Communication for Social Change Framework (Figueroa et al, 2002). Within this framework a catalyst –a community leader, for instance– initiates social change leading to a process of community dialogue, collective action and resolution of a common problem.

Caldwell (1999) claims that Christian leaders' views are even more important now than ever before because the great majority of the population in the Africa's AIDS belt is now Christian. Recognizing the valued role of religious leaders in communities, the United Nations Joint Programme on HIV and AIDS has called for broader engagement on issues related to HIV by religious leaders (UNAIDS, 2005). Religious leaders were deemed essential in helping with the eradication of discrimination towards people living with HIV and AIDS (PLWHA) and the fear of stigma, which often undermines willingness to seek out testing. The importance of views of church leaders is further exemplified by studies such as that of Bazant and Boulay (2002) who, in a study on the factors associated with religious congregation members' support to people living with HIV and AIDS in Kumasi, Ghana, concluded that the largest effect on provisioning of support was whether the respondents had heard their leader speak about HIV and AIDS. Respondents who heard

their leader speak about HIV and AIDS were five times more likely to provide support to people with HIV and AIDS than respondents who did not.

In light of this documented importance of church leaders in the health needs of their churches, studies have explored the link between the leadership characteristics of church leaders and provisioning of church-based health services and found that these leadership characteristics 'may both shape *and* reflect the nature of a congregation's commitments' (Trinitapoli, Ellison, and Boardman, 2009: 2233) and thereby create variations in the degree to which churches' engage in health related initiatives. Trinitapoli, Ellison, and Boardman (2009)'s study of US religious congregations and their church-based programs questioned the degree to which a number of congregational characteristics such as church leaders' level of education might have influence over the sponsorship of church-based health programs. Previous studies (Chaves and Tsitsos, 2001 and Thomas et al. 1994 as cited in Trinitapoli, Ellison, and Boardman, 2009) found the leader's education to be one of the most influential factors in the provisioning of church-based health programs. Thomas et al. (1994) cited the level of education of the black church leader as being one of the two most important predictors of church involvement in outreach programs (alongside church size). Leaders with a college degree or higher were identified as being more likely to engage in church-based health programs. Chaves and Tsitsos (2001) confirmed these findings. Those who found that congregations lead by clergy who held a graduate degree were more involved in providing social services.

Trinitapoli, Ellison, and Boardman (2009) reasoned that a leader's ability to plan, coordinate and facilitate social services would be influenced by his or her 'level of

experience and education, as well as their leadership skills, ideological orientation, and personal commitment to the endeavor' (ibid: 2233). Leaders with a higher level of education were thought to have a greater ability to seek out new information, network with health specialists and an increased understanding of the health-related issues within their communities (Trinitapoli, Ellison, and Boardman, 2009). It was therefore hypothesized that churches made up of clergy with graduate degrees would be more likely to facilitate church-based health related programs. Their analysis of data extracted from the 1998 National Congregation Study (NCS), a survey of 1236 churches in the United States, supported their hypothesis; church leaders who held graduate degrees being four times as likely to facilitate church-based health programs. While the initial findings suggest that an educated clergy would be a prerequisite for program provisioning, Trinitapoli, Ellison, and Boardman (2009) explain that education as a prerequisite tends to go hand-in-hand with other factors. Well educated clergy tended to be part of larger congregations with greater resource pools and vast networks which facilitate the acquisition of resources. In addition, other studies have found that *specialized* training in counseling regarding basic life issues and concerns remain minimal even among ministers who have pursued postgraduate education (Friesten, 1988; Weaver, 1995 as cited in Taylor, 2000). Therefore, simply being in possession of a degree may not always mean that a church leader is equipped with the skills necessary to properly facilitate church-based health programs.

Theological orientation

Research has suggested that the theological orientation of a church might impact the direction a church decides to take with regard to its church-based health programs. In

their study of church-based health programs geared towards the elderly in the United States Adams and Stark's (1988) study found little evidence that the theological orientation of the church affected the provision of CBHPP. Instead, they concluded that social conservatism[9] as opposed to doctrinal conservatism was of significance as a predictor. However, Chaves and Higgens' (1992) study concluded that theologically conservative congregations[10] had lower levels of participation in their communities. Furthermore, another study by Chaves and Tsitsos (2001) supported Chaves and Higgens' earlier findings by providing evidence that theologically conservative congregations provided fewer social services for their congregants. This effect was maintained across denominations (i.e.- Mainline liberal Protestant churches offered more services than conservative Protestants churches and conservative Catholic churches).

Lasater et al. (1986)'s study of a 4 year CBHPP on cardiovascular disease found that the ease of integrating the project into their normal church routine, both spiritually and physically, appealed to the church leaders and influenced their decision to participate in the project. Church leaders cited the following aspects of the project as being most favorable to them: lack of contradiction or liberalization of church dogma, program relevancy to the congregation members and minimal time commitment. Conversely, in a review of faith-based HIV prevention programs, Francis and Liverpool (2008) found that

[9] Adams and Stark (1988) chose to focus on two aspects of church conservatism: social and doctrinal. Social conservatism referred to the social action taken by the church or social orientation of the church. Doctrinal conservatism was measured by the degree of fundamentalism exhibited by the church.

[10] Chaves and Higgens (1992) define conservative congregations as 'congregations associated with conservative denominations or congregations identified as theologically conservative by National Church Survey informants in response to the question asking them to describe their congregations, theologically speaking, as "more on the conservative side," "right in the middle," or "more on the liberal side." (680). Chaves and Tsitsos (2001) state that theologically conservative, middle of the road and liberal denominations differ in religious tradition.

many churches struggled with what were seen as the moral issues at the heart of HIV and AIDS. As a result, programs presented in a way so as to keep in line with the church's tenets were generally not comprehensive. Despite the theological leanings of a church, the beliefs, interests, sense of social obligation and/or perception of the church leader in relation to the needs of the congregation and community could still influence the provisioning of the service (Lincoln and Mamiya, 1990; National Council of Churches, 1992; Taylor et al., 2000).

Governmental, non-profit or interchurch collaborations

Given that churches may not always have all of the resources or expertise necessary to run their programs, their ability to collaborate with government departments, development agencies, local civil society organizations or other churches may have bearing on their ability to facilitate church-based health programs, such as the HIV and AIDS-related programs explored in this study. Yet, collaborations are not always the norm, nor are they always desired.

Thomas (2004) explains that some of the reluctance on the part of government and development organizations to embrace religion on a local, national and international level may stem from a view that religion in some way hinders the ability to promote development. A number of regions of the world, Europe for example, have reasoned that the state should remain a neutral and secular entity in the sense that it does not enforce any specific religion or religious beliefs. Religion is viewed as a personal and private choice 'not to be dictated by the state' (Deneulin, 2009) and therefore the separation of church and state in secular countries provides a way to prevent the commingling of

development and faith. Development actors such as the World Bank, which has historically favored economics when shaping its approach to development, have also opted to avoid religion in order to 'divorce what were seen as political dimensions from development work' and focus instead on technical issues (Marshall, 2001).

Conversely, publications such as Snidle and Yeoman's (1997) *Christ in AIDS* highlight the importance of collaborations by stating, 'the church cannot work in isolation, it must work in the community and its efforts must be coordinated and integrated with existing health development packages; and with other bodies working in this field' (4). Yet, others such as Weller (2005) explain that religious groups might avoid collaboration with government departments because they feel as if they are being used to convey the messages of others.

> [Religious groups] must be able to feel that they can contribute on a basis that is rooted in the integrity of their own self-understanding... Religious groups may be suspicious and/or resistant to the possibility of being merely co-opted into government agendas (Weller, 2005: 276).

In addition, some religious organizations have chosen to keep their affairs separate from government agencies or non-governmental organizations (NGOs) out of fear of state intrusion in the conducting of their affairs or auditing (Campbell et al., 2007).

> Claims of this sort usually emphasize the possible consequences of government collaborations. The underlying logic implies that collaborations with secular nonprofits also risk undermining religious organizations'

> distinctive approach to social services...[and] that approach will not be shared by government collaborators. (Chaves and Tsitsos, 2001: 663).

To date, only a handful of studies have focused exclusively or in part on CBHP collaborations between churches and government or nonprofits. In a national US study on congregational social services and their collaborators, Chaves and Tsitsos (2001) found that 78% of all church programs were done in collaboration with others with no evidence that such partnerships undermined or impeded the congregations' approach to care. When the impact of collaborations was investigated by DeHaven et al. (2004) it was found that there existed no significant difference in the success rates between faith-based, faith-placed and collaborative CBHP. Chaves and Tsitsos (2001) did conclude, however, in their own study that the programs offered by churches in collaboration with governments and NGOs tended to be more longterm in nature.

Clarke (2006) explains that generally international donors tend to fund civil society organizations (CSOs) which subscribe to 'key elements of donor ideology and strategy' (836), and as a consequence they often '[do not] connect with large groups of intended beneficiaries because they failed to understand the faith tradition and its political and cultural import' (846).

The engagement of government agencies and NGOs in faith-based activities is further complicated when the development plans of NGOs and government and faith-based organizations (FBOs) fail to coincide. In countries where the faith and trust that citizens have placed in religion far outweighs the trust and faith assigned to the politicians in charge, researchers have found that governments whose policies are out of line with those

of religious organizations may find themselves at a disadvantage. Yet, it was the recognition of this 'disadvantage' and the reach of FBOs that captured the attention of organizations such as the World Bank and the United Nations which have in turn both sponsored faith-based conferences to address issues such as HIV and AIDS over the past decade.

Lastly, other studies have concluded that the absence of interfaith or intrafaith collaborations as well as the presence of interfaith or intrafaith collaborations has the potential to impede church-based HIV and AIDS mitigation efforts. For example, Foster et al. (2009) and Togarasei et al. (2008) cited both noted the negative impact that the absence of networking, cooperation and collaboration between churches had on the implementation of HIV and AIDS activities in Mozambique and Botswana respectively. While Foster et al. (2009) placed lack of transport and communication infrastructure at the root of Mozambique's poor networking, Togarasei et al. (2008) "territorialism...the spirit of competition…or mutual distrust, both within the faith sector as well as between the faith sectors and the public health sector" as the source of the poor collaboration witnessed (ibid: 9). Agadjanian and Sen's (2007) study on churches and HIV care in Mozambique confirms that interchurch tensions might present barriers to collaborations. Interfaith tensions arising from congregation-based HIV and AIDS-related outreach work in communities outside a church's own in Mozambique, and the perceived threat to member allegiance that such actions evoked, 'hindered interfaith congregational cooperation initiatives…which were already crippled by a shortage of financial resources' (ibid: 366).

African religion scholars such as Dr. James Amanze (in Amanze, Nkomazana, and Kealotswe, 2007) contend that often collaborations, such as those between churches in African countries and their international parent bodies, may benefit the local church financially but ultimately serve as constant reenactments of a longstanding state of dependency:

> The Church in Africa cannot be separated from the political and economic realities of Africa…In spite of many years of autonomy, the church in Africa also depends on handouts from its mother churches in the western world. In spite of the fact that many churches in Africa have become self-propagating and autonomous, whenever there is serious need for help, the churches still go to the western world and make appeals to their mother churches for help. It is for this reason that in the era of HIV/AIDS, many churches in Africa have done nothing without assistance from the western churches (ibid: 23).

Because of this financial dependency, such collaborations may cause the local churches to alter their programs to comply with the wishes of their parent churches, thereby removing their sense of autonomy and control.

So while networks could certainly assist churches in strengthening and furthering their capacity to provide HIV and AIDS services, the benefits of such collaborations might vary based on the context.

Summary

This literature review provided an overview of church-based health promotion, presented evidence-based HIV and AIDS-related church programs and activities from selected studies on sub-Saharan Africa, and explored the factors affecting the provision of church-based health programs.

Through health promotion and social service programs, churches in countries of the North and South are encouraging and facilitating the physical, social and economic requirements needed to keep their members at the highest level of well-being possible given their circumstances. Although this review has demonstrated that CBHPPs have shown promise as a community tool in dealing with health, this review has also highlighted the fact that their existence is impacted by number of factors.

Furthermore, this chapter has shown that there is limited evidence-based information on church-based health programs beyond the North American experience. Ransdell and Rehling (1996) maintain that there is a need to 'expand the populations and individuals served' (204) as the majority of published literature details church-based health promotion programs on similar target conditions within similar communities found in similar geographical regions. Few studies tackled the challenges associated with the implementation of church-based HIV and AIDS-related programs (see Derose et al., 2010) and fewer still approached this issue within an African context though HIV and AIDS remains one of the greatest concerns facing the social and economic development of several countries in sub-Saharan Africa. Moreover, many studies tend to lack theoretical explanations for the observed results. Ransdell and Rehling (1996) cite the

lack of 'applicable church-based health program theories on which to base programs' (203) as an ongoing barrier to the exploration of the development and implementation of church-based health programs by researchers.

Overall, this review has shown that churches continue to serve as a valuable resource in many countries, yet evidence-based research on organized religion and HIV and AIDS remains an underexamined area in literature (Bazant and Boulay, 2007; Liebowitz, 2002; Mukuka and Slonim-Nevo, 2006; Trinitapoli, 2006; UNAIDS, 2005). Given the documented importance and influence of religion and religious organizations in communities, further rigorous evaluation and scholarly inquiry into evidence-based church-based HIV and AIDS programs and the factors affecting them is required if they are ever to have a significant impact on mitigation efforts in countries such as Botswana.

CHAPTER III: METHODOLOGY

An exploratory qualitative study with elements of grounded-theory was undertaken to understand participants' perspectives, experiences, attitudes and cultural beliefs surrounding HIV and AIDS, and Christian church involvement in HIV and AIDS mitigation efforts. The study sought to address two main questions: 1) which HIV and AIDS services or activities are churches offering, and 2) what factors affect a church's ability to provision HIV and AIDS-related services.

3.1 SELECTION OF METHOD

Because the study was quite specific in that it did not aim to come to a conclusion which would generalize about all religious denominations across sub-Saharan Africa, but instead focused on the experiences of a group of 13 Christian church leaders, within one region in one country, a qualitative approach was deemed most suitable.

Mason (2002) explains that qualitative research allows the researcher to explore a wide array of dimensions of the social world including the 'understandings, experiences and imaginings' (1) of research participants and the significance of meanings generated by institutions and social processes. Unlike quantitative research which relies on surveys with closed ended questions that may edit out or fail to include elements which do not fit into the generalized picture being built, qualitative research factors these elements into the analysis and explanations to provide a richer and more meaningful interpretation of the data within a particular context. Mason's explanation of the benefits of qualitative research is supported by that of Mikkelsen (2005) who states that qualitative research is seen as a 'flexible approach of building up an in-depth picture of a situation, community,

etc. often combining a variety of methods' (349) such as open-ended questions and semi-structured interviews, mapping and other participatory approaches.

Berg (2004) cautions that the drawbacks to qualitative research are that it 'takes much longer, requires greater clarity of goals during design stages, and cannot be analyzed by running computer programs' (p. 2). It could also be argued that quantitative research might take just as long because in order for data from quantitative research to be deemed valid the sample size must be representative. This representative sample could entail the administration, collection and inputting of hundreds of surveys.

Because prior theories or research into the chosen area of interest was minimal at best, an inductive approach to inquiry and analysis was deemed to be most suitable. As defined by Mikkelson (2005), an inductive approach is one in which the researcher begins with empirical details and then works towards a general principle or a hypothesis. In other words, researchers using the inductive approach will derive theories through the analysis of 'the patterns, themes, and common categories discovered' (Babbie, 2004; p. 291). This is different from the deductive approach that works in the opposite sense: starting with a hypothesis and then collecting empirical details to test the hypothesis (Mikkelsen, 2005). Berg (2004) explains that the "research before theory" approach may 'suggest new problems for theory, require theoretical innovation, refine existing theories, or serve to vary past theoretical assumptions' (19), while McTavish (2002) states that this approach is designed to lead to the development of ideas for theory. The inductive approach, or research before theory approach, is thought to be best for 'exploring issues in unfamiliar contexts, and is used in the grounded theory approach' (Mikkelsen, 2005: 169).

3.2 SITE SELECTION

The fieldwork for this thesis was carried out in Gaborone, the capital of the Republic of Botswana. Although there were many compelling reasons to explore church-based HIV and AIDS programs in various districts across Botswana, given the time and resource limitations, it was only feasible to focus on Gaborone. Home to 191,776 residents, or 10.8% of the population (CSO, 2009b), Gaborone is one of seven major towns and serves as the country's 'economic, political and infrastructural capital' (CSO, 2009b: 48).

While Gaborone's estimated HIV prevalence level is slightly below the national average of 17.6% at 17.1% (CSO, 2009a), several factors made the district an ideal setting for examination of Christian church-based HIV and AIDS programs. Given that Gaborone draws its population from the rural areas of the country as well as surrounding countries, it is a city that is always in flux with a mixture of residents, visitors and migrants. Gaborone contains the largest cluster of churches as well as a significant proportion of the churches that had previously participated in University of Botswana's church-based HIV and AIDS-related studies. In addition, the city was not only headquarters to a number of denominations but also a number of key Christian umbrella groups.

Despite the adoption of a secular democratic model of governance at the time of its independence from Britain in 1966 (Haron and Jensen, 2008), Botswana is often described as a country with a strong religious system (Amanze, 1998). Christian churches were chosen as the focus of this study for two reasons:

- Christianity is the world's largest religion and is the fastest growing religion in sub-Saharan Africa.

- Christianity remains the dominant religion in Botswana with an estimated 83%[11] of adherents, 60% of whom attend Christian churches on a regular basis (Botswana Tourism Board, 2007).

3.3 STUDY POPULATION

As mentioned in the preceding section, Botswana is often portrayed as a country with a strong religious system. African religion scholars such as Dr. James Amanze (1998) have gone so far as to say that Batswana are so inherently religious that it would be difficult to draw a line of separation between religious and secular life because for Batswana, religious and secular life are one and the same.

Following the lead of Togarasei et al. (2008), this study drew participants from three main groups of Christian denominations in Gaborone, Botswana: the first group was composed of "mainline" churches, the second group was made up of Pentecostal and Evangelical churches, and the third group consisted of African Independent Churches.

Mainline churches, also known as "historic or mission churches" (Amanze, 1998), consist of churches introduced to Batswana society by missionaries from various missionary societies in Europe in the mid-19th century. The churches serve as extensions of their parental European churches and are overseen in part by these parental churches. Amanze (1998) explains that 'denomination, church practice, forms of worship, spirituality, aims

[11] This figure remains contested. As Haron and Jensen (2008) point out in their discussion of religious identity in Botswana, the number of adherents varies dramatically depending on the source consulted. For instance, the 2nd BAIS report found that 83% of Batswana were Christian and a 2006 Population Studies International report indicated that 72% of respondents identified as Christians. Most recently the Botswana Demographic Survey 2006 (CSO, 2009b) concluded that 62.7% identified with Christianity although only 10,970 households were interviewed for the survey. Haron (as cited in Haron and Jensen, 2008) attributes this fluctuation to the fluid religious identity that exists between Christianity and African Traditional Religions.

and objectives, church structures as well as church leadership' (ibid: 35) mirror those found within the parental churches regardless of geographical region. The doctrines and beliefs of mainline churches can typically be dated back by a century or more to early missionary efforts (Ucheaga and Hartwig, 2010). Because of their historical longstanding, mainline churches are also believed to have strong political connections with secular establishments in their communities (Agadjanian and Sen, 2007).

Pentecostal and Evangelical churches[12], like Mainline churches, were introduced to Batswana society from abroad with the majority stemming from the United States of America or Europe by way of South Africa sometime in the 1930s. Such churches place emphasis on 'being borne again, baptism by immersion and spirit possession' (Amanze, 1998: 43).

African Independent Churches (AICs) remain the most burgeoning church in Botswana. They consist of indigenous independent churches founded towards the end of the 19th century (Amanze, 1998; Haron and Jensen, 2008). Described as being created in/by/for Africans to enable them to express Christianity from their own perspective, the AIC movement also took place in many other African countries. The movement in South Africa was borne primarily out of a desire to move away from the 'paternalistic attitude of missionaries, intense colonial situation and the policies of apartheid in the country' (Amanze, 1998: xvi), while in countries such as Ghana AICs emerged in response to a need for 'healing, diving, prophesying and visioning' (Amanze, 1998: 63). Within

[12] Evangelical and Pentecostal churches were placed into one category. Evangelical churches are described as having leadership structures similar to that which is found in mainline churches although they are more similar to Pentecostal churches due to the emphasis placed on evangelism (Haron and Jensen, (2008).

Botswana no attempt had been made to adapt the Christian message to Tswana culture and the country's independent church movement was propelled by a desire to preserve the Tswana culture, customs, traditions and religious culture that were seen as being pushed aside by missionaries (Amanze, 1998).

Though the origins of religion in Botswana are not well known, scholars state that prior to the arrival of Christianity, traditional religion had been practiced. Tenets central to the religion had been 'Tswana concept of God, the ancestors, religious specialists, the concept of evil, initiation ceremonies ... [and] agricultural rites' and other concepts deemed to be important in the lives of Batswana (Amanze, 1998: 1). God or *Modimo* was conceptualized as a remote, single, eternal, benevolent and supreme being that could only be contacted through intermediaries, namely ancestors. Prayers were offered up to God through ancestors for everything from good health to success with work (Amanze, 1998) and could take the form of dancing, singing and spirit possession and often include an offering or sacrifice.

Ancestors or *Badimo* were anyone ranging from living parents to deceased relatives chosen for their longevity, social standing and model behavior in life. Such characteristics gave them a "god-like" status on Earth and therefore ascribe to them the type of moral superiority needed to act as intermediaries with *Modimo* (Amanze, 1998). Ancestors stood the closest to God and some had direct contact with God. Their spirits kept watch over their descendants and ensured them a fruitful life. These spirits also possessed the power to curse descendants should a descendent fall out of favor (Amanze, 1998). Atonement for perceived wrongs could be achieved through sacrifice and offerings to

God through ancestral spirits.

With the arrival of Christianity, traditional ceremonies such as rainmaking ceremonies were viewed as idolatrous because they involved prayers, offerings and sacrifices to ancestral spirits. It was decided that Batswana should place their faith in God alone without resorting to medicines and charms, as these were unchristian ways of obtaining desires.

The religion, which emerged from the independent church movement in Botswana, is what Amanze (1998) calls "African Christianity" (xiii). Based on teachings and tenets of African culture as well as the Old and New Testaments, the practices and doctrines of AICs in Botswana are explained in 'Tswana cultural terms that are easily understood and appreciated by Batswana' (ibid: xiii). Hence, AICs made Christianity relevant to Batswana and preserved the aspects of traditional religion –such as faith healing and traditional medicine- previously denounced by missionaries.

As in other countries (Agadjanian and Sen, 2007), AICs in Botswana are community-based and are generally found in poorer neighborhoods. Prophets, viewed as representatives of the Holy Spirit to whom God imparted secrets of healing, found a substantial number of churches and hold a place of prominence in the church. While there is no special theological school that a church leader must attend to become leader of an AIC -'every single Christian is a minister by virtue of his calling into the church as a fellow worker of Jesus Christ' (Amanze, 1998: 133)- prophets are appointed to their role through dreams.

In many AICs, Jesus has come to replace the role of the individual ancestor as intermediary and now represents all ancestors (Amanze, 1998). Church is viewed as a place where total healing can occur and AICs have continued on with the provisioning of healing services to parishioners through Jesus via church leaders. Jesus is seen as the greatest healer and prophet and alleviates physical and mental ailments and diseases as well as other misfortunes (Amanze, 1998). The Holy Spirit is believed to provide healers, bishops and prophets with the knowledge needed to identify diseases and its cause, and then guides the healers in prescribing the appropriate remedies. In other AICs, ancestors remain as the chief intermediaries though Jesus presents them with an additional channel to deliver their messages to God.

Because sickness or misfortune are conceptualized as a curse from God for 'wrong committed in one's life against God, the ancestors or one's neighbor' (Amanze, 1998: 167), within AICs specific ceremonies are held at several stages of an individual's life (birth, puberty, marriage and death) to guard that individual's passage through those rites. Nevertheless, when misfortune occurs members turn to their AICs to resolve the problem. Amanze states that this reputation for healing people who suffer from various ailments is one of the most distinctive features of AICs. Curing is usually done in several stages which can be accomplished in one visit or require a year long stay at a church in some instances. Divination through the Bible may be used to get to the root of the problem as well as its cause and cure. Because some AICs persuade their members to forsake hospitals and doctors in favor of belief in the healing power of God alone, in many AICs, traditional medicine –seen as a being given by God to man- is used to heal ailments. Alternatively, treatments prescribed by prophet-healers may comprise prayers for the

sick, animal sacrifices, induced vomiting, ritual baths, healing by baptism, water immersion, exorcism, or massages (Amanze, 1998).

For the purpose of this study, 13 church leaders from the three aforementioned groupings were selected as were key informants from faith-based umbrella groups.

Church leaders

Church leaders were chosen as subjects because of their revered and influential position within their churches and communities. Though it was understood that the church leaders interviewed might not be the sole decision makers in their churches, it was also understood that they could still provide great insight into the answers sought by this thesis. Questions were designed to account for the fact that the final decision making of church-based HIV and AIDS programs may lie outside the power of some church leaders.

Faith-based umbrella groups

Faith-based umbrella groups have the potential to play an important role in the well being of the church community. They can serve as liaisons between churches and government, provide guidance and mentoring on issues of importance and keep churches abreast of faith-based conferences or other social activities of interest. The faith-based umbrella organizations included in this study were chosen because their mandates include the sensitization of churches to HIV and AIDS and a number of the 13 churches were members of one or more of these umbrella groups.

3.3.1 Recruitment of subjects

A mapping exercise used to identify and list faith-based organizations for the *Assessment of the capacity of faith-based organizations for HIV Prevention in Botswana* project yielded a listing of 572 faith based organizations (FBOs) in seven districts of Botswana: Gaborone, Francistown, Serowe, Ramotswa, Ghanzi, Kasane and Selibe-Phikwe (Togarasei, 2008). The complete listing of these organizations was obtained from the assessment project's principal investigator at the University of Botswana.

Of these organizations, 42% identified themselves as African Independent Churches, 28% as Pentecostals, 17% as Mainline churches, 9% as other religions (Islam, Judaism) and 4% as umbrella FBOs (Togarasei, 2008). Because the focus of this study was Christian churches in Gaborone, other regions, religions and faith-based organizations were eliminated. Churches in Gaborone were stratified according to type (see **Table 1**) and then were randomly selected in proportion to their type.

Theoretical sampling led to the sampling of more churches and the inclusion of faith-based umbrella organizations (see **Table 2**). In all cases, sampling with replacement was initially attempted but cancellations, postponements and other interruptions presented unforeseen complications.

Religious Affiliation	Frequency	Percent
Mainline Churches	15	15.5
Pentecostal Churches	42	43.2
African Independent Churches	40	41.2
Total	**97**	**99.9**

Table 1. Christian churches in Gaborone as found by the mapping exercise (Adapted from Togarasei et al., 2008)

Religious Affiliation	Frequency	Percent
Mainline Churches	3	23.1
Pentecostal Churches	6	46.2
African Independent Churches	4	30.8
Total	**13**	**100.1**

Table 2. Breakdown of Christian churches sampled by main group

Potential participants were initially contacted by telephone.

3.4 DATA COLLECTION

The data were gathered primarily through questionnaires and face-to-face interviews utilizing semi-structured open-ended interview questions. Secondary data sources were also consulted.

3.4.1 Interviews

Because standard information (demographics, training, church-based HIV and AIDS programs) was required, as well as detailed information that required more in-depth investigation, a semi-structured interview was the most useful interview type. Semi-structured interviews consist of open-ended questions that can be followed up on with further probing when unexpected or relevant information surfaces during an interview, and they may include simple questionnaires (Mikkelsen, 2005). Questions are asked of each interviewee in a systematic and consistent order, but the interviewers are permitted to "probe far beyond the answers to their prepared standardized questions" (Berg, 2004; p. 81). In semi-structured interviews questions may be reordered during the interview and the interviewer is permitted to answer questions and make clarification, unlike in the case of standardized interviews that are more formally structured and leave no room for deviations from the set order (Berg, 2004).

The questions were developed to enable church leaders to provide both the standard information required as well as to share their opinions and knowledge. To begin with, simple questionnaires, which were short and easy to code, were administered individually to church leaders prior to the commencement of the semi-structured interviews.

The questionnaires were designed to collect information on:

- Demographic factors related to the church and the church leader,
- the HIV and AIDS related services offered by the church,
- changes to the church-based HIV and AIDS programming within the last five years,
- source and availability of financial and human resources related to the church-based HIV and AIDS services.

Following administration of the questionnaires, church leaders were asked questions pertaining to their opinions about HIV and AIDS within Gaborone and Botswana, the church-based HIV and AIDS related services offered by their church and their social ties and networks. Church leaders were also allowed to share their insight and opinions on any other issues or topics of importance that might not have been covered over the course of the interview.

Faith-based umbrella organization interviewees were engaged in semi-structured interviews that were meant to illuminate their experiences and involvement with the churches and church-based HIV and AIDS mitigation. In addition, these interviews were meant to provide additional information and clarification on a number of issues raised during the interviews with the church leaders.

Interviews with church leaders followed a standard format in terms of the goals of the interview, the general questions asked, and the informed consent procedures. However, probing questions were inserted, planned prompts were used to gather more information, the sequence of questions asked varied based on participant's response and participants were free to ask questions or provide supplemental information.

Participants were responsible for completing the initial questionnaire themselves though I recorded the answers to interview questions on a piece of paper. Interviews were taped when permission was granted and interviews occurred at a time and place of the interviewee's choosing within reason. Interview length varied depending on interviewees' response to interview questions.

Focus groups were determined not to be a viable option because of variations between and amongst the religious denominations. Also, finding an appropriate time to bring everyone together would have proven challenging.

Protection of human subjects

Applications to obtain permission to conduct research with human subjects was submitted to the appropriate review boards in Canada and Botswana (see appendices A and B). The applications included: a description of the purpose, design, methodology and data collection. Copies of the letters of invitations, consent forms and interview guide used were also submitted to the review boards.

Participants were required to express a willingness to articulate their opinions and to assist with the goals of the study and were given the option of opting out at any time prior to the end of the interview session. All participants were provided with a letter of information, which explained the study, informed them of issues of confidentiality, and their rights as participants. Participants were asked to sign a consent form if they agreed to the information contained in the information letter.

3.4.2 Secondary sources

Mikkelsen (2005) explains that, "no matter...the research topic... there is always a wealth of information hidden in a variety of sources" (p. 87). Secondary sources like documents can be described as such sources. Described as research and other official and unofficial studies and reports from journals and newspapers, archives and files, documents can serve to provide valuable information on the social and political conditions within an area of interest. McTavish (2002) points out that the use of secondary sources can also save the researcher "money, time, and [the] effort involved in the collection of new data" (p. 211) though McTavish also adds that shortcomings of secondary data is that the information available may not pertain to your target population and the accuracy of such data may be of concern. For the purposes of the study, an examination of in-country studies and publications related to church-based HIV and AIDS programs in Botswana was the final stage in the triangulation process. Documents consulted came from church leaders, CSO and NACA.

3.5 DATA ANALYSIS

When permitted, interviews were recorded and then transcribed. Interviews recorded by hand on paper were typed after the interview. Once transcribed or typed, the interviews were examined for accuracy. Memo writing and content analysis was conducted at various times during the data collection process. Interviews were examined in their entirety and read line-by-line. Loose themes were created based on review and repetition of the data and handwritten notes were made about the themes and ideas that the interviews elicited. Additional sampling with church leaders and faith-based umbrella groups occurred in an attempt to clarify or support themes.

Upon completion of the data collection process, another round of analysis was done and interviews were examined to reveal similarities and differences in the information shared. Patterns in HIV and AIDS-related services and activities and significant factors were identified across the sample. Finally, interview excerpts which best illustrated the patterns were selected.

3.5.1 Validity

Neuman (1997) states that, 'perfect reliability and validity are virtually impossible to achieve' (188). They are instead ideals that researchers should strive for. Within qualitative research validity can be described as proving a 'fair, honest, and balanced...portrayal of social life that is true to the experiences of the people being studied' (Neuman, 1997: 196). While qualitative researchers strive to capture a truthful and detailed account of those being studied, threats to validity can be mitigated by a number of techniques.

For the purposes of this study the following list explains the techniques that were utilized to mitigate threats to validity.

Triangulation. Often times when information is only gathered from one perspective we tend to assume that the reality as we have just observed is "fairly constant and stable" (Berg, 2004: 5) but this may not always be the case. For this reason, Berg (2004) suggests using triangulation, described as the use of 'three known points or objects...to draw sighting lines toward an unknown point or object' (Berg, 2004: 6). Or in other words, measuring something in more than one way in order to see all aspects of it (Neuman, 1997). Mikkelsen (2005) concurs with

Berg, describing triangulation as 'a criterion of good practice in qualitative research using several methods or conceptualizations on the same problem' (197). However Mikkelsen is also quick to advise that this technique might also lead to contradictory evidence, which will need to be documented. Triangulation of data sources through interviews with Christian church leaders, key umbrella groups and consultation of in-country documents was used to clarify and support emerging themes and improve the validity of the empirical results.

Rich and diverse data. Neuman (1997) argues that a researcher's empirical claims gain validity when they are supported by numerous pieces of diverse empirical data. Furthermore, data should be 'detailed and complete enough that they provide a full and revealing picture of what is going on... Rich data [should] provide a test of one's developing theories, rather than simply a source of supporting instances' (Maxwell, 1996: 95). The use of rich diverse data creates a "heavy weight of evidence" (Neuman, 1997: 197) that raises validity. In this study, thematic content analysis of all data was performed before examples were contextualized for theory generation.

Open questions. The use of open questions holds the advantage of allowing the interviewee to further develop their responses. Closed questions severally limit the ability of the respondent to elaborate or clarify their position or provide reasoning behind their answers. The interview questions used during this study were open-ended and prompts were used where needed to elicit further discussion or clarification of previous responses.

CHAPTER IV: RESULTS

This chapter will present the results of the data analysis. It is organized into three sections. The first section describes the study's participants, including demographic data about the interviewees and their church as collected through the initial questionnaire. The second and third sections will present the emerging themes from the qualitative findings and will answer each research question: 1) what are the HIV and AIDS related services provided by Christian Churches in Gaborone, Botswana; 2) what are the factors that affect the provision of HIV and AIDS-related activities and services by Christian churches in Gaborone, Botswana. To protect the anonymity of the participants, all names have been omitted and replaced by their religious affiliation.

4.1 DEMOGRAPHICS

Table 3 provides an overview of the study participants and their churches. The church leaders represented 13 churches from 3 denominations across Gaborone. The summary statistics indicate that on average the church leaders interviewed completed their formal schooling and went on to complete a form of tertiary education. Tertiary education varied from Bible College to university studies. One participant was attending law school by correspondence while another had recently obtained her PhD. Two out of the four African Independent Church (AIC) church leaders had not completed primary school and did not have any other form of formal education.

The majority (n=11) of those interviewed had been in a position of leadership for more than 5 years. Males accounted for 62% of the interviewee pool. AICs tended to have smaller congregations with an even mixture of youth and adults of both sexes while the

Pentecostal churches had larger, more youthful congregations comprised of more woman then men.

	DENOMINATION			TOTAL n= 13
	Mainline (n= 3)	Pentecostal (n= 6)	African Independent (n= 4)	
Age (years)				
< 30	-	-	1	1
30-39	-	2	1	3
40-49	-	3	-	3
50-59	3	-	1	4
60-69	-	1	-	1
> 70	-	-	1	1
Gender				
Male	-	5	3	8
Female	3	1	1	5
Education (highest level)				
None	-	-	2	2
Secondary	-	-	-	-
Tertiary	3	6	2	11
Church leadership (years)				
< 5	1	-	1	2
5-10	-	4	-	4
> 10	2	2	3	7
Congregation size				
< 100		1	1	2
101-250	-	-	3	3
251-500	1	2	-	3
501-750	1	1	-	2
751-1000	-	-	-	-
> 1000	1	2	-	3
Congregational makeup				
Men > Women	-	-	-	-
Men < Women	2	3	-	5
Even	1	3	4	8
Youth > Adults	-	3	1	4
Youth < Adults	-	-	-	-
Even	3	3	3	9

Table 3. Demographic characteristics of participants and their churches

4.2 CHURCH-BASED HIV AND AIDS-RELATED SERVICES AND ACTIVITIES

Church leaders were asked to note whether their churches provided any HIV and AIDS-related services. Of the 13 churches surveyed, most (n= 10) facilitated some form of HIV and AIDS-related service or prevention activity. Two Pentecostal churches and one AIC were among the 3 churches without any type of church-based HIV and AIDS-related program, service or activity.

While some of the HIV and AIDS-related programs available through the churches had been in existence for years and were coordinated by a church committee, others were more informal and occurred on an as-needed basis. **Table 4** provides an overview of the types of programs offered.

Type of HIV and AIDS-related activities and services offered by Christian churches in Gaborone, Botswana
Youth groups
Guest speakers
Home visits
Counseling
Prayer groups
Hospice care
Accommodation assistance
Orphanage for young children
Material support and food drives
Support groups (includes unisex groups)
Day care for orphans and vulnerable children
HIV and AIDS seminars
Voluntary counseling and testing

Table 4. Church-based HIV and AIDS-related services

The size, scope and type of HIV and AIDS-related service or activity offered varied within and between denominations. The most common type of service offered by the churches tended to be counseling (n=8) and programs for youth (n= 8) followed by material support and food drives (n= 7), prayer groups (n= 7) and home visits (n=7).

Youth Programs

In defining the Christian response to the AIDS epidemic in Botswana one faith-based umbrella group official explained:

> The Christian response lies in promoting values of faithfulness [and] abstinence... For others it is abstinence until one is ready. Others means other interventions. That is the difference with us. So for us, because it is from the scripture it has to be abstinence until marriage and there has to be faithfulness in marriage as a way of preventing HIV transmission.

This opinion was evident within the churches surveyed. Abstinence before marriage was a belief held by all 13 churches and the majority of youth programs tended to focus exclusively on the promotion of abstinence. Some church leaders expressed concern about the Abstinence, Be faithful or Condomize (ABC) model and felt that attention to abstinence was something that was lacking in the lives of youth. They expressed concern over the ramifications that sex before marriage could have on youth later on in life. One Pentecostal church leader commented:

> Teaching the ABCs... It is not effective because the condom is not 100% effective. Condoms encourage young people to indulge in sex and that is not moral. It does not help the young person. Sex has psychological effects and having sex could have an effect later on in marriage... Sex before marriage is a sin.

Another mainline church leader elaborated further, stating:

> We try to go to the young people because they are still young and maybe [they] can be changed... [They] must learn that there is a time for sex and learn self-control...There are ways to be friends with members of the opposite sex without giving them your body. When you meet the right man you have already given to someone else your precious gift and are giving to this one second helpings.

This church leader explained that by choosing abstinence until marriage youth were choosing life over death.

> We have these books that say choose life. In Deuteronomy it says, "I have come with life and death, so choose life." If you don't want to choose life you will die. John 10:10 says, "I have come that you may have life to the fullest." So if you do not want to live life to the fullest you could have problems... We tell them through role playing and in the end when they form the support groups they fill out these manuals and these manuals have got these topics like abortion, preparing for a life long partner [and] Christian marriage.

The youth programs varied from annual international conferences, local bimonthly conferences or weekly after church get-togethers that allowed youth to converse with each other about HIV and abstinence within their faith. One Pentecostal leader explained that youth in their church participated in "youth conference nationwide gatherings also teaching on faith teachings and abstinence."

Although there was agreement regarding teaching abstinence to youth, two mainline church leaders recognized the ABC model as a prevention tool that could be endorsed by the church. The first proposed that it was important to be realistic about what was happening within their congregations and the larger community. In explaining the reasoning behind her church's approach to its youth programs, she stated:

> Churches are addressing morality but the society we live in is not like 100 years ago. Girls and boys are not like before where they were only active when they are married. We preach about it a lot. We say knowing him does not mean you have to sleep with him. If you cannot protect yourself from having sex use a condom. We as a church agree to the use of condoms because the problem is there. If we say you must abstain, you are hitting a dead end. We do not have a problem with condoms.

Similarly the other mainline church leader explained:

> The thing is that the way HIV is spread is through very intimate behaviours that you cannot judge. We are focusing on how to teach them how to abstain and how to use condoms. The church has to realize that people are having sex. We should give them option. When we teach we give them options. We are not as ridged as the [other mainline] church. You should abstain but if it has been very difficult for you to abstain you should use condoms. [This] church is known as being more liberal than the [other mainline] church. It is one of those unwritten rules to talk about condoms. Providing more practical solutions to problems.

Counseling

HIV and AIDS specific counseling was another service offered by a number of churches. HIV and AIDS counseling occurred in two ways. First, to prepare couples for married life, a few Pentecostal churches required couples to attend pre-marital counseling sessions that included components on HIV and AIDS. As part of the counseling session, one church required that couples test for HIV and disclose their status to one another before marriage could take place within the church. Individuals who tested positive were required to seek treatment and additional counseling from a clinic before marriage counseling could resume. The Pentecostal church leader responsible for the counseling

session stressed:

> In that way they will both enter into the marriage with a clear conscience and later on their parents cannot say to us, 'How could you have allowed my child to marry someone who was positive?'

Other churches such as one mainline church placed greater emphasis on encouraging couples to remain faithful once married and only mentioned HIV and AIDS in passing during their counseling sessions. "In premarital counseling we have not formally integrated information about HIV and AIDS. I don't remember any seminars for priests to teach them how to integrate this information," the church leader explained. Teaching faithfulness to couples was of the utmost importance in the fight against HIV and AIDS to a number of those interviewed. As one Pentecostal leader mentioned:

> [It is necessary to promote] the teachings of the Bible without diluting them... [By showing] where it says that faithfulness is necessary for married couples, we will have really addressed HIV/AIDS. People will not be doubling up on lovers and hopping around.

Second, in addition to offering counseling on a wide host of issues, churches tended to provide one-on-one counseling to those living with, or affected by, HIV and AIDS. These one-on-one counseling sessions allowed church leaders to "offer hope and comfort" and "support [HIV and AIDS members] so they did not dwell in the past." One-on-one counseling sessions for PLWHA was said to be the preferred method over support groups because most PLWHA did not disclose their status to their church communities or family until towards the end of their lives. One mainline church leader explained:

> We know we have HIV positive members but they have not disclosed. If we start a group they might not go because they don't want others to know. So

we have groups which include all people.

A Pentecostal church leader affirmed, "We are slow to form groups. People come to me for help but don't want their status disclosed. People still live in fear." Any support groups available existed within the confines of group meetings and tended to touch on issues of HIV and AIDS in addition to other topics of interest to the group. Groups tended to be small and gender specific. The church leader of a Pentecostal church, which facilitated group meetings on a regular basis, explained:

> The ladies, men and children have their own ministries. It is easy to introduce this stuff that way. Introduce through small groups. It is more effective because more people attend small group seminars than attend church on Sunday. Small groups meet on weekends so it is more convenient for them to meet.

Material support and food drives

Material support in the form of clothing or food was also common. In general any food and clothing gathered was not for HIV or AIDS affected individuals within the church but more so for hospices or orphanages caring for children orphaned by HIV and AIDS. Churches such as one mainline, which ran their own hospice and day care for orphans and vulnerable children, conducted regular clothing and food drives. They also facilitated home based feeding programs to community members living with HIV and AIDS. Another mainline church produced vegetables that they gave to the needy and sold at a reduced price to others in order to support their various HIV and AIDS related projects.

Prayer groups

Prayers were a common activity mentioned by church leaders. Church members joined

prayers groups and said prayers for those affected by HIV and AIDS. Several churches were formally involved with the Month of Prayer activities, which took place every September in churches and communities across Botswana. Originally initiated by a group of church leaders over a decade ago to pray for those touched by HIV and AIDS, the Month of Prayer was now an officially recognized activity and received financial support from the government of Botswana. One Pentecostal church leader shared the invitation he had received from the government. In it he had been asked to deliver a scripture specific prayer at a scheduled ceremony during the month of prayer.

Home visits

Churches also mentioned providing home visits to members of their church and people outside their community. While members did not usually disclose their status, some church leaders stated that often it was known who among them had HIV. Home visits made to members who were positive provided church leaders with a chance to check up on their members and encourage them to seek appropriate treatment. A mainline interviewee illustrated the situation she often observed:

> The challenge is that many people are sick and they do not go for testing until they are about to die. It is because of fear. A person gets ashamed. "What will I tell people. If I tell them I have AIDS people will say, 'Oh you've been running around' so I better just die without telling anyone." People go to the clinic and instead of just saying what is the problem people will say, "Oh I have a headache." The doctor will give the person the wrong medication, which will not help what is really the problem. And this goes on. During our home visits we say to them, "Now we have exhausted all the other means. Would it not be better to test for something else?" We then

> take that person for testing and it comes back that it is positive and at least then we can address their needs.

One Pentecostal church leader detailed how she had been providing regular home visits to a member living with AIDS. Though this woman lived with her brother the brother would not assist her with her day-to-day activities. The church leader prepared meals for the young woman, helped her with things around the house and provided her with company during the home visits. That church member passed away during the last week of this study.

Another mainline church leader explained that home visits also provided church members with a chance to "confront peers they know are positive who have not been taking their medication" and ensure that they are put back on the right track. One Pentecostal church called their prayer group a Healing Room and provided "visits and [encouraged] those affected in faith and [encouraged them to take] their medication."

Other programs and activities

The majority of churches stated that it was important that personal responsibility should not be overlooked. Though few churches indicated that they addressed HIV and AIDS directly in their sermons, faithfulness was recognized as the best way to educate adults on how to protect themselves from becoming infected with HIV and many churches placed great emphasis on teaching the importance of faithfulness and encouraged behavioral change. "Any church which says I am preaching God should preach behaviour change," a mainline church leader stated. Faithfulness and behavioural change were usually broached during sermons or during the occasional HIV and AIDS-related workshops.

Workshops varied from gender inclusive workshops to separate seminars held by gender, age and marital status.

Churches generally did not invite outsiders to their churches to facilitate programs or address issues of HIV and AIDS. Two churches reported having had guest speakers in the form of outside speakers come to the church to discuss issues on HIV or lead an activity related to HIV. A Pentecostal church leader explained that he preferred to shape the messages himself:

> As Christians they must not get their information from all over because it might distort the message. We contextualize this information to our faith. We act as a channel of information to all our people. We might receive information from NACA and adapt it.

An AIC church reported that they offered cures to HIV and AIDS. The church leader reported that PLWHA often came to his church specifically to be healed of their affliction by the prophet. Another AIC explained:

> Because our church is apostolic church there are prophets and if someone has a problem they can go and be told to go for testing. Which means we are having that testing using the spirit [because] we can say if you are ill we will just pray for you.

All the participants were interested in participating in National efforts to mitigate HIV and AIDS, not necessarily in response to the NSF but more so because they viewed the epidemic as a serious issue affecting the community in which they resided[13]. Most of the churches that currently offered programs voiced a desire to grow their programs. All of

[13] 12 of the 13 church leaders maintained that HIV and AIDS was a serious issue affecting their communities.

the churches without programs expressed interest in establishing an HIV or AIDS-related service or activity for their congregation and one church which no longer offered a church-based HIV and AIDS component hoped to reactivate the program in the future.

4.3 FACTORS AFFECTING THE PROVISION OF CHURCH-BASED HIV AND AIDS-RELATED SERVICES AND ACTIVITIES

Participants were asked a number questions geared towards uncovering factors which could impact directly or indirectly on the churches' ability to provide HIV and AIDS services. Following an analysis of the data collected, themes surrounding actual and perceived information support, instrumental and member support emerged.

Resources in the form of financial and material resources (e.g., brochures) and community resources (e.g., guidance) emerged as central to the engagement of churches in HIV and AIDS-related services provisioning. In explaining the needs of churches with regard to their church-based HIV and AIDS programs, a faith based umbrella group official explained, "Churches need funding. They also need training. They lack the necessary skills to know how to start. Most have buildings and human resources already." One Pentecostal church leader without any church-based HIV and AIDS programs explained that his church's parent body in South Africa had "formal [HIV and AIDS] programs in place [elsewhere] and...[we] could do a lot if [we] had the resources to do it." Another Pentecostal leader with a host of small scale church-based HIV and AIDS programs asserted, "If we had resources our programs could fly." Several participants cited this lack of resources as affecting their capacity to offer HIV and AIDS-related services while access to the resources needed afforded churches the ability to engage in HIV and AIDS-related services or activities at the level they found most appropriate.

Financial resources in particular were often said to be lacking. "Churches are not doing this or this kind of thing...because of the resource challenge... Sometimes these things really drain your resources," the previously mentioned Pentecostal church leader without any church-based HIV and AIDS programming explained. Churches reported that members were usually asked to donate specifically to an HIV and AIDS-related activity; money was not simply removed from the offerings. To fund their HIV and AIDS services and activities, Mainline churches usually relied on a wide reaching support network made up of member churches in the USA, Europe and South Africa. Two of the three mainline churches also relied on their community contacts to assist with the funding and human resources needed to run their HIV and AIDS programs.

While admitting that churches lacked the funding necessary to run their programs, one faith-based umbrella group official insisted that churches needed to be active in looking for sources:

> I think that apart from getting money from the members they should also apply for funding from other organizations...that are based in Botswana. The thing is that [the churches] don't go out to find out how they can get funded. If they were interested they could go out and try they don't just have to sit there and say that it is very, very difficult. They have to go outside and asked how can we be helped. They should take a step.

Material resources were also greatly needed. "We need documents for people to read and books and Bibles with the 10 Commandments," an AIC leader explained. A faith-based umbrella group official reiterated this need for materials and said, "I can say that firstly they don't have materials to teach on HIV and AIDS issues. They don't have anything to

train themselves."

Analysis of the data also revealed that an individual's perception or the level of expectation of support available seemed to have high bearing on the church's engagement in HIV and AIDS mitigation efforts. The issue of support manifested itself in many ways throughout this study. Financial, educational, material and human resource support from networks internal and external to the church featured prominently in discussions with church leaders and was determined to be central to a church's ability to not only incorporate HIV and AIDS-related programming but also to provide it in the scope and scale desired. In particular the perception of support from parent churches, faith-based umbrella groups and church members was most significant.

Parent churches

When discussing their HIV and AIDS programs mainline churches often made mention of their parent churches. Parent churches were often international entities with African bases in South Africa or another neighboring country. Parent churches seemed to be useful in assisting churches with the packaging of their HIV and AIDS programs, and they provided church leaders with the training and material resources they needed to carry out the programs.

Within mainline churches the approach to HIV and AIDS prevention was usually unified from the parent church straight through to its affiliates so that there was little room for improvisation or interpretation on the part of local churches. One mainline church leader explained how this produced a feeling of unity in the message and gave her comfort and a sense of self-assurance. "We [all] preach the same thing. There is nobody who can say, 'I

will do this in my church.' We are guided by the Bishop and the Bishop is guided by [country is named]. All [denomination is named] churches abide by [this message]."

Guidance was an ongoing process within mainline churches. Mainline churches reported that their parent churches facilitated any number of regional conferences or workshops geared towards instructing church leaders on issues of HIV and AIDS or instilling in youth messages of abstinence. A mainline church leader explained that youth who attended the organized conference were equipped with books and brochures and were encouraged to "form support groups [within their churches] so that we can go to them and find out how many of them have sustained their pledges." The church leader explained that the youth became ambassadors within the church and were expected to spread the messages they had learned to their peers. A simpler amplification strategy was encouraged following workshops for church leaders. In speaking of the conferences, one mainline church leader explained, "Every year we have refresher courses ... We get instructions through that... Each church leader is [then] supposed to invite us to come and give their church the behavioral change programs." In addition to providing participants with adapted instruction on HIV and AIDS related issues, these gatherings provided participants with a chance to exchange ideas, discuss issues specific to their denomination and strengthen relationships with other churches of their region.

Faith-based organizations

Several government funded HIV and AIDS-focused Christian umbrella groups exist in Botswana. A number of the interviewees were members of these umbrella groups yet uncertainty about the services they offered seemed to limit the perception of their support

amongst the churches they were meant to sensitize. Each of the three umbrella organizations reported that they were available to assist churches with things such as proposal writing and one umbrella organization reported having funds available from time to time to facilitate the running of church-based HIV and AIDS workshops yet none of the churches made reference to these services when speaking of the umbrella organizations. Several members reported having attended workshops hosted by the umbrella organizations at some point but none seemed to view the organizations as sources of support. "We reached out to them, but they say they are also struggling," a mainline church leader reported when asked whether she had ever approached the organizations for assistance with her church-based HIV and AIDS programming.

While the faith-based umbrella groups received official support from the government and other international organizations, all three reported a range of barriers which prevented them from doing more to provide churches with the support they desired to run their HIV and AIDS programs. One umbrella organization reported a funding shortage prevented her organization from distributing an internationally sponsored HIV and AIDS prevention booklet to churches and a lengthy accreditation process had halted the HIV and AIDS training program -which would soon require that church leaders pay for the training.

Another umbrella group official stated that, "We also expect churches to help us... If they support this organization [then] we can work together so that we ca bring the messages to the community." Two of the umbrella organizations indicated that it was the reception they had received from the churches themselves that affected their enthusiasm for providing further services and support to churches.

> They believe that if you are a church member you have a good character so we do not have to go to them and preach to them about HIV and AIDS... We have workshops. Mostly at all our sites we have trained church leaders and youth church leaders. The response was not good. They don't tell us why [they do not attend]. I think that it is because it is HIV the truth be told.

One of the faith-based organizations official reported that his organization had hosted an HIV and AIDS-related social event for churches to which only a couple of leaders showed up. Since then the organization has turned its focus towards providing faith-based HIV and AIDS services directly through its organization and offers a minimal amount of services to the churches it is supposed to sensitize.

Church Members

Churches such as AICs which lack ties to other churches in their area and have no parent body to organize conferences or supply materials or financing are left to rely on members for support. Support from church members was paramount to the church's engagement in HIV and AIDS activities in all cases. Church members' support usually emerged through their involvement in the church-based HIV and AIDS activities as either a participant, organizer or donator. Analysis revealed that attitudinal barriers rooted in fear and denial on the part of church members and the church itself challenged the support perceived and received within some churches. And in turn, this perception or reception of support influenced the provision of church-based HIV and AIDS-related activities and services.

Denial on the part of church leaders and members was found to be a barrier for two reasons. First, people who do not feel threatened by the AIDS epidemic often believe they are immune to the risk of infection and this denial translates into a lack of participation or

interest in church-based activities related to HIV and AIDS. In turn perceived lack of interest or participation is viewed as a lack of support from church members and this seemed to dissuade church leaders from mounting similar activities in the future. As one mainline church leader explained:

> Some people think that they are educated enough. They can read books and think they know better. At the same time you go to their house and see them fighting and not being faithful to each other and yes, they are graduates from the university [and] some are even doctors yet they still do this and infect their partners and this is shameful. We need workshops on faithfulness in the marriage but the problem is that we will advertise [the workshops] and nobody comes. So this is the problem. It is discouraging.

An AIC leader said that she did not feel motivated to offer any programs because "Young people don't care about the disease. Even the older people [don't care]." She explained that they were too busy and would not want to participate in any activities related to HIV and AIDS.

A Pentecostal church leader whose 800+ member church did not offer any HIV and AIDS programs also stated that his members showed little interest in HIV and AIDS issues:

> People ignore the issue and pretend that it doesn't exist. They are not serious enough about it. It does not have the effect of scaring people. People think, 'It doesn't happen to me' so they go on sleeping around, playing around. I am speaking generally, because not everyone gets AIDS this way...

Similarly, another AIC leader expressed an interest in providing HIV and AIDS services but explained, "Other leaders don't take it as a serious issue. They think that just by

talking about abstaining you could be encouraging people to have sex... People won't receive it as a serious issue." The church leader went on to explain that there would not be much support from members for HIV and AIDS services with messages about faithfulness because "some churches have other rules like saying you should have two wives so when the message becomes 'You should stick to one partner' you will be insulting [their leader]."

In explaining the reluctance of some churches to address issues or HIV and AIDS or provide HIV and AIDS programming within their churches, a FBO official went on to say:

> The church members feel that, us, we are born again and then this messages or issues are for the wild and in that way they are the ones most affected because they just ignore [it]. They think the message is not for them. It goes from the church leader down to the church members because if the church leaders were including this in their sermons maybe the church could not be ignoring them.

Similarly, another FBO official offered the following analysis, "Maybe you want to start a project like [a] support group but it becomes difficult for people to accept that this will be in their church. Issues of denial on the part of church members at acknowledging that AIDS exists [present challenges]."

The third FBO umbrella group official explained that for some churches, the embrace of HIV and AIDS services by members would be paramount to admitting that God no longer had the power to intervene. "It's like they are compromising their faith," the official explained.

So a lack of support for previously hosted activities or the expectation of a lack of support due to denial of the need for such activities in turn seemed to affect the provisioning of church-based HIV and AIDS programming.

Fear also presented itself as an indirect challenge in a few different ways. First, fear was found to exist within some church leaders over the reaction of congregants should they decide to offer church-based HIV and AIDS programs. One AIC leader whose church did not offer any church-based HIV and AIDS services expressed fear over the reaction of church elders:

> We are into teaching about the gospel instead of talking about HIV and AIDS. In our culture the elderly people do not feel free to discuss sex when young people are there. I do not know how we can go about it. This is why we do not have facilities. The old people do not feel free.

Similarly, another young AIC leader whose church did not offer formal HIV and AIDS programming explained, "Us youth are afraid to talk to our elders. When an elder says you do not have to go for sex we are getting…afraid to talk to elders. And the elders do not want to talk to the youth about it."

So, fear over the reactions of church members reduced the church leaders' perception of the support for HIV and AIDS programming within their congregations.

Fear of association was also mentioned by a few church leaders. "You do not want to be classified with people who are considered to be loose people," a mainline church leader explained. So members were reluctant to participate in activities which they perceived as being geared towards "loose people."

CHAPTER V: DISCUSSION AND CONCLUSION

This chapter will present a summary of the study and findings, theoretical implications for development, recommendations for development practitioners, NGOs and government, and close with final comments on directions for future research and an overall conclusion.

5.1 SUMMARY OF THE STUDY AND FINDINGS

This qualitative study explored the main factors that affect the provision of church-based HIV and AIDS programs, activities or services by Christian churches in Gaborone, Botswana and subsequently vary the degree to which churches participate in the HIV and AIDS mitigation efforts of the country. In-country documents showed that the government of Botswana had officially recognized the strengths of churches in contributing to its AIDS mitigation plans, yet churches, in addition to other civil society organizations, had not participated on the level previously anticipated. The objectives of this study were to determine the HIV and AIDS activities and services provided by Christian churches and determine common factors that influence their provision.

The data collection methods consisted of in-depth interviews with thirteen Christian church leaders and three senior officials of Christian umbrella organizations mandated to sensitize churches to HIV and AIDS. As illustrated in other studies on Christianity in Africa, it was evident that the Christian churches in Botswana were not a homogeneous group. The church membership varied with one church reporting 85 members and another church reporting over 1200 members.

A number of themes emerged in this study. All but one of the church leaders interviewed viewed HIV and AIDS as a serious issue in their communities and all seemed to be

genuinely interested in church-based HIV and AIDS programming. Ten out of the thirteen church leaders interviewed facilitated some form of HIV and AIDS related program, activity or service within their church. Discussion of HIV and AIDS activities and services brought attention to the range of topics that church leaders deemed acceptable to discuss within their congregations. Overall the type of preventative services offered was limited by the churches' teachings. Churches which viewed sex before marriage as going against their church's main teachings were not liable to advocate for condom use although they recognized that youth were having sex before marriage. For these churches, the best preventative method for HIV and AIDS remained abstinence for youth and faithfulness for married couples and preventative activities reflected this belief. Contrary to what was found by Togarasei et al. (2008), HIV and AIDS itself was not often discussed in sermons though the need for faithfulness was sometimes mentioned along with Bible passages to support the message. No churches reported having self-affirmed PLWHA within their churches though it was sometimes known by members, and often known by church leaders, who amongst them was ill. Support for persons affected by HIV and AIDS activities was generally provided through one-on-one counseling at the congregant's request. Home visits were also provided to ill members. In contrast to Ucheaga and Hartwig (2010) and Trinitapoli (2006), few churches incorporated HIV and AIDS components into the premarital counseling or mandated pre-martial HIV testing.

Data analysis of the information collected over the five week interview period revealed that while churches are being called upon to fill a valuable role in the country's National Strategic Framework for HIV and AIDS, not all are adequately equipped to take on this

role and the result is a level of participation below that which was expected by government officials.

Analysis of factors affecting the provision of church-based HIV and AIDS programs revealed themes which did not coincide with the findings of other church-based health promotion studies. Many studies found that larger churches (with their greater access to human, structural and financial resources) would be more likely to provide CBHPPs. Yet the results of this study revealed that church size had no bearing on programme provisioning. Smaller churches were just as likely to offer services however on a much smaller scale. Neither theological orientation nor the church leader's level of education emerged as factors affecting program provision. All but two of the church leaders had attained at least a tertiary level of education and this education touched many different sectors including health and law.

Various forms of support within and without the church emerged as the most significant factors affecting HIV and AIDS program provision. The availability of support was often not enough to elicit the provisioning of church-based HIV and AIDS-related programs and services. The church leaders' perception of the availability of support in the form of guidance, finances, materials, and participation from members was found to be just as important as, if not more important than, the actual availability of such support. Church leaders who anticipated a lack of support towards church-based HIV and AIDS programs from within their congregation were less willing to provide the services. Perceived lack of support seemed to stem from feelings of congregants' denial of the need for such services. Similarly, church leaders who feared negative reception to church-based HIV

and AIDS programming by older members of their church, tended to reason that there would be little internal support for the programs and therefore there was no point in providing the services.

Interfaith/intrafaith collaboration was non-existent unless initiated by umbrella organizations. However, collaborations in the form of local churches and their parent churches were commonplace amongst mainline churches. Mainline churches tended to have a multitude of connections with any number of other social actors in their communities, as well as a supportive web of national and international organizations. These external organizations facilitated a myriad of supportive pillars that churches and FBOs mentioned as being of importance to engage fully in church-based HIV and AIDS programming. Namely, they facilitated training, materials and funding. These collaborations appeared to be welcomed by the local churches involved but because these churches were generally carrying out programs coordinated by their parent churches, there was little autonomy.

Though almost all the churches with the exception of the three African Independent Churches belonged to a faith-based umbrella organization in their community and were therefore networked on paper, results showed that these umbrella organizations were generally not regarded as sources of support. The church leaders were not always aware of the services available to them. For their part, the faith based AIDS organizations responsible for the sensitization of churches to issues of HIV and AIDS received financial support from several sources yet this funding was often not enough for them to reach all churches as intended. In addition, a lack of participation by church leaders in previous

HIV and AIDS activities mounted by the umbrella organizations seemed to dampen the organizations' drive to mount similar initiatives in the future. Churches that lacked parental churches also tended to lack ties to other churches in their community and were therefore almost entirely dependent on their own initiative, as well as that of their members, to design, fund and implement a variety of activities.

5.2 THEORETICAL IMPLICATIONS FOR DEVELOPMENT

While officially Botswana is a secular state, in essence religion permeates nearly all facets of life in the country. As explained by Denbow and Thebe (2006) in their book *Culture and Customs in Botswana*, "Religious ideas affect in fundamental ways how people in Botswana perceive themselves, their relationships with their families, their friends and neighbour, and their interpretations of daily events" (37). This ongoing adherence to religion in the face of rising prosperity within this middle-income country runs contrary to theories such as the secularization thesis, which maintains that as 'societies modernize, they may be expected to rely less on the sacred to interpret events around them or seek solutions' (Deneulin and Bano, 2009: 15). Inasmuch as Christianity and the church remain important cultural forces in both the public and private lives of Batswana, there are theoretical implications for religion in development studies. As such, religion as a cultural force and as an institution should be considered as an important part of development interventions and not simply as a vehicle through which messages to the masses are delivered.

As evidenced by the results section of this thesis, health promotion practices and beliefs may sometimes run contrary to that which is practiced or promoted by governments or

development agencies. In the face of such differences in practice and beliefs, the question faced by development agencies becomes, as Marshall asks, how and to what extent should varying ideas and cultural dimensions found within a given society be accommodated and integrated into the planning efforts directed at that society? Clearly, culture and the agencies which uphold cultural traditions are important fixtures in the lives of citizens and harnessing an understanding of the beliefs and values in poorly understood communities such as the ones documented in this thesis is an important first step in the creation of effective development projects.

In addition to the question of culture in development, the importance of support to civil society actors and the underlying social relations that help to shape this support, are concepts that emerged from this thesis. In the case of the churches that participated in this study, social relationships and connections were shown to have both costs and benefits. These cost and benefits resulted in variations in the level of support available to churches. For instance, the well developed social relations or ties between mainline churches, community organizations and/or parent churches allowed mainline churches to secure a multitude of informational, instrumental and emotional support. In turn, this support provided churches with the ability to offer an array of programs to their immediate community as well as to their surrounding communities. For other churches (e.g., AICs), the lack of social ties or relationships to other CSOs, CBOs, parent churches or like-minded national organizations meant that they were denied the benefits of similar levels of support and remained inwardly focused and dependent on themselves for guidance.

Social ties also bore costs. The HIV and AIDS-related activities carried out by mainline churches were usually coordinated by parent churches, and as such, their content and execution was often restricted to what the parent church deemed permissible and necessary. Though a few church leaders expressed a desire to implement new ideas and approaches, little room for variation was permitted. So while mainline churches were well supported, this support came at the cost of their autonomy.

Social relations also carried costs that emerged when the perceived expectations of that relationship were not met. For instance, the faith-based umbrella groups mandated to assist churches with their HIV and AIDS-related programs viewed their relationships with churches as one of reciprocity; they provided services and activities to churches and expected churches to respond by either by showing up to these events, contributing money when possible or volunteering their time. When churches did not respond accordingly, the faith-based organizations felt that the churches did not support their efforts and therefore were not as eager to repeat these programs in the future. Some churches, especially those lacking other ties, expected the faith-based umbrella organizations to facilitate the informational, instrumental and emotional support that they lacked. When these organizations failed to live up to these expectations, the relationship between the church and the umbrella group stagnated.

Strong social ties and connectedness within some churches resulted in a sense of obligation of the church towards the wellbeing of the congregants and communities, and, for the congregants, a sense of obligation towards their church. Churches recognized HIV and AIDS as having an impact on their communities and congregants and offered services

to address these issues; congregants offered contributions towards church-based HIV and AIDS programs, participated in certain church-based HIV and AIDS activities (e.g., prayer groups, home visits, conferences, youth groups) or steering committees.

An understanding of the web of social relations of a given community and the effect these relations have on community-based organizations and their initiatives could help to provide richer explanations of the outcomes observed when these community-based groups are solicited to assist with national initiatives as in the case of Christian churches in Botswana. These explanations, in turn, could have important implications for development policy and interventions not only in Botswana, but also in other countries of the developing world where community-based institutions continue to serve as a valuable resource.

5.3 RECOMMENDATIONS

Given the implications for development mentioned in section 5.2, this study suggests that there are several areas of need that can be targeted by development practitioners, NGOs and governmental departments in Botswana to ameliorate the effectiveness of the church and its leaders as valid and reliable sources of HIV and AIDS-related succor. This study noted the following:

- Discussions with umbrella bodies suggest that all church leaders undergo training in counseling while preparing for their position as leaders of the church, yet this study found that generally among church leaders there exists little preparation where HIV and AIDS is concerned.

- Though church leaders seemed to have a good grasp of the severity of the AIDS epidemic in Botswana and possessed well articulated ideas about how best to address the issues within their congregation, a number of them faced similar barriers which prevented them from translating these ideas into reality.
- Some church leaders found it difficult to broach issues of HIV and AIDS within their congregations for fear of the reaction of their congregants. They remained torn between a desire to assist with what they viewed as a need in their community and a sense of obligation towards respecting the views held by their older congregants.
- All church leaders interviewed indicated a willingness to offer HIV and AIDS-related services but many seemed to face a wall when trying to acquire funding. Several church leaders were not aware of sources outside of their churches or did not understand where to go for assistance with things such as proposal writing.

These points would suggest a need for capacity building for church leaders beyond the basics of HIV and AIDS education to equip them with the practical skills needed to cope with the increasing obligations placed upon them as facilitators as of health promotion during this era of HIV and AIDS. Because church leaders expressed that they were most at ease when amongst those of their own denominations and most receptive when the context of messages were tailored to the beliefs and needs of their church, it would be worthwhile for the government to sponsor capacity building forums or regular denominational HIV and AIDS-related workshop sessions specifically for church leaders based in each district. A committee made up of FBOs and church leaders who have been

well trained in this area could facilitate these tailored workshops. These regular gatherings by district will allow church leaders to network, learn, share and address concerns. These workshops could also be used to equip church leaders with practical skills such as advice on how to form and manage HIV and AIDS committees, undertake proposal writing, or update them on new resources available within their immediate communities. A newsletter could be used to disseminate the key developments of each meeting and communicate future initiatives to the broader community. Such forums would be especially helpful to churches lacking in social ties and would provide, in part, the informational and emotional support that they currently lack.

In a similar fashion, development practitioners could assist churches indirectly by providing reinforcement in the form of technical support, targeted financial support and medical advice to faith-based HIV and AIDS umbrella organizations. Development organizations may assist umbrella organization with the technical skills and direct financial costs required to produce reading and teaching materials for churches. Development practitioners might also help umbrella organizations create a universal monitoring system accessible to other churches, umbrella groups and development organizations to document and share the activities and progress made by churches in the area of HIV and AIDS mitigation.

5.4 DIRECTIONS FOR FUTURE RESEARCH

This study offers a limited presentation of organized religion's role in a particular health initiative within one country and suggests a number of directions forward for future research on the topic of church-based HIV and AIDS research in Botswana.

First, the small sample size of this study makes the task of presenting a detailed description of church response problematic, particularly when addressing Pentecostal and African Independent Churches in other metropolitan areas that may have vastly different leadership styles and values. The use of a larger sample in future research is likely to yield a more accurate presentation of the Christian response to HIV and AIDS in Botswana as well as provide a greater ability to detect significant differences between and within denominations.

Second, as the fastest growing and largest religious affiliate in Botswana, African Independent Churches are an influential and diverse group, yet highly under researched. Future studies may wish to examine in greater depth the response of the African Independent Churches to the HIV and AIDS epidemic throughout Botswana.

Third, during one interview a leader emphasized that HIV and AIDS prevention was "part of what we do, not what we do. It is part of our program, but it is not our program." Further studies may also seek to better understand how churches prioritize HIV and AIDS programming in light of other health challenges facing their communities. The findings of this thesis seem to suggest that the reticence of some churches to aggressively confront the HIV and AIDS epidemic lies in the amount of support they expect to receive.

5.5 CONCLUSION

Through an examination of churches and their HIV and AIDS-related services in Gaborone, Botswana, this study sought to address the NSF II's claim of weak ownership and participation of civil society in the mitigation of the greatest threat to Botswana's human and economic development. This study confirmed that churches are involved in a

variety of HIV and AIDS prevention and care activities. It was however determined that Christian churches were interested in playing a larger role but perceived, or actual, varying degrees of internal and external support for their HIV and AIDS-related efforts had great bearing on their ability and desire to provide services. It was recommended that the government must be prepared to assist church leaders with their capacity building through the creation of a number of regularly sponsored denominational workshops. Development agencies could also be of assistance to churches by providing social support in the form of technical, financial and educational support to the faith-based umbrella organizations responsible for the sensitization of these churches.

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APPENDIX B. Notification of IRB Review (Botswana)

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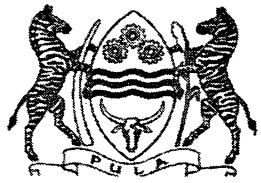

MINISTRY OF HEALTH
PRIVATE BAG 0038
GABORONE

REPUBLIC OF BOTSWANA

REFERENCE NO: PPME 13/18/1 PS V (115) 14 July 2010

Health Research and Development Division

Notification of IRB Review: New application

Ms Antoinette Davis

Protocol Title:	**AN EXAMINATION OF THE FACTORS ASSOCIATED WITH THE PROVISION OF CHURCH BASED HIV AND AIDS RELATED SERVICES BY CHRISTIAN CHURCH LEADERS IN BOTSWNA**
HRU Protocol Number:	HRU 00637
Sponsor:	N/A
HRU Review Date:	13 July 2010
HRU Expiration Date:	12 July 2011
HRU Review Type:	HRU reviewed
HRU Review Determination:	Approved
Risk Determination:	Minimal risk

Dear Ms Davis

Thank you for submitting a new Application for the above referenced Protocol.
This approval includes the following:

1. Application form
2. Proposal
3. Consent form
4. Data collection tools

This permit does not however give you authority to collect data from the selected sites without prior approval from the management. Consent from the identified individuals should be obtained at all times.

QUESTIONNAIRE

I. DEMOGRAPHIC INFORMATION

The following questions ask you for demographic information about yourself and your church members. Your answers to these questions are confidential and will not be disclosed to anyone other than the principal researchers of this study.

1. Your age range

under 30
30-39
40-49
50-59
60-69
70 and over

2. What is your gender?

Male (2) Female

What is your educational background? (Please circle all that apply)

(1) Completed secondary school
(2) Completed tertiary education
(3) Other _____

What is your religious affiliation? (i.e.- denomination of your church)

5. How many people attend your church?

6. How many years have you been the church leader at this particular church?

7. Congregation makeup: Please explain the general makeup of your congregation. For example, is your congregation composed of mostly females or males; is it made up of people of all ages or mainly older congregants (age 60 and over)?

II. CHURCH-BASED HIV AND AIDS RELATED SERVICES

The following questions ask you for information about the church-based HIV and AIDS-related services your church provides and the support received to facilitate the provision of these services. Your answers to these questions are confidential and will not be disclosed to anyone other than the principal researchers of this study.

1. Does your church currently provide any church-based HIV and AIDS-related services to your church members? If yes, please indicate whether you provide the following services. (Circle each service offered)

Preventative activities
Youth groups
Guest speakers

Support for people living with HIV and AIDS
Home visits
Counseling
Material support (clothing, food etc)
Support group
Prayer group
Accommodation assistance

Prevention of mother-to-child transmission
Women's group
VCT promotion (voluntary counseling and testing)
Teaching

Other *(please add any other activities or services below)*

2. If your church offers any HIV and AIDS-related services, who manages these services? i.e.- do church members run these programs or are programs facilitated by church staff members?

3. If your church currently offers church-based HIV and AIDS related services, have you made any changes to your services over the past five years? Why or why not? (Changes may include changes to the types of services offered or the frequency or any other changes you'd like to mention. If you did offer HIV and AIDS-related services in the past but no longer do so, please indicate why.)

4. Please explain how your church funds these church-based HIV and AIDS-related programs and services are funded.

INTERVIEW GUIDE

III. CHURCH AND COMMUNITY

Church community questions

1. Do you consider HIV and AIDS to be a serious problem in the local community in which your church resides? If yes, why? If no, why not?
2. Do you consider HIV and AIDS to be a serious problem to the country [Botswana]? If yes, why? If no, why not?
3. What goals should the Christian churches, as a whole, establish to confront the issues surrounding HIV and AIDS?

Christian church questions

4. What have you heard that other churches have done? Do you feel that these programs are effective?
5. Do you think that local churches can help provide solutions to the AIDS problem amongst Batswana?
6. What would be the wisest way to introduce AIDS awareness into the churches in Botswana?

Questions about your church, HIV and AIDS and networks

7. To your knowledge, has your denomination developed a unified approach to address HIV and AIDS?
8. How do you define the responsibility of your church:
    a. In providing ministry to people with HIV and AIDS?
    b. In providing information and education about HIV and AIDS?
9. What are some of the obstacles or challenges in dealing with AIDS-related issues in your churches?
10. Do you think that attitudes in your church (about AIDS) are different from other churches? How so?
11. Have you undergone any HIV and AIDS-related training? Where? How long ago? Duration of training?
12. Have you assisted with any HIV and AIDS programs outside of the church?
13. Have you ever met with our churches to discuss HIV and AIDS or to coordinate a program for your respective churches? Why or why not?
    a. If no, have you ever wanted to coordinate your churches HIV and AIDS-related services with that of another church? Why or why not?
14. Do you feel that your church has the resources necessary to respond to the needs of a Batswana congregant with HIV and AIDS? If yes, why? If no, why not?
15. Have you ever attempted to meet with government officials to seek support for your HIV and AIDS-related services? Why or why not?

16. Have you ever tried to develop HIV and AIDS-related services for your church with the assistance of faith-based HIV and AIDS organizations in your community? Why or why not?
17. Have you drawn on the WCC's support materials (such as training guides, telephone contact, workshops) to assist with the development of your church based HIV and AIDS services?

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