

Journal for the Study of the Religions of Africa and its Diaspora

An AASR e-Journal

August 2015 - Volume 1 - Number 1

 **AASR**
African Association for the Study of Religions



**Journal for the Study
of the Religions of Africa
and its Diaspora**

August 2015 - Volume 1 - Number 1
ISSN: 2311-5661

EDITORIAL MANAGEMENT BOARD

Editor in Chief

Afe Adogame, *The University of Edinburgh, UK*

Deputy Editor

J. Kwabena Asamoah-Gyadu, *Trinity Theological Seminary, Legon, Ghana*

Reviews Editors

Jan G. Platvoet, *Bunnik, Leiden, The Netherlands*

Abel Ugba, *University of East London, UK*

Janice McLean, *City Seminary, New York, USA*

Lovemore Togaresei, *University of Botswana, Gaborone*

INTERNATIONAL ADVISORY BOARD

Jacob Olupona, *Harvard University, USA*

Philomena Mwaura, *Kenyatta University, Nairobi, Kenya*

James Cox, *The University of Edinburgh, UK*

Oyeronke Olademo, *University of Ilorin, Nigeria*

Ulrich Berner, *University of Bayreuth, Germany*

Deidre Crumbley, *North Carolina State University, USA*

Abdulkader Tayob, *University of Cape Town, South Africa*

Gerrie ter Haar, *Institute of Social Studies, The Hague, The Netherlands*

Elias Bongmba, *Rice University, USA*



**Journal for the Study
of the Religions of Africa
and its Diaspora**

August 2015 - Volume 1 - Number 1
ISSN: 2311-5661

COPYRIGHT AND OPEN ACCESS POLICY

© 2015 under the Creative Commons Attribution-NonCommercial-NoDerivatives 4.0 International License (CC BY-NC-ND 4.0)

This journal provides immediate open access to its content on the principle that making research freely available to the public supports a greater global exchange of knowledge. Users are allowed to read, download, copy, distribute, print, search, or link to the full texts of the articles in this journal without asking prior permission from the publisher or the author. This is in accordance with the BOAI definition of open access.

ABOUT THE JOURNAL

The Journal for the Study of the Religions of Africa and its Diaspora is a peer-reviewed, open-access journal for the academic study of the religions of Africa and the African Diaspora. It will serve primarily as an interdisciplinary journal in which AASR members, but also non-AASR-members, publish the outcomes of their original research on the religions of Africa and the African Diaspora.

The journal will cover the wide range of religious traditions that were founded, were or are found, and exist and operate in Africa and the African Diaspora; and topics useful to scholars involved in the academic study of religions in Africa and the Africa Diaspora, and to a wider readership of academics in the general study of religions.

The journal shall be published as electronic issues only, with two (2) issues per year. It will be administered on behalf of the AASR by the Editorial Management Board and the International Advisory Board.



**Journal for the Study
of the Religions of Africa
and its Diaspora**

August 2015 - Volume 1 - Number 1
ISSN: 2311-5661

ABOUT THE AASR

The African Association for the Study of Religions (AASR) is an academic association that promotes the study of religions in Africa through international collaboration in research, publishing, and teaching. AASR was founded in 1992 in Harare, Zimbabwe at a Regional Conference of the International Association for the History of Religions (IAHR). The AASR has been an affiliate organization of the IAHR since 1995.

In particular, the AASR aims to stimulate the academic study of religions in Africa in the following ways:

- By providing a forum for multilateral communications between scholars of African religions
- By facilitating the exchange of resources and information
- By encouraging international collaboration in research between scholars and institutions in Africa and those outside the continent
- By developing publishing opportunities particularly for scholars based in Africa
- By establishing a travel fund to enable scholars to attend academic conferences
- By organising conferences in Africa and panels on the religions of Africa
- By establishing a newsletter and website to increase communication between scholars of African religions
- By creating a directory of scholars in the field of African religions

AASR MEMBERSHIP

Any scholar with suitable qualifications in the study of the religions of Africa and its diaspora, or in the study of other religions when appointed to an academic institution in Africa, may apply for membership with the AASR. Membership is open to scholars of religions working in the fields of African indigenous religions, Islam in Africa, African Christianity, new religious movements, and other religions with followers on the continent, such as Hinduism and Judaism, as well as in the religions of the African diaspora.

For more information about membership requirements, please visit the AASR website:

<http://www.a-asr.org/membership/>

CONTENTS

EDITOR'S NOTE

Afe Adogame 1

ARTICLES

Mukondombera: HIV and AIDS and Shona Traditional Religion in Zimbabwe
Tabona Shoko & Agness Chimara 5

Similarities and differences in the healing practices of Pentecostal churches and the African traditional religions in Botswana
Fidelis Nkomazana 18

Church's Role in Prevention, Care and Management of HIV and AIDS in Western Kenya: Case of Vihiga and Busia Districts
Sussy Gumo-Kurgat & Susan Mbula Kilonzo 33

Healing Culture, Healing AIDS: A Review of some African Cultural and Religious Beliefs and Practices in Contexts of HIV and AIDS
Lovemore Togarasei 49

REVIEWS

Cox, James L., *The Invention of God in Indigenous Societies*
Oyeronke Olademo 65

Kumalo, Simangaliso, *Religion and Politics in Swaziland: The Contributions of Dr JB Mzizi*.
Rosinab Mmannana Gabaitse 73

Bongmba, Elias Kifon, ed., *The Wiley Blackwell Companion to African Religions*
Ezra Chitando 75

RESEARCH OPPORTUNITY

Research Grants from the Nagel Institute for the Study of World Christianity 76

Editor's Note

I am very much delighted to introduce and welcome readers to the maiden issue of the *AASR E-Journal for the academic study of the religions of Africa and the African Diaspora*, a peer-reviewed, open-access journal of the African Association for the Study of Religions (AASR). This marks a significant milestone in AASR's history, and represents a systematic progression in published output by the AASR, which also produces a bi-annual AASR Bulletin that is available to AASR members; as well as libraries and universities through subscription. The E-Journal will serve primarily as an interdisciplinary journal in which members and non-AASR members, publish the outcomes of their original research on the religions of Africa and the African Diaspora. It will cover the wide range of religious traditions that were or are found, were founded, and exist and operate in Africa and the African Diaspora; and topics useful to scholars involved in the academic study of religions in Africa and the African Diaspora, and to a wider readership of academics in the general study of religions. The E-Journal shall be published as electronic issues only, with two (2) issues per year. Articles will be published in English only in the first instance, but in future, if the number of Francophone AASR members would expand significantly, articles will also be published in French. AASR E-Journal will be incorporated into the AASR website and be posted in its public part in order that, as an open access journal, it will be accessible to the widest academic and general public.

This maiden issue marks a turning point for the African Association for the Study of Religions (AASR), since taking responsibility for an electronic journal opens a new vista of academic publishing particularly for its members, but also non-members. I will encourage scholars with interdisciplinary focus and orientation to take due advantage of this new publication channel. This first issue features four interesting papers, drawn from presentations at the IAHR Regional Conference and Third AASR Conference in Africa on 'Health, Healing, and the Study of the Religions of Africa' at the University of Botswana, Gaborone (8-13 July 2007). As the planned publication from the conference never saw the light of day owing to obvious reasons, we deemed it fit to wet your academic appetite from that stimulating unpublished corpus, however belatedly.

The continent of Africa is sometimes stereotyped as the cradle of disease and death. With the HIV and AIDS pandemic this stereotype has not been helped. Within three decades HIV and AIDS was claimed to have infected 40 million people, 30 million of those are in Africa. The pandemic has claimed more than 22 million lives, seventeen of those from the continent of Africa. There are up to 14 million children that have been orphaned, many of which are in the African continent. HIV and AIDS is, as some have noted, an 'African Holocaust.' Moreover, HIV and AIDS has brewed social stigma against 'People Living with HIV and AIDS' (PLWHA) and their families. It traumatizes the infected and the affected, leading to fear, hopelessness and desperation that manifest itself in surprising social evils. More than three decades of living and struggling with HIV and AIDS has brought the continent and the world to realize that HIV and AIDS is not

just a virus that wreak havoc of individual bodies; it is not simply about individuals lacking sexual morals to abstain from sexual activities or to be faithful to their partners or to condomize. Rather HIV and AIDS is an epidemic within other social epidemics of poverty, gender inequality, violence of all forms, abuse of children rights, racism, national corruption, international economic policies of injustice, oppressive cultural practices of various forms etc. HIV and AIDS, in other words, dwells and thrives through pathways of social injustice.

The experience of HIV and AIDS and its interconnection with all aspects of our lives has challenged the world to have a wider understanding of health and to realize that health and healing is more than just attending to a virus or bacteria that attack our biological bodies. Health and healing is also beyond the medical guild. Health and healing should involve all disciplines and departments of our lives. That is, all of us should be part of interrogating and highlighting what constitutes health and healing. All of us should interrogate their role in seeking to curb the spread of HIV and AIDS and its accompanying social epidemics. This brings the responsibility at the door of the academic study of religion as well. Be that as it may, during the over three decades of the 'African holocaust,' African scholars of religion in the continent, diaspora and among Africanists have largely gone around with business as usual. Their conferences, articles, books, courses and projects hardly reflect a significant response to HIV and AIDS or much preoccupation with health and healing. Scholars of African religions such as African Indigenous Religions, Christianity, Islam, Judaism and other religions of the continent may not boast of several academic responses to the 'African Holocaust' and their contribution to understanding health and healing.

Thus, the relative silence of scholars of African religions and their programmes in the face of growing health inequalities and an HIV and AIDS epidemic puts a question mark on the academic study of religions in Africa, in the African Diaspora and among Africanists generally. How are academic programmes of religion structured? What are the frameworks of analysis that inform the study of religion in Africa, the African Diaspora and among Africanists? How is religion taught in the ivory tower and what are its goals? Is the academic study of religions of Africa and its scholars decolonized and depatriarchalized? Is the academic study of religions of Africa socially detached from African struggles? Is it still western founded and directed? How do we explain the silence of scholars of African religion's and their programmes to the 'HIV and AIDS holocaust'? Does the academic study of African religions in Africa, the African Diaspora and among Africanists need to be decolonized? How can and should the academic study of African religions be reconstituted? What are available models that have demonstrated engagement to health and healing? What are available models that have decolonized programmes of studying African religions in the continent, African Diaspora and among Africanists?

It is to some of these pertinent questions that the four papers in this maiden issue respond, situating their conversations within the broader spectrum of health and healing, and the academic discourse of religion in Africa. Generally, the contributors explore the general understanding and conceptualization of health and healing; how particular religions such as African Indigenous Religions and Christianity contribute to health and

healing; and how they deal with health care, and any other aspects of various diseases of concern.

Tabona Shoko and Agness Chiwara interrogates HIV and AIDS in light of Shona indigenous cultural practices in Zimbabwe, focusing on indigenous cultural practices that facilitate the spread of the disease, the impact of the spread on society, the role of Indigenous healers and claims to curing the disease, AIDS education and research into a cure for AIDS, and problems faced by traditionalists in the fight against AIDS. They contribute to the scanty literature on HIV and AIDS in Zimbabwe, by employing sociological, anthropological and historical approaches to explore the role of indigenous culture and beliefs in the fight against the pandemic. Their emphasis was on case studies of healing practices in the indigenous contexts as perceived by the Shona people, indigenous practitioners and their association ZINATHA, their clients and use of indigenous medicine.

The second contributor, Fidelis Nkomazana, contrasts healing practices of Pentecostal churches and the traditional religions in the context of Botswana. He identifies the major similarities against the backdrop of their strong belief in supernatural interventions in times of crisis in order to preserve, prolong and protect life. He contends, that while certain methods and strategies are similar, the belief in ancestors in the case of traditional religions, and in Jesus and the Holy Spirit, who are the key agents of healing for Pentecostal churches, mark the major points of difference.

Based on specific case studies of randomly sampled churches in the Vihiga and Busia Districts in Western Kenya, Sussy Gumo-Kurgat and Susan Mbula Kilonzo focus on Church's role in prevention, care and management of HIV and AIDS. They explore the role of the Church in the care of persons living with HIV and AIDS and the affected, and critically examines the strategies and efforts of the Church in prevention and management of HIV and AIDS in Western Kenya. Discussions were framed under the concept of holistic care and development for humanity. Given the numerous challenges that the churches face while responding to HIV within communities, they advocate for an integrated approach where churches can borrow strategies that work best from their counterparts.

Finally, Lovemore Togarasei provides a critical review of some African cultural and religious beliefs and practices in the context of HIV and AIDS, envisioning culture as a double-edged sword in HIV and AIDS response. He argues that while scholarly attention has mainly been on how certain cultural practices facilitate the spread of HIV and stand in the way of prevention, treatment and care, there are some ethno-cultural and religious beliefs and practices that are relevant for positive HIV and AIDS response. His contribution tease out ethno-cultural and religious factors that facilitate the spread of HIV with the aim of 'healing' those that fuel the spread of HIV and promoting those that can be used for positive response.

These four rich papers turn the first maiden issue of AASR E-Journal into one with a perceptibly strong methodological and theoretical focus, backed with interesting case studies. This is a fitting new beginning for AASR E-Journal, since the place of the study

of religions as a field of study in its own right forms a continuing point of contention amongst scholars. In this regard, these initial articles may set the stage for more robust brainstorming on the nexus between health, healing and the academic study of religion in Africa and the African diaspora. I therefore encourage African scholars of religion and scholars of African religions to join this debate by paying attention to the enormous health-related challenges that confront the continent and the African diaspora; whether, how and to what extent the study of religion can contribute, not simply to the debate, but also explicating how health and healing are at the core of religious/spiritual concerns.

Words of profound gratitude need to be extended to those who have made this project possible, particularly the AASR Executive Committee, the Editorial Management Board and International Advisory Board respectively. No doubt, it has taken a while for this project to come to fruition, no thanks to unanticipated logistic and operational hurdles. The good news however is that we overcame those barriers and can now sit back, relax and enjoy the rich conversation. Dear friends and colleagues, the ball is now in your court, happy reading!

I therefore also welcome and invite your submission of articles that make a new contribution to scholarship on African religions and religions of the African diaspora, particularly from scholars working in Religious Studies and all related disciplines in the humanities and social sciences.

Afe Adogame

Editor-In-Chief

August 2015

Mukondombera: HIV and AIDS and Shona Traditional Religion in Zimbabwe

Tabona Shoko and Agness Chiwara¹

Abstract

This essay explores HIV and AIDS in light of Shona indigenous cultural practices in Zimbabwe. We will focus on indigenous cultural practices that facilitate the spread of the disease, the impact of the spread of the disease on society, the role of Indigenous healers and claims to curing the disease, AIDS education and research into a cure for AIDS, and problems faced by traditionalists in the fight against AIDS. This essay examines case studies of healing practices in the indigenous contexts as perceived by the Shona people, indigenous practitioners and their association ZINATHA, their clients and use of indigenous medicine. Medical specialists the world over are occupied with efforts to find a cure or vaccine for the epidemic. The elusive nature of the disease and failure to attain a cure by the international community warrants continuous efforts to grapple with the problem. Yet in the midst of this, very little in the literature on HIV and AIDS has focused on indigenous cultural practices in Zimbabwe. As a result, it is urgent that we explore the role cultural practices play in contributing or the promotion, prevention and containment of the AIDS epidemic. The essay makes use of sociological, anthropological and historical approaches to establish the role of indigenous culture and beliefs in the fight against the pandemic.

Introduction

HIV and AIDS has become a global challenge for individuals and organisations, not least for scholars in different academic disciplines. In Zimbabwe, it is estimated that over five thousand people are dying of HIV and AIDS, and AIDS related illnesses every week (Government of Zimbabwe Magazine, 2007). Scholars in Medicine and the Social Sciences have explored HIV and AIDS and healing in scientific medical context.

¹ Tabona Shoko is Professor of Religious Studies at the University of Zimbabwe. Email: shokotab@yahoo.com. Agness Chiwara is Lecturer in Religious Studies at the University of Zimbabwe.

However, very little literature has given attention to the role of Indigenous religion and culture on meaningful intervention against the disease.

In order to address this lacuna, it will help us to turn to those who have studied medicine, religion and culture in the Shona context. Among these scholars in Zimbabwe is the late Michael Gelfand (1956), an empathetic medical doctor and lay anthropologist who lived among the Shona and analysed the Shona understanding of disease and its causes and cures. Gordon Lloyd Chavunduka (1994) also discussed indigenous religion and medicine from a sociological dimension. Other scholars who have studied Shona medico-religious beliefs and practices using a variety of approaches include: Michael Bourdillon's (1976) anthropological studies of the Shona, Hubert Bucher's (1980) sociological assessment of the Shona cosmology, Herbert Aschwanden's (1987) symbolic analysis of death and disease among the Shona-Karanga and Gordon Chavunduka's (1978) sociological approach to indigenous healing and medicine in Zimbabwe. In addition, a number of articles appear occasionally in some magazines and the daily media with stories about the role of indigenous medicine on HIV and AIDS. This essay intends to introduce new perspectives into the pattern of healing in this context of HIV and AIDS in Zimbabwe. Such material will make a significant contribution to Religious Studies and also complement the body of extant literature in Medical studies and Social Sciences.

Although a number of scholars have written on the Shona medical beliefs from a variety of disciplines, nothing significant has been produced on HIV and AIDS and cultural practices. Moreover, indigenous healing in particular is yet to be explored. This essay seeks to investigate the role that indigenous culture plays in the spread and eradication of HIV and AIDS.

The essay adopts an eclectic approach. Based primarily on empirical data, it utilises the anthropological method to capture the interaction between individuals in society. This method explores how society influences individual behaviour and vice-versa (Bourdillon 1990: 10). It also examines social interaction between social institutes and events. In this essay it enables the researchers to discern how culture affects or is affected by HIV and AIDS beliefs. The sociological method is also used in this essay. This is but one aspect of the study of the relationship between ideas and ideals embodied in movements, flourishing and decline (O'Dea 1983: vii). A sociological approach is therefore crucial in this essay because sociological approach to an interpretation of religious phenomena offers an important avenue for understanding the human significance. T. F. O'Dea states that no explanation of religion can be complete without considering its sociological aspects, thus society provides one with an overall environment in which inner potential may be brought to some kind of realisation and expression (O'Dea: 1883: 1). The sociological method enables the researcher to make an overview of the Shona society in general especially how the indigenous worldview, socio-economic and medical system is affected by culture. The essay also uses the historical approach. The method is of great importance in this essay because the researcher deals with historical facts. According to T.O. Ranger and I.M. Kimambo, the study of religion in African studies far neglected is absolutely essential to the understanding of the dynamics of African society ((1972: 1). The historical method is therefore very crucial in this essay because it helps to comprehend the dynamics of cultural practices in their historical context.

Indigenous Shona Religious and Cultural Worldview

Spirits

The indigenous Shona believe that there are spirits that help spread HIV and AIDS (Shoko 2010: 85). Spirits such as *midzimu* (ancestral spirits), *shave* (alien spirits), *ngozi* (spirits of vengeance) and nature spirits, *tokolotsbes*, spooks and ghosts and *bvuri* (shadow of a dead person) can cause illness, misfortune and death. Witchcraft beliefs also prevail. Such cultural beliefs offer alternate interpretation to scientific understanding of HIV and AIDS (Shoko 2007: 57-64). Ancestral spirits cause illness and disease of a complex and serious nature. Such illness is believed to defy all treatment. However this is not meant to kill the victim but to alert the descendants to search for the spiritual cause from the diviners. Besides their role in guarding and protecting living members of the family, ancestors can be angry if neglected or forgotten. This is usually the case when some rituals are not done for the spirits like *kurova guva*, an indigenous ritual that calls back the spirit of the dead.²

Ngozi (avenging spirit) is one of the most dreaded spirits in the Shona society. This is the source of the worst kinds of illness and disease and can even cause death. *Ngozi* is a spirit of a person whose death came as a result of foul play or a person who had been wronged and indebted and dies harbouring feelings of having been mistreated, who now seeks justice against the living. It may also be the spirit of the dead mother, who dies without reconciliation with one or more of her rebellious children who have assaulted her while still living. This quest for justice takes the form of causing illness to the family of the wrongdoer. The illness is seen as a form of punishment meted out in various ways that may include death by lightning, disappearance or bleeding through the nose. The Indigenous Shona hold the view that “*mushonga wengozi kuripa*” (cure for avenging spirit is payment),³ which is normally done in the form of a large herd of cattle and a girl who is meant to raise offspring on behalf of the dead.

Alien spirits (*mashavi*) constitute another category of spirits that cause illness and disease. These are spirits of people who died far away from home suddenly and without death rituals being undertaken for them. So they possess individuals in search for recognition and a home to reside. *Shavi* spirit possession is heralded by illness. The Shona make a distinction between a good alien spirit and a bad one. While the good one gives its host new skills such as hunting, healing, dancing, singing and other indigenous specialties, the bad one brings on evil spirits, causing the host to indulge in witchcraft, prostitution and stealing (Shoko 2007: 61).

The shadow (*bvuri*) of a dead person is also capable of causing serious illness and even psychiatric problems. *Bvuri* resides in an anthill. If one passes by this anthill, the passer-by will most certainly catch the spirit and lose his voice while trying to speak to it. Thereafter, he may become seriously ill. Thus there are various spirits that cause illness and disease among the Shona. Although some illnesses are attributed to spirits, the Shona also see most illnesses as a result of witchcraft. Witchcraft is linked with spiritual entities like *zvutupwani* (witch agents) who have no physical identification but are used in this practice. Witches are seen as malicious human beings, especially older women who are motivated by hatred and jealousy. It is also a nocturnal craft with a nightmare quality (Shoko 2007: 62).

² Private Interview: 21/12/1989

³ Private Interview: 9/01/1990

Most common illnesses such as wind fever (*mambepo*) are a result of being beaten by witch familiars. The victim convulses, and if not exorcised quickly, dies immediately. Spirits of dead people raised from the graves (*zvibhoma*) are particularly dangerous. Regarded as the children of the witches, they are believed to cause madness, paralysis and even death to their victims. Also many diseases such as down syndrome, small pox and epilepsy are seen as due to witchcraft. If society experiences a sharp rise in cases of illness the Shona explain this as a rise in witchcraft practices.

Sorcery also features as a dominant source of illness and disease. For both witchcraft and sorcery, the Shona use a common term, *uroyi*. Sorcery involves ritual manipulation of natural forces for evil purposes. It is often practised by unscrupulous *n'angas* who abuse their powers for financial gain. A sorcerer may brew and transmit illness and disease to an intended victim by setting up lethal traps with medicines and by remote control mechanisms. They apply poison in food and drink or through contact with nail clippings, hair or scrapping up dust from human footprints. As a result, illnesses caused by sorcery are *chitsinga*, some form of physical disorder, *chikwinho* that tugs and paralyses hands or legs and *chivhuno*, which result in loss of power.⁴

Deviance from the socio-moral code of behaviour is a potential cause of illness and disease. Here the Shona differentiate between violation of rules of respect and sex-related causes. Both the dead and the living must be accorded due respect and certain religious, social and cultural taboos and norms are upheld. Failure to observe such values and prohibitions in society provokes the spiritual forces that mete out punishment like physical illness, drought and epidemic, which affect the entire community and environment. Illness and disease that originate from the earth (*pasi*), that disappear after a short while and that require simple or no medication at all are regarded as having natural causes. Such illnesses are coughs, colds, slight fever and headaches. But when such illnesses resist treatment or persist, the Shona search for an alternative causal explanation: “why to this particular person and why at this time and place” (Bourdillon 1976: 173).

Therefore the causes of illness and disease in Shona society range from spiritual forces, to witchcraft and sorcery, social and moral factors and natural causes (Gelfand 1985). Such causal agents may appear as distinct categories but greatly overlap in the total belief system. From the accounts illness and disease do not occur by chance but have a definite cause, which is diagnosed and cured by the *n'anga*. Since the Shona experience illness and disease as a threat to their lives, diagnosis, centred on the *n'anga* is crucial. He applies different methods to determine the cause of the problem and prescribe appropriate medication. Possession is one such means of diagnosis used by the *n'anga*. The diviner puts on colourful clothes, takes snuff and induces trance, wields in his right hand a spear, walking stick or hand axe and in possession speaks in the voice of the invading spirit, interpreted by an assistant. The most common style of diagnosis is throwing *hakata* (dice), usually made from a bone, wood and other materials with small images and symbols on them. Bones have different names such as *Mabwe*, *Gata*, *Chirume*, *Chitokwadzima*, *Kwami*, and *Zunga*.⁵ These are thrown by the *n'anga* and have different meanings, which he interprets depending on the way they fall. Other methods of diagnosis include use of special medicated objects like a 'talking calabash' or water to reflect the source of trouble.

⁴ Private Interview: 2/08/1990

⁵ Private Interview: 9/01/1990

However, diagnosis is not the monopoly of the *n'anga* alone. Elders of a community are also consulted on the source of disease because of their wisdom and experience. Also mothers have the ability to discern the cause of an illness in their own children. So these practitioners have a wide range of methods at their disposal. The average person, therefore, knows which practitioners to approach. In the event of HIV and AIDS, the diviner will identify any abnormal illness with any of the spirits mentioned above and apply the requisite medicinal treatment for cure. Most traditional healers claim they have the power to cure HIV and AIDS.

Cultural Beliefs

In the Shona society, there are several indigenous beliefs and cultural practices that may facilitate the spread of HIV and AIDS. The Shona share one of the most distinctive characteristics of African indigenous religions that they are secret religions (Platvoet 1988). Accordingly, Shona religion is also secretive and people are not open on matters that pertain to sexuality. Open discussion of HIV and AIDS, sexuality and reproduction issues are often considered too sensitive and too controversial. Sex in indigenous belief is secret and sacred such that no one speaks about it in the open. Most indigenous Shona people believe that talk about sex is *zvinonyadzisa* (it is an embarrassment). Such matters are shrouded with shyness and taboo that prevent open discussion and therefore hinder education. For instance elderly Shona people refer to genital parts as *zvinbu* (things). Sexual intercourse is called *kukwirana* (to sleep with one another). However, this does not mean that the Shona do not have blunt terms for these things, but they avoid use of words with deeper meaning.⁶ So when someone contracts HIV and AIDS, the Shona attribute the fundamental cause of the illness to spirits. More bluntly they also pinpoint *chibure* (prostitution) as the cause of illness. In that case HIV and AIDS are categorised among sexually transmitted diseases (*siki*). The afflicted is depicted as *akarumwa ne siki* (bitten by venereal disease). The analogy here equates the disease with a snake that bites. As such HIV infection is classified as *runyoka* (a sickness that comes as result of illicit sex).

In Shona culture, the Korekore people in Mt Darwin share a belief called *runyoka* or *rukawo*. *Runyoka* manifests in various forms of illness: *rwemajuru* (ants), *rwehove* (fish), *rwekuzvimba dumbu* (swollen tummy), *rwokunamirana* (gluing together), *rwebanga* (knife), *rwetsuro* (rabbit).⁷ So the imagery is evil and invokes embarrassment and the consequence may be reversible if attended to early or can be fatal if delayed. However since Indigenous healers can reverse the symptoms of attack by *runyoka*, people also believe that HIV and AIDS infection can be reversed. The Shona also refer to conditions of sickness due to HIV and AIDS in metaphorical language. The most common term is *Mukondombera* (fatal disease). Mashiri et al (2002) discuss the Shona practice of naming both the pandemic in descriptive terms that use “indirection” as way to “save face”. For instance the Shona refer to the disease as:

- Mubatanidzwa* (One who unites)
- Zvamazwa ano* (Contemporary things)
- Shuramatongo* (Warning of disaster that wipes out everyone)
- Chakapedza mbudzzi* (Disease that killed goats in large numbers)
- Jemedza* (One who causes severe pain)
- Kurudzzi kunemakwa* (A clan ridden with graves)

⁶ Private interview 2/08/04

⁷ Private interview 10/4/02

Mutswairo (A broom)
Paradzai (One who destroys)
Mupedzanyika (One who kills indiscriminately)
Gukurabundi (Rain that falls in autumn)
Chazezesa (Scaring)
Jehova Ndonyako (Lord I am coming home)
 (Mashiri 2002: 229)

Accordingly, the infected person's condition is also described in terms that are meant to enlighten the plight of the sufferer and his kith and kin. The Shona refer to the condition as:

Akarobwa namatsotsi (He/she has been beaten by thugs)
Ari pabus stop (He/she is at the bus station)
Ane pemu (He/she is with perm) (thinning and loss of shine hair).⁸

Mashiri et al (2002), also provide terms that explain the symptoms of people affected or infected with HIV/AIDS:

Mudonzvo (Loss of weight)
Bhemba (Head becomes as thin as a hoop-iron)
Pemu (Thinning and loss of shine of hair)
 Go slow (Gradual deterioration of health/long illness)
Tsono (Very thin like a needle)
 (Mashiri 2002: 257)

Cultural myths and beliefs that create misconceptions about the existential reality of HIV and AIDS also prevail. From its inception, the Shona have always been sceptical about the origins of the disease. They believe the disease originated in the West especially America hence they interpreted the acronym AIDS to mean, "American Ideas of Discouraging Sex" (Mukweva 1997: 15) So when it comes to sexual practice some people resist having sex with a condom on the grounds that "one cannot eat a sweet in its packet". The idea is to equate a condom with a sweet packet that inhibits sweetness. Also disregarding its vitality as protective device, a condom is also considered lightly as *jombo* (gumboots) or 'raincoat' that one can easily do without.

There are also other beliefs that promote unprotected sex. Some Shona people think they cannot restrain from sexual intercourse since deprivation is tantamount to death. So they argue, *kusiri kufa ndokupi* (Either way one has to die).⁹ Also culturally-fuelled stigma and discrimination like the belief that certain types of gender or people are infection carriers facilitate the spread of the disease. There are some people who believe that if one sleeps with a virgin, one could rid himself/herself of HIV and AIDS. This practise of the father having sexual relations with his daughter, also facilitates the transmission of HIV and AIDS.

Cultural Practices

Other practices that facilitate the spread of HIV and AIDS are of deep cultural orientation. Marital practices such as *barika* (polygyny), a practice whereby a man marries more than one wife (small house phenomenon), *kugara nbaka* (wife inheritance),

⁸ Private interview 4/8/05

⁹ Private interview: 5/06/02

sarapavana (take care of children), a practice that stipulates that when an elder sister or aunt fails to conceive then a young sister is supposed to marry the brother-in-law in order to conceive children on behalf of her sister and *kupindira* (overtake) whereby a brother of a deceased man is expected to sleep with his sister-in-law in order to produce children on behalf of his brother. In these cultural practices, the chances of spreading HIV and AIDS are abundant. But while some argue that some of these practices, such as polygyny, do not negatively impact on the pandemic, others believe they do fuel infection such as the case of spouse inheritance, where the original partner died of an AIDS related illness.

On polygyny, the Shona culture enjoins that a man is not obliged to have only one wife. This indigenous practice is highly regarded. In Shona society most peasants depend much on agricultural production and that cultivation requires an immense amount of labour and polygyny ensured the availability of sufficient cheap labour. A polygynist Vio Makazhu also argued that a labour input can only be ensured through the size of the household and that this was what made the practice rampant.¹⁰ But the manner in which the practice can promote the spread of HIV is that if the husband or one of the wives becomes unfaithful and gets infected then a number of people contract the disease. The possibility of infidelity increases and this in turn increases the chances of getting HIV (Mukweva 1997: 12). However, some traditionalists defend the system as one health worker confirms, “polygamy can help curb the promiscuous behaviour of married men and thus reduces the chances of getting infected by HIV”.¹¹ The traditionalists argue that HIV rates are lower in polygynous marriages.

Wife inheritance is a common practice among the Shona traditionalists. This practice means that if a man dies and leaves behind a wife or wives and children, his younger brothers can inherit the deceased’s surviving spouses by marriage and then look after the children of the dead. The problem with the practice is that if the deceased was infected by HIV then his wives may also be infected and then infect the man who inherits the wives. He too will also infect his own wife and further spreads the disease (Mukweva 1997: 13).

Other practices likely to spread HIV and AIDS are healing methods conducted by the *n’anga* (indigenous medical practitioners) in administering treatment for the disease. Such practices are *kutema nyora* (cutting incisions), *kuruma* (biting) to remove the object, and circumcision. All these involve the use of unsterilized instruments that can cause infection and re-infection. The danger is that the practitioner may end up contracting the disease and further spread it to other clients.

When cutting incisions, it is common practice for indigenous practitioners to use a single blade to administer their herbs. The chances are that if one person is infected, many people may end up becoming infected. Very often the medicine is rubbed into the cuts using the fingers. This may in turn lead to the infection of the person who is administering the medicines since he or she will also come into contact with blood (Chavunduka 1993: 7). The same also applies to the piercing of ears using a single needle.

Some traditional healers specialise in the extraction of disease causing objects from the bodies of infected victims. The extraction is normally done using the mouth or teeth. The method is called *kuruma* (biting). If the skin breaks during the process, the

¹⁰ Private interview 14/01/97

¹¹ Private interview 10/01/97

practitioner may end up being infected by the patient or vice versa. Also traditional healers often prescribe *mushonga womusana* (aphrodisiacs) to young men as sexual stimulants. The tendency is that the young men may end up indulging on sexual sprees to satisfy their appetite. In that way they become exposed and can help spread HIV and some other sexually transmitted diseases (Mukweva 1997: 13).

Midwifery, the exclusive duty of elderly women to help deliver babies is another method that may help facilitate the spread of HIV and AIDS. At times especially in rural areas where there are inadequate facilities such as protective gloves, midwives are forced to use bare hands to deliver babies. This poses a great risk to their health as they are in direct contact with blood and amniotic blood that may be infected with HIV and AIDS. All these are the major indigenous practices that may promote the spread of HIV. But when the disease has set in what follows next are efforts to procure healing.

Traditional Healing

The Shona strive to heal all sorts of illness and disease that include HIV and AIDS through a variety of methods such as rituals administered by the *n'anga*. Since they believe that spirits are primarily responsible for their health and welfare, they are constantly engaged in ritual contact with the spirit world to get rid of illness and disease and other ills of life. They use herbal medicines at birth, initiation, marriage, death and communal rituals. However it is outside the purview of this essay to treat all types of ritual treatment used by the *n'anga*.

Apart from rituals, treatments are also applied to deal with ailments. Methods of treatment of serious illness include herbal treatment, extraction of disease-causing objects, and exorcism. These treatments vary according to the level of illness. HIV and AIDS manifests like every other serious illness in form of chronic headaches, diarrhoea, chest pains, etc. Just like most abnormal illnesses, the disease persists over a very long time and defies treatment. Healing is effected by any one of the methods mentioned above.

The Shona believe that witches and sorcerers can inflict pain and incapacitate the victim by inserting certain items such as insects, worms, eggs, hair and blood into human bodies. Healing is done by a specialist through *kuruma* (biting), *kukwiza* (rubbing), *kuvhija* (surgery), or *kupfungaidzira* (blowing smoke) on the affected parts of the body. Objects removed are rarely displayed for public viewing lest they turn blind. Extraction of disease-causing objects may supplement herbal treatment.¹² When a spirit enters into a person and causes serious illness and disease and is identified by a specialist as troublesome then exorcism is used to expel the spirit. Common methods include blood-letting, emetics or purgatives and sniffing.

There are minor illnesses and diseases which affect the Shona that are believed to be natural and whose cause is not necessarily attributed to the spirits, witches or sorcery or contempt of socio-moral laws. Such diseases as head-aches, flu and stomach problems are usually healed through home curative medicines administered by the elders of the family. But when they are prolonged and do not respond to treatment then the herb *karibekandu* is most effective.¹³

¹² Private interview: 10/01/1991

¹³ Private Interview: 13/02/1991

Healing in Modern Context

The attainment of Zimbabwe independence in 1980 saw the government's adoption of equal policy which promoted religious liberty in the country. In line with this policy, Parliament passed the Traditional Medical Practitioners Act in 1981 that saw the reappraisal of Indigenous medicine in Zimbabwe. As a result, the first Cabinet Minister of Health, Dr. Herbert Ushewokunze, himself a medical doctor, approved the introduction of a body of Indigenous medical practitioners called Zimbabwe National Traditional Healers Association. (ZINATHA). On 13th July 1980. Prof. Gordon Chavunduka, was appointed the first President of ZINATHA. The association set as its primary aims to unite Indigenous healers into one body and to promote Indigenous medicine and practice (Chavunduka 1994: 23). As one time Vice Chancellor of University of Zimbabwe, Chavunduka was open to practice of traditional medicine at tertiary institutions.

This encouragement saw the mushrooming of indigenous healing practices in the city. Harare as capital housed the offices of ZINATHA and that boosted its membership and clientele. The association posted conspicuous adverts on buildings and streets with inscriptions, "ZINATHA Pharmacy Styles Building Room S6: We Supply Drugs for: HIV related Symptoms; Blood Purification; Sugar Diabetes; *Vuka-Vuka*, Malaria, Herpes, Asthma, STD, *Jeko*, *Kugeza Munyama*, *Kubvisa Mishonga yechiDzimai*; *Mambepo*; *Mbepo yeMudumbu*, Cancer, Syphilis, *Chomusoro*, BP, Lucky, Albinos Cream, TB" (ZINATHA: 2002) etc. As a result numerous state-of-the art traditional healing centres have sprouted at Mbare *Musika* (Market) and Machipisa Shopping Centres in Highfields in Harare. Surgeries have been established in other areas particularly at homes in the high-density suburbs in the city. In some cases notices written, "*Chiremba Pano*" (Practitioner is here) are a common sight at doors and gate entrances of houses in the suburbs (Shoko 2005: 8).

In the city centre, traditional concoctions like *vbukavbuka* that enhances male potency are sold in pharmacies at Market Square and other places. At Mbare *Musika* and Highfields markets indigenous herbs in form of dried roots, barks, shells, etc. are on display for "*vachada*," (those who are prepared to buy), interested customers. A traditional surgeon also operates in the industrial areas along "Beatrice" road now Simon Mazorodze. At one time city supermarkets like TM and Food World have been hit by a spiral wave of long chains of people queuing for "*Musimboti*" (Indigenous *mambo's* brew). In the Indian shops hot spice and some flour-type powder, mixed with hot lemon juice is used as remedy for flu. The list of all names and centres dealing with or catering for indigenous medicine in Harare is endless. Due to Harare's location as capital and also in the wake of national cries of HIV and hyperinflation; it is not surprising to find all types of "genuine" and "fake" medicinal concoctions on market in the city.

In Harare, traditional medical services can be sourced from prominent traditional practitioners of the calibre of Prof Gordon Chavunduka, President of ZINATHA, and the late Sec General Mr. Sibanda whose prowess has been inherited by his son. Mr Sibanda (junior) operates surgeries in Mufakose and city centre that provide divination services and sale of drugs. Other healers of great repute include one outspoken woman in Mabvuku Tafara, Kapasule from Malawi operating from Hatfield. Spirit mediums of eminence in the vicinity of Harare are Mushore in Nharira Hills of Norton. Some contemporary self-styled healers running TV programs include Sekuru Victor Mugwagwa. Of late ZINATHA has proposed the construction of an indigenous healing training college and hospital; introduction of medical aid scheme; administration of

televised and radio programmes; holding conferences and workshops and its dissemination of services in town.¹⁴

Recently ZINATHA has received negative publicity with some of its charlatan members accused of charging exorbitant fees or conning desperate people seeking medication. Some victims have testified that some ZINATHA members deceive people by raising fatal myths such as "sleeping with a virgin" as cure for AIDS. On 26th January 2006 the association shocked the people in Harare when they lobbied for the phasing out of condoms on the grounds that they are "unAfrican". But the government, through the Ministry of Health spurned the request as ridiculous, "This is really madness, how can a group masquerading as healers call for the phasing out of protection measures."¹⁵

Burombo's Aids Clinic

Benjamin Burombo, a Kuwadzana famous healer has featured prominently as a "Harare *n'anga* who cures HIV and AIDS patients' treats Aids people"¹⁶. The healer claims he has overwhelming evidence that shows that patients who have been under his care have tested HIV negative at a local health laboratory. At one time he threw out a challenge to Dr Timothy Stamps, then Minister of Health, that he would invite confirmed HIV patients whom he claimed treated, tested negative and referred to the Ministry for further tests for confirmation. Burombo's stance came in the wake of several *nangas'* claims that they could cure Aids. One such claim came from a Mrs Chihuri who had documents to prove that the patients she had cured had also tested HIV negative at the local medical laboratory.

Immunity Enhancement Centre

Also in Harare, the controversial Richard Ngwenya has been widely publicized as administering HIV therapy at the Immunity Enhancement Centre in Harare. Although he uses drips to strengthen blood and recommends Western food rich in vitamins and wheat porridge for good health, he also maintains indigenous foodstuffs such as *rapoko*, *sorghum*, *millet*, ground and monkey nuts, vegetables and wild fruits make up good healthy diet. He disburses drugs with indigenous medical ingredients to combat thrush, the result of severe infections. As former army personnel his fame backdates to the liberation struggle when he served guerrilla fighters with medicines during the second *Chimurenga* war.

Herbal Gardens

Due to a growing number of people resorting to indigenous medicine, a group of herbalists and conservation experts have teamed up to set an indigenous herbal garden that grows local medicinal plants and promotes natural remedies. A nursery has been established in the city with hundreds of indigenous trees and grass species with medicinal properties. The Medicinal Plant protection group sponsors the project. Its membership includes doctors, nurses, chemists, environmental experts and teachers. Similar projects have also been established in other cities such as Bulawayo.¹⁷

According to ter Haar et al (1992), the Shona people have three options of healing systems at their disposal: Western scientific, faith healing and Indigenous healing. They

¹⁴ *Zim Daily* 2/19/2006

¹⁵ *Zim Daily* 2/19/2006

¹⁶ *Sunday Times*: 15/08/1993

¹⁷ *Sunday Mail*: 7/07/1996

often appeal to indigenous healing particularly when the illness persists and requires a spiritual diagnosis and explanation. In such cases the urban Shona people in Harare and other cities make use of indigenous medicine. Whilst some draw herbs from their villages in the rural areas, others travel for distances to famous forests to seek herbs known to them. Basically, indigenous herbs are believed to be efficacious. However some medicines may be mixed with modern ingredients. For instance the cure of flu requires a mixture of lemon, honey and cinnamon. Whilst *Tsangamidzi*, (ginger) is effective for stomach-ache, the urban Shona firmly believe the basic remedial medicine for all health problems is garlic.¹⁸ Since HIV and AIDS has been largely regarded as a modern disease, the indigenous system of healing has also assimilated modern trends. This is particularly so considering that religious phenomena is dynamic and conforms to changing times.

Conclusion

The above shows that the power and potency of spirits in indigenous religious and cultural context of HIV and AIDS is significant. Most Shona people acknowledge the existence of the spiritual entities in the religious cosmology. Indigenous cultural beliefs and practices also account for HIV and AIDS in the indigenous Shona society. But it can also be noted that similar beliefs also prevail in the Shona modern healing system. The spiritual realm dominates the Shona society as a powerful source of illness and disease. Although scientific explanations may be proffered in modern context, the indigenous belief that spirits are a prime causal explanation for illness and disease abounds. Beliefs in witchcraft and sorcery as conspicuous explanation of illness, disease and misfortune exist in the Shona society. They operate clandestinely to perpetrate evil. Such beliefs in fact constitute an integral part of the Shona indigenous religious and cultural system.

Health is one of the primary concerns of the Shona religion. Their indigenous religious belief system identifies numerous and varied causes of illness and disease. Many times certain illnesses and diseases have a distinct reason for appearing. It is then the *n'anga's* (diviner-healer) task to diagnose who or what causes the illness and to give the patient the appropriate cure. Therefore the *n'anga* plays an important role in determining the cause of illness and disease and prescribing an effective cure. Such indigenous medical beliefs have a bearing on indigenous healing system.

While in the traditional past administration and prescription of drugs and herbal medicines lay with the herbalist, the modern specialist practitioner dispenses medicines and scientist caters for some clinical treatments. What is striking about the indigenous healing system is that the herbal nomenclature is apt and meaningful in their interpretation. For instance, the herb called *chifumuro* that is used to cure an unspecified chronic illness is derived from the verb *kufumura* that is "to expose to shame." As such, it is perceived as capable of exposing and thus weakening illness in a patient. The herb used for the treatment of *biripiri* (measles) is called *bazviri* which means "unrestricted". In the indigenous interpretation, such a herb destroys the problem without restrictions. Some natural characteristics or properties of certain species explain the therapeutic value of the herbs. For instance *gundamiti* (one which overpowers all) dominant in modern healing is invested with curative potential for HIV/AIDS. Another one, 'African Potato' derives from a tuber.

Re-appraisal of traditional medicine in post independent Zimbabwe has seen the genesis of traditional medical associations like ZINATHA. This explains the importance accorded

¹⁸ Private Interview: 1/08/2004

indigenous therapy in Zimbabwe. It is also significant that the legislation to promote Indigenous medicine emerges from a policy adopted by government that recognises different religious faiths. This encouragement of tradition has boosted ZINATHA operations. Such initiative has also seen the promotion of traditional medicine by professionals in tertiary institutions, clinical trials of medicines for chronic diseases, introduction of Indigenous colleges, medical aid facility, growth and development of surgeries and pharmacies that serve indigenous herbs and medicines in the suburbs of Harare such as Mbare, Highfield etc.

HIV and AIDS is indeed a complex socio-economic and cultural phenomenon that must be considered in the perspective of indigenous religion and culture. The Cultural Approach to HIV and AIDS clearly espouses the fact that to fight the pandemic effectively it is essential to understand the diversity of people's culture and acknowledge that there is no one universal approach to the fight. This stems from realisation that HIV and AIDS is not only a medical problem but a multifaceted issue which requires multidimensional strategies.

REFERENCES

- Bourdillon, M. F. C. *Religion and Society: A Text for Africa*, Gweru: Mambo Press, 1990.
- Chavunduka, G.L. *Mashoko Okudzidzisa Varapi Vechivanhu nezve Aids*, Harare: ZINATHA, 1993.
- Chavunduka, G. *Traditional Medicine in Modern Zimbabwe*, Harare: University of Zimbabwe Publications, 1994.
- Chavunduka, G. *Traditional Healers and the Shona Patient*, Gweru: Mambo Press, 1978.
- Gelfand, M. *Medicine and Magic of the MaShona*, Cape Town, Juta, 1956.
- Haar, G. ter, A. Moyo and S.J. Nondo (eds.), *African Traditional Religions in Religious Education. A Resource Book with Special Reference to Zimbabwe*, Utrecht: Utrecht University, 1992.
- O'Dea, T. F. *The Sociology of Religion*, 2nd ed., New Jersey: Prentice Hall, 1983.
- Platvoet, J.G. *Essays on Akan Traditional Religion*, Unpublished MA Course Packet, Harare: University of Zimbabwe, 1988.
- Mashiri, P. Mawomo, K. and Tom, P. "Naming the Pandemic: Semantic and Ethical Foundations of HIV/AIDS Shona Vocabulary". *Zambezia*. 29 (ii), 2002.
- Mukweva, T.B. "HIV and AIDS: A Study of the Role that is Being Played by Traditional Religious People in the Fight against the Disease", Unpublished B.A Hons Dissertation, Harare: University of Zimbabwe, 1997.
- Ranger, T. and Kimambo, I.M. *A Historical Study of African Religion*, London: Sheldon Press, 1972.

Shoko, T. “Traditional Healing in Harare: Continuity and Change”. In Togarasei L & Chitando, E (eds) *Faith In The City: The Role And Place Of Religion In Harare*, Swedish Science Press, Uppsala, 2010, 85-106.

Shoko, T. “HIV/AIDS and Christian Ethics”. In Amanze, J.N. (ed.) *Christian Ethics and HIV and AIDS in Africa*. Bay Publishers, Gaborone, 2006.

Shoko, T. “Karanga Traditional Medicine and Healing”. *African Journal of Traditional and Complementary Medicine*, 4 (4): 1-9, 2007.

Shoko, T. *Karanga Indigenous Religion in Zimbabwe: Health and Well-Being*. Ashgate Publishers Ltd, UK, 2007.

Sunday Mail: 7/07/1996.

Sunday Times: 15/08/1993.

Zim Daily 2/19/2006.

INTERVIEWS

Private interview: 4/8/2005
Private Interview: 1/08/2004
Private interview: 2/08/2004
Private interview: 5/06/2002
Private interview: 10/4/2002
Private interview: 10/01/97
Private interview: 14/01/97
Private interview: 10/01/1991
Private Interview: 13/02/1991
Private Interview: 9/01/1990
Private Interview: 2/08/1990
Private Interview: 21/12/1989

Similarities and Differences in the Healing Practices of Pentecostal Churches and the African Traditional Religions in Botswana

Fidelis Nkomazana¹

Abstract

The essay examines the similarities and differences in the healing practices of Pentecostal churches and the traditional religions in the context of Botswana. The major similarities result from the fact that in both the Pentecostal churches and the traditional religions there is a strong belief in supernatural interventions in times of crisis in order to preserve, prolong and protect life. While certain methods and strategies are similar, the belief in ancestors in the case of traditional religions, and in Jesus and the Holy Spirit, who are the key agents of healing for Pentecostal churches, mark the major points of difference. The term 'healer', is accepted and generally used to describe the traditional healing practitioners, while it is never used to refer to Pentecostals possessing and exercising the gift of healing. For Pentecostals the healer is either Jesus Christ or the Holy Spirit.

Introduction

This essay examines, describes, and compares the strategies and methods used by adherents of the African traditional religions and Pentecostal churches in healing various diseases. The concept of healing generally has different implications, depending on one's belief about existential forces, the nature of diseases, and disease causation. The subject of the essay is religion and healing practices in the context of Pentecostal churches and the traditional religions in Botswana. I will, in particular, focus on the similarities and differences in the healing practices of both the Pentecostal churches and the traditional religions in Botswana.

¹ Fidelis Nkomazana is Professor of Theology and Religious Studies at the University of Botswana.

In the process of examining the similarities and differences between the Pentecostal and the traditional forms of healing, the essay will also assess whether Pentecostal churches in Botswana have made any efforts to contextualize their beliefs and practices. This is important because it helps us to see how the two religious traditions have impacted or influenced each other. The question of accommodation or tolerance is therefore central to understanding the relationship between the Pentecostal churches and the traditional religions in Botswana.²

Another important point to mention regarding the relationship between the healing practices of the Pentecostal churches and the traditional religions is that the former have tended to claim exclusive ownership over the authenticity of healing. They interpret Christian healing practices to be the norm, while the traditional practices on the contrary are said to be pagan, heathen and evil.³ Right from the inception of Pentecostalism (the Azusa type of churches)⁴ in Botswana, there has never been any deliberate attempt by scholars to interpret Pentecostal healing practices in the context of the traditional religious practices.⁵ The Pentecostal churches therefore do not just speak a different spiritual language from the traditional religions, but also hold different doctrines. They regard those who do not profess Christ as heathens, pagans or idol worshippers. While the belief in ancestors is central to the traditional religious practices of Botswana, Pentecostal churches totally reject healing practices that involve the ancestors.

Religious Demography

Various religious groups are at home in Botswana. The country's constitution allows for freedom of worship and association of various religious and cultural traditions. The traditional religion is not only the oldest religion in Botswana, but has developed within the local contexts and specific experiences of the people.⁶ Christianity especially the mainline churches,⁷ on the other hand, were introduced to Botswana during the last part of the 19th century mainly by the London Missionary Society, Dutch Reformed Mission, the Methodists, which were later on joined by the Anglicans, Seventh Day Adventists and the Roman Catholic Church in the 20th century. The African Independent Churches⁸

² Fako, T.T., "Traditional medicine & organizational issues in Botswana, Working paper No 20, University of Botswana, July 1978, discusses the relationship between traditional medicine & traditional doctors. He also discusses the attitude of government to traditional medicine. Due to the negative attitude people have towards traditional medicine people deal with it secretly.

³ Akiiki & Kealotswe, (1995:9), mention that Africans see a lot of similarities between Christianity and the African view. They however state that Christianity is afraid of the ideas of many deities or divinities, such as ancestors.

⁴ There are some debates as to whether Pentecostalism is linked to African Independent Churches or not. In this essay Pentecostalism refers to churches that believe in the baptism of the Holy Spirit with evidence of speaking in tongues and emphasizing the born again theology. See Cephas Omenyo, *Pentecost outside Pentecostalism*, pages 86 – 90 for further clarification. James Amanze (1994), *Botswana Handbook of Churches* and Fidelis Nkomazana and Lanner (2007), *Aspects of the History of the Church in Botswana* and Amanze (2003) *African traditional Religions and Culture in Botswana* like the rest of the other works on African Traditional Religion and the life of the church in Botswana do not attempt to discuss the healing factor.

⁵ Amanze, (1994), simply provides a survey of churches in Botswana. No effort is made in this volume to discuss the practices and theologies of the different churches in the context of Botswana.

⁶ Nkomazana, "The Botswana Religious Landscape" in Togarasei, et al (2011), *The Faith Sector & HIV/AIDS in Botswana*, pages 2 – 11.

⁷ The phrase Mainline Churches is here used to refer to church that were formed by European Missionaries. See James Amanze's (1994) *Botswana Handbook of Churches*.

⁸ The churches that broke away from the Mainline Churches protecting the failure of the former churches to incorporate the African styles of worship and practices into Christianity. See Amanze (1994)

started to flourish in the 1960s, and immediately after that registered 233 churches out of the 262 total of registered churches in Botswana.⁹ This was a remarkable progress. The figure is obviously much higher today.¹⁰ Pentecostalism was first introduced to Botswana from North America via South Africa from the 1950s to the early 1960s.¹¹ At the beginning of 2003 there were more than 75 registered Pentecostal churches. These churches have not only numerically increased today, but have become the most vibrant and fastest growing group of churches in Botswana.¹²

It must be mentioned therefore that out of a population of approximately 2 million, about half of the country's citizens identify themselves as Christians.¹³ The other 50 percent adhere to the traditional religions or a mixture of religions. There is also a small Muslim, Bahai, Buddhist and Hindu communities, approximately 2 to 3 percent of the population.¹⁴

General Observations About Healing Practices in Pentecostal Churches and Traditional Religions

Let me start with some general observations. First, healing practices among Pentecostal churches and the traditional religions represent the largest available resources of health delivery in Botswana.¹⁵ Second, for many years, traditional medical practices were and continue to be the source of therapy available for the majority of Botswana, especially in rural areas. This is so because traditional healing systems are seen to be deeply rooted in the culture and ecology of the people.¹⁶ Third, while the definition of a disease for Pentecostal and traditional healers¹⁷ widely varies from that of modern medical practitioners, they have striking similarities to one another. Both Pentecostal churches and the traditional religions do not make strict distinction between a disease, such as malaria, headache, tuberculosis, HIV and AIDS and a variety of conditions created by a deficiency in certain food properties, such as iron calcium causing anaemia, a state where the condition has become a disease. In fact, they are more interested in the spiritual causes, as opposed to modern medicine, where some experiments are conducted in order to diagnose the causes of diseases. What is important for them is the supernatural power to heal the disease. They believe that behind their practice is a supernatural power that heals all forms of diseases. Categorizing diseases is seen as lack of faith in the supernatural power. Whether the disease is caused by a deficiency in certain minerals or

⁹ A close examination of the date of the establishment of churches in Botswana demonstrates this fact. Amanze (1994)

¹⁰ Nkomazana, (2011), "The Botswana Religious Landscape, pages 12-13; Amanze, (1994), *Botswana Handbook of Churches*, 166-167.

¹¹ Nkomazana's ongoing study of the History of Pentecostalism in Botswana.

¹² Nkomazana & Tabalaka, "Aspects of healing practices and methods among Pentecostals in Botswana", in *BOLESWA Journal of Theology, Religion & Philosophy*, Vol. 2, No, 3, 2009: 137-159.

¹³ James Amanze, (1994), *Botswana Handbook of Churches*,

¹⁴ Botswana National Atlas.

¹⁵ Togarasei, L et al, An Assessment of the Capacity of Faith – Based Organizations for HIV Prevention in Botswana Report of Theological, University of Botswana, 2008, pages 7-16. This study has confirmed that religious institutions are playing an important role in the health delivery of the majority of Botswana.

¹⁶ Togarasei, L et al, An Assessment of the Capacity of Faith – Based Organizations for HIV Prevention in Botswana Report of Theological, University of Botswana, 2008, p. 13.

¹⁷ The word healers will not be appropriate for Pentecostals, since they do not regard themselves as healers, but simply as channels of healing. The power of the Holy Spirit is believed to be responsible for healing people.

not, is not usually regarded as the major issue. What is important for both the Pentecostal healing practices and traditional healers is an intimate relationship with the supernatural source of the healing power.¹⁸ Fourth, healing is a gift of the “spirit” for both the Pentecostal and the traditional healers. For Pentecostal churches it is the power of the Holy Spirit and the name of Jesus Christ, while for the indigenous healers, it is the power of the ancestors, the supreme deity and other divinities. For Pentecostals, the Holy Spirit and Jesus are believed to be the channel through which the healing power of the Supreme Being is accessed.¹⁹ Individuals such as the prophets, evangelists, pastors and the name of Jesus are the channels through which the healing power reaches the sick person.²⁰ Pentecostal churches make reference to 1 Corinthians 12:7-11 about “the manifestation of the Spirit” as follows:

Now to each one the manifestation of the Spirit is given for the common good. To one there is given through the Spirit the message of wisdom, to another the message of knowledge by means of the same Spirit, to another faith by the same Spirit, to another gifts of healing by that one Spirit, to another miraculous powers, to another prophecy, to another distinguishing between spirits, to another speaking in different kinds of tongues, and still to another the interpretation of tongues. All these are the work of one and the same Spirit, and he gives them to each one, just as he determines.

Similarly, for the traditional healers, *badimo* (ancestors) are to be accessed for the healing power of the Supreme Being to be effected. A diviner would, for instance, ask the family of the sick person to make a sacrifice to the ancestors in order to restore any broken relationship. In the process, protection against the source of trouble is provided.

The African Traditional Religions and Pentecostal Churches are associated with a great diversity of skilled health practitioners. While both the African Traditional Religious and Pentecostal healers perform their healing activities within the confines of the African cultural context, Pentecostal Churches claim to be strictly guided by the biblical teachings and strategies. But they are generally both highly respected for their therapeutic skills. Both the African Traditional Religious and Pentecostal church medical traditions may be subdivided into those which are essentially secular and those which involve spiritual models of healing. The former include various kinds of traditional healers with special skills such as midwifery, etc. Their skills are based on personal and family local knowledge transmitted from one generation to the next. Traditional spiritual healers, or intercessionists, like Pentecostal healers, ultimately attribute their healing powers to their privileged access to some supernatural power. This enables them to learn about potent medicine unknown to others and to act as intermediaries on behalf of their patients, approaching the supernatural sources of affliction and of potential relief. The *dingaka tsa bola* (diviners) or sangoma spirit possession is a prime example of a therapy based on intercession with spirits. These are indigenous healers or diviners, who likewise depend upon the guidance of spirits in their medical practice.²¹

¹⁸ Nkomazana & Tabalaka, pages 237 – 159,

¹⁹ Ibid.

²⁰ ABT Byaruhanga-Akiiki & Obed N. Kealotswe, *Healers, protective Medicine in Botswana*, (Department of Theology: University of Botswana, Gaborone, p. 9.

²¹ Amanze, J.N., *African Traditional Religions and Culture in Botswana*, (Gaborone: Pula Press, 2002) pp. 88-114.

Pentecostal church healers practice a type of intercessionist medicine, which is highly antagonistic towards the traditional spiritualists, whose medical practices they regarded as demonic.²² There is, therefore, no intention for co-operation between the Pentecostal churches and the African Traditional Religious healers. There is also no overlap amongst the various types of medicines they use, although their strategies and methods have striking similarities.

Healers and Their Diagnostic Tools

As part of this study I interviewed five traditional healers and five Pentecostal healers in various parts of Botswana regarding their healing practices in order to gain insight into the extent and character of their activities. The healers are a very heterogeneous group of persons with much in common with regard to their gender and educational level. While the traditional practice is usually inherited from the family, Pentecostal healers claim that there has to be a divine calling from God. For Pentecostals, the gift of healing is understood as an office as described in 1 Corinthians chapter 14, which talks about the gifts of prophecy, healing, wisdom, knowledge, faith, discernment of spirits, miracles, speaking in various kinds of tongues and interpretation of tongues.²³ While for Pentecostals, healing is a gift of the Spirit, the reasons frequently given by traditional healers for becoming healers is that a person has been called by the ancestors, through dreams and this usually takes place within a given family line. This requires intense training and mentoring, which could go on for many years.²⁴ The majority of these traditional healers are mainly older males. The older you are, the more knowledgeable, more experienced and skillful. The older people are also believed to be more connected to the ancestors than younger ones.²⁵

Unlike the Pentecostal healers, who conduct their healing practices in public and mainly during their services, traditional healers are more secretive. The diagnosis of their patients, their prophetic utterances and the treatment recommended to patients are strictly confidential, contrary to those of the Pentecostal healers that are mostly performed in public during a church service in the presence of the congregation. In the case of the traditional healers, only the patient and a few selected family members are allowed into the consultation room. The other major difference that exists between the Pentecostal and Traditional healers is that in the case of the latter, patients can come and stay at the residence of the healers for days, weeks and months, while receiving treatment. While patients may attend Pentecostal healing services for many hours, they usually do not take temporary residence with the healers as it happens with traditional healers and in the case of African Independent Churches.²⁶

²² Ibid, Akiiki & Kealotswe (1995:9).

²³ 1Corinthians 14:1-40 therefore outlines the various categories of spiritual gifts. In Akiiki and Kealotswe (1995:11) five categories of traditional healers are given as follows: the ngaka ya ditshotswa (the herbalist); ngaka ya ditaola (the diviner – herbalist); ngaka e dupang (the sucker) and the Sangoma (the spirit – medium). The categories are widely varied from those in the Pentecostal healing practice.

²⁴ The training of Dingaka is elaborate.

²⁵ Mackenzie, J., *Ten Years North of the Orange River*, (Edinburgh: Hodder & Stoughton, 1871) p. 397.

²⁶ Kealotswe, O., "Healing in the African Independent Churches in the Era of AIDS in Botswana", *Missionalia*, Volume 29:2, August 2001, pages 220-231 discusses the concept of *diagelo*, faith clinics. In this essay I make a clear distinction between Pentecostal and AICs. Pentecostal refers to the born again type Christians, who put emphasis on the baptism of the Holy Spirit with evidence of speaking in tongues.

For both the Pentecostal and traditional healers, the diagnosis of the disease is a very important aspect of the healing operations that has to be carried out. For traditional healers, divination is a very common and main method of diagnosis used. Others use divining bones, which they throw on the ground and the pattern they form suggests the nature of the problem.²⁷ Others will use the touching method and then get a revelation of what the problem is. In recent years, others will use a Bible as a diagnostic tool. The patient is asked to open the Bible, after which the healer claims to see the condition of the patient on the pages of the Bible. They say that the revelation and the interpretation of the message is communicated to the healer by ancestors or the spirit. No one is expected to question what the ancestors have communicated.²⁸

For Pentecostal healers, prayer is regarded as their diagnostic tool. Prayer is believed to have the power to reveal the nature of the problem to the healer through the Word or the Holy Spirit. It is sometimes accompanied by prophecy, speaking in tongues and the demonstration of power. At times this is followed by people being prayed for falling to the ground or being “slain in the Spirit” as the Pentecostals would prefer to call it. At times, the process is followed by casting out of demons and laying on of hands on the sick person.²⁹

Some of the Pentecostal and traditional healers reported referring patients to the hospital, when the patient would be better treated at the hospital. The traditional healers did not discourage their patients from seeking for help from the Pentecostal healers, while on the other hand, the latter discouraged their members from participating in activities of the traditional healers. Any member of the Pentecostal churches, who participates or who sought for help from the traditional healers was punished or even banned from the fellowship of other believers.

Methods of Healing Adopted by Pentecostal and Traditional Healers

Signs and Wonders

Signs and wonders are another catch phrase used by Pentecostal healers to describe their healing operations. They quote Acts 2: 22 saying ‘Jesus of Nazareth was a man accredited by God to you by miracles, signs and wonders, which God did among you through him ...’ Using the same text, the Pentecostals say that Jesus promised that they will perform greater miracles than he did. Although the traditional healers do not categorically speak of signs and wonders, they claim to perform supernatural works. Like the Pentecostal healers they claim to supernaturally heal diseases and situations such as HIV and AIDS, the lame, the blind, cripples and cast out demons and evil spirits. Some African traditional practitioners have blamed Pentecostal “healers” for their judgmental and negative attitudes towards the traditional healers. Pentecostals on the other hand condemn African traditional healing as evil and therefore unacceptable. Pentecostals are

²⁷ Setiloane, G.M., *The Image of God Among the Sotho – Tswana*, (Rotterdam: AA. Balkema, 1971), pp. 45 - 58.

²⁸ This section has benefited greatly from Patrick M Ramocha's study entitled '*An Analysis of Healing Methods Within Pentecostal churches: Focus on Goodnews Church Fellowship*', Diploma in Pastoral Theology, Theology & Religious Studies Department, University of Botswana, 1998/99.

²⁹ Ibid.

also blamed for adopting manipulative methods of healing, characterized by unrestrained emotionalism and learned responses.³⁰

One of the cases of healing by both the Pentecostal and traditional healers was to do with infertility. Traditional healers claim to possess the knowledge to assist women with problems of barrenness by opening closed wombs and reversing curses. They usually blame the problem on witchcraft, demonic activities, etc. Pentecostal healers likewise claim to deal with the problem of barrenness through deliverance prayers as is evident in the Zoe Worldwide International Ministry, a Pentecostal church that was established in Botswana in 1995 by the Nigerian evangelist, Patrick Anwuzia. There are many examples given. But even in the case of infertility, Pentecostal churches, like the traditional religions, insist that sick believers do not need to remain sick. To support this, they usually quote the following scriptural texts: James 5:14 that reads as follows: “Is any one of you sick? He should call the elders of the church to pray over him”; Ex. 15:26 that reads: “If you listen carefully to the voice of the Lord your God and do what is right in his eyes, if you pay attention to his commands and keep all his decrees, I will not bring on you any of the diseases I brought on the Egyptians, for I am the Lord (NAV).”

Pentecostal churches argue that no diseases/illnesses are excluded from this great benefit. Quoting scriptures such as Isaiah 53:5.1 and 1 Peter 2:24 they insist that God has promised to heal all forms of diseases. These serious illnesses that God heals can either be emotionally or physically devastating. The best example usually given is that of HIV and AIDS.³¹

Concerning healing of infertility, I once listened to the preaching of a young AFM Pentecostal pastor (Mmoloki Mogokgwane) prophesying on a young lady saying: ‘As I was preaching the Lord revealed this to me about you that your barren days are over. Put your feet to your faith and buy a room full of nursery furniture and start thanking God for the baby you will conceive and bear in the next 12 months. I have already prayed for many women in your position and the Almighty God has already answered their cries and removed their shame and agony.’³² It was claimed that after 12 months the woman delivered her firstborn son. The Pastor disclosed that the Lord’s healing was so complete that in subsequent years, the woman bore another healthy child. This he said demonstrates that Jehovah is our healer, who is able and willing to heal all the diseases and infirmities of his people. One of the influential leaders of a Pentecostal Church has labeled HIV and AIDS as falling among the Egyptian diseases,³³ which he used to refer

³⁰ This section has benefited greatly from Patrick M Ramocha's study entitled '*An Analysis of Healing Methods Within Pentecostal churches: Focus on Goodnews Church Fellowship*', Diploma in Pastoral Theology, Theology & Religious Studies Department, University of Botswana, 1998/99. Interviewed (25 July 2014) James Amanze, who has paid a close interest on the Pentecostal methods of healing and worship and has described what he has observed with a lot of bias.

³¹ Togarasei, et al (2011), *The Faith Sector & HIV/AIDS in Botswana: Responses and Challenges*, Newcastle: Cambridge Scholars Publishers.

³² Interviewed with Pastor Mogokgwane, Apostolic Faith Mission Youth minister, 27 July, 2008; Mogogi Keakile, Apostolic Faith Mission tent crusade preaching, August 2014.

³³ Making references to Deut. 7: 15 that says ‘The Lord will keep you free from every disease. He will not inflict on you the horrible diseases you knew in Egypt, but he will inflict them on all who hate you.’ Pentecostals have referred to a wide range of illnesses as Egyptian and argued that these diseases should not be found among the children of God. Conversation (30 January 2015, Gaborone) with Rosinah Gabaitse, New Testament scholar at the University of Botswana and a Pentecostal, who refers to flu and other associated diseases as malwetsi a dipeba) diseases that should bother fable animals). Deut. 7: 15 ‘The Lord will keep you free from every disease. He will not inflict on you the horrible diseases you knew in Egypt, but he will inflict them on all who hate you.’

to diseases that brought severe suffering due to the disobedience of the people. He however pointed out that God's heart is towards his people in matters of health and healing. He however pointed out that God has also promised healing saying: 'If my people called by my name will pray and repent from their ways, I will heal their land (Chronicles 7:14). The other scriptures that are commonly used to prove God's supernatural ability to heal are: Ex 23:25-26 'I will take away sickness from among you, and none will miscarry or be barren in your land. I will give you a full life span'; and Acts 10:38 'How God anointed Jesus of Nazareth with the Holy Spirit and power, and how he went around doing good and healing, all who were under the power of the devil, because God was with him.'

Both Pentecostal and traditional healers believed that God's healing power extends to all diseases and infirmities. No illnesses are excluded from his great "benefit". They believed that God has promised to heal all the diseases, including serious illnesses, such as HIV and AIDS, which were emotionally devastating. Both traditional and Pentecostal healers have no problem with people's emotional responses during the healing procedure. These emotions are characterized by screaming, shouting, jumping, falling and rolling on the floor, laughing etc. However, the Pentecostals also hold the view that these emotional actions are not necessarily a prerequisite to healing. What it means is that healing has nothing to do with these different emotional responses, but simply shows the impact of the power of the Holy Spirit on the people being prayed for.

Slain in the Spirit or Slaying in the Spirit

The terms "slain in the Spirit" or "Slaying in the Spirit" is used by Pentecostal and charismatic Christians to describe a prostration, whereby an individual falls to the ground under the influence of the Holy Spirit. It is attributed to the power of the Holy Spirit and is sometimes referred to as falling under the power of the Holy Spirit. In her book *The Assemblies of God at the Cross-roads: Charisma and Institutional Dilemmas*, Margaret Poloma (1989: 28, 323-233) defines "Slaying in the Spirit" as "the power of the Holy Spirit so filling a person with a heightened inner awareness that the body energy fades away and the person collapses to the floor". She observes that this can take place in a variety of settings when a person prays in solitude, but can also occur in group settings such as small prayer groups, conferences or retreats, regular church services and in large healing crusades.

On 25 January 2015, Johannes Kgwarapi of the Apostolic Faith Mission, Broadhurst (Gaborone, Botswana) congregation preached on the subject "From Egypt to Canaan: A Journey of Faith". He pointed out that this involved God's divine intervention and that it was a journey of God's deliverance and provision. At the end of this particular service, Kgwarapi invited attendees to the front of the church to receive prayer for various needs. As the elders lay hands on the people, spiritual manifestations began to show up. Some were 'slain in the spirit', staggering from side to side and others fell on the floor facing up and with their eyes closed. When I later spoke to some of these people, they claimed that the experience was great and felt that the hand of God was touching and healing them. Some began to laugh, while others were singing songs of praise and worship and also speaking in tongues.³⁴

³⁴ Personal observation of the Apostolic Faith Mission Church service, 25 January 2015; Johannes Kgwarapi preaching on the topic "From Egypt to Canaan: A Journey of Faith", Braodhurst Congregation, Gaborone.

While the above method has been heavily criticized by non-Pentecostals, it is common in both the healing traditions of the traditional and Pentecostal healers. Among the Basarwa spirit possession, for instance, falling out and some form of slain in the spirit is a very common feature of the traditional healing activities. The recipient of the healing ritual often remains silent and slain in the spirit for many hours with dancers singing and dancing around the fire, as the healers continue to diagnose and prescribe medicine. The healing operations of these healers involve exorcism and deliverance services or exercise, which can go on for a long time.³⁵

The slaying in the spirit or falling out is believed to occur as a sign of victory over the disease or demonic force. It might signify the coming out of a pain from the body or defeat of or destruction of a tormenting spirit or devise deliberately put in the body of the victim by witches, sorcerers etc. This spirit or work of witchcraft is exorcised out of the body by using more powerful medicine provided by the traditional healer, and by the power of the Word of God and the Holy Spirit through the Pentecostal healer.

In one of my visits to a Sangoma at Mookane in 1995, I found out that different people suffering from various kinds of diseases such as HIV and AIDS, cancer, tuberculosis, etc. were visiting these traditional healers for help from different parts of the country. Some of the sick people would remain with the healer for many days and weeks. I was told that even people of high social status such as politicians were paying regular visits to the Sangoma.³⁶ Slaying in the spirit is also common among Pentecostal healers. The manifestations that are found in a traditional setting sometimes persist in some Pentecostal churches in Botswana today. Pentecostal healing revival meetings can go on for many hours with people being slain in the spirit as part of the healing process. Some of those attending can also be seen staggering around as if drunk, which is termed as being “drunk with the spirit.”

In 1995, a huge Pentecostal revival meeting was organized by Pastor Patrick Anwuzia (Pastor and Founder of Zoe International Ministries). Anwuzia’s healing prayers included such manifestations as roaring, vomiting, “falling out” or being slain in the spirit for many hours. The services could go on for up to seven hours. As recipients of these prayers of healing regained consciousness, they would receive personal prophetic utterances and some would be told that they were demon–possessed and that unless they were delivered from those demons, they would not be totally healed from the diseases they were suffering from. Some would be given 2, 3, 4, 5, or 7 days of deliverance prayer rituals. The difference with the healing practice of traditional healers is that patients do not move to stay at the healer’s residence. Those attending sessions still return to their homes and come back to see the healer the next session. The period of the deliverance exercise is determined by the seriousness of the problem. Serious or difficult cases are normally given more days. Furthermore, the deliverance practice of Pentecostals greatly differs from that of the African traditional religions owing to the concept of demon possession or exorcism, which was not commonly used among the African traditional healers. What Pentecostals regarded as demons and evil, was described as and partly equated with the spirit of the ancestors in the traditional setting. The traditional healers

³⁵ Interview with Ntema Mazunga, December, 1995, Gweta; Isaac Schapera, (1960), *Livingstone’s Private Journals, 1851-1853*, (London: Chatto & Windus), p. 110; Dinama, 1985: 78.

³⁶ The study took place in Mookane Village in the central district of Botswana in December, 1995. The Sangomas from the Southern African region had congregated at the village for their annual religious practices and were led by a Swati woman.

did not therefore fight against demons or try to deliver their patients from ‘demonic spirits’.³⁷ However, they fight against malevolent spirits, witches, wizards and sorcerers.

Pentecostals such as the Zoe Ministries Worldwide International basically emphasize three fundamental themes: soul winning, deliverance and warfare, and prosperity gospel.

1.) Soul winning: The pastor through God’s power must be able to win members, mainly through preaching the gospel and praying for the sick. Signs and wonders are seen as some of the most powerful means for reaching the lost. Their services always ended with an altar call with miracles becoming a common feature.

2.) Deliverance and warfare prayer: Zoe teaching also focuses on deliverance and warfare. They believed that prayer had the power to liberate people from the bondage of sin, the power of the devil and demons. Zoe also holds the view that all Christians are in principle struggling with various levels of different kinds of demonic bondages.³⁸ Patrick Anwuzia usually asks those who come for deliverance to repeat the following prayer:

I cancel out all demonic working that may have passed on to me from my ancestors...I denounce all satanic assignments that are directed toward me and my family, and I cancel every curse that Satan and his workers have put on me ... I reject all other blood sacrifices whereby Satan may claim ownership on me. I cover myself with the blood of Jesus and call upon the fire of God to burn all the works of the enemy. I plead the blood of Jesus and ask all this in His name. Amen.³⁹

These prayers are for all desiring deliverance. Through faith and prayer it is believed that believers can be delivered from the power of curses and other demonic powers that dominate them and cause them to be sick. The deliverance exercise sometimes involves exorcism, the procedure during which evil spirits are believed to be “driven” or “cast” out of a person. It is sometimes performed when a newly saved Christian undergoes counseling, because it is believed that every demonic spirit must be cast out of him/her before the Spirit of Christ could enter and dwell in his/her heart. However, not only new converts, but also those already among the faithful are to be given pastoral care or go through exorcism if they showed signs of demonisation.⁴⁰

There is always a close connection made between sickness and demons. They assumed that at least some sickness had demonic origins. The casting out of evil spirits is sometimes accompanied by the laying on of hands and anointing with oil for healing. That sickness and sin are linked is supported by such passages as follows:

³⁷ See David Barnnet, *Unearthly powers*, pp. 61, 122-125; John Mbiti, (1990) *Introduction to African Traditional Religions*, p. 119

³⁸ This is sometimes referred to as a generational curse, which is believed to be passed from generation to generation. Patrick Anwuzia’s 1995 preaching at his crusades held at the University of Botswana and Boipuso Hall.

³⁹ 1995 Zoe Crusade – held at the Boipuso Hall and at the University of Botswana.

⁴⁰ Two of the candidates for the deliverance, who were members of the Tlokweg Apostolic Faith Mission, were put into a deliverance programme that was to last for 14 days. One of the women had been prophesied to be under the influence of the spirit of witchcraft. In my interview the woman expressed anger against the whole idea of deliverance and consequently stopped attending the deliverance exercise.

Afterwards Jesus findeth [the healed man] in the temple, and said unto him, Behold, thou art made whole: sin no more, lest a worse thing come unto thee (John 5:14).

Is any sick among you? Let him call for the elders of the church; and let them pray over him, anointing him with oil in the name of Lord: And the prayer of faith shall save the sick, and the Lord shall raise him up; and if he have committed sins, they shall be forgiven him. Confess your faults one to another, and pray one for another, that ye may be healed (James 5:14-16).

And, behold, there was a woman which had a spirit of infirmity eighteen years, and was bowed together, and could in no wise lift up herself ... And ought not this woman, being a daughter of Abraham, whom Satan hath bound, lo, these eighteen years, be loosed from this bond on the Sabbath day (Luke 13:11-16)

These texts have encouraged Zoe members to believe that the view they hold is that since Christians still commit sin, and get sick, they perhaps also get demonized as well. Such a testimony as the above, of the woman who was struck down by a demonic illness, are given as an example of how demons cause more than just spiritual trouble. The above scriptural reference makes a strong link between sickness and disease; faith and sickness; sins and healing; Satan, spirit of infirmity and healing.

Methods and Stages of Deliverance Adopted by Zoe

The methods and stages of deliverance adopted by Zoe are many and varied. They strongly believe that they are based on biblical principles as follows⁴¹:

1.) The pure praise and proclamation of the truths of scripture are said to be enough to drive out demonic presence. They insist that every Christian should confidently proclaim the Lordship of Christ, who they say has been made the head over of all principalities and powers. They often sing a song as follows: “In the name of Jesus; In the name of Jesus; we have a victory. In the name of Jesus, Jesus, Satan will have to flee. In the name of Jesus, Jesus, we have a victory”. Similarly, the traditional healers, on the other hand, also see a link between sickness and sin. The displeasure of the ancestors was believed to result in an epidemic, famine, drought, etc. To normalize the situation, there was need to appease the ancestors by making offerings and sacrifices.

2.) Spiritual warfare - deliverance is characterized by physical operations and manifestations. They term this exercise spiritual warfare. One member of Zoe church said: “The exercise looks stupid but creates fervent and aggressive prayer with astonishing results”.⁴² The stages of deliverance are as follows:

When a person is delivered he/she is held by a Zoeite with a hand. The person is turned round and round in circles, until he/she goes dizzy and falls down, sometimes vomiting. This is accompanied by the chanting of songs or mumbling of words, coupled with speaking in tongues. This includes shouting and warning the devil and his demons to leave the person in Jesus name. As they pray they kick, jump up and down, throw their hands and fists in the air as if they are in a karate training session, claiming to be

⁴¹ Personal witness in 1995, Ditshupo Hall Crusade, (Gaborone) led by Patrick Anwuzia founder of the Zoe Ministry Worldwide International.

⁴² See Ephesians 6:11-20.

crushing and destroying the devil and his demons. Patrick Anwuzia's TV programmes are similarly characterized by this style of prayer. He is sometimes seen and heard shouting: "the devil is in trouble, kick hard, get serious, do it brother, do it sister, do it in the name of Jesus".⁴³

When engaged in warfare prayer Zoe members act as if they are fighting a physical battle. They claim that this practice derives from the Bible which says (Eph. 6:10-20) that Christians are not fighting against flesh and blood, but against the spiritual powers of darkness or wickedness in high places and that their weapons are not carnal but mighty through Christ Jesus. Zoe teaches that Christians have been given power to trample upon devils. This is probably the reason for practically acting it out.

3.) The aspect of prosperity is closely connected to the two mentioned above in that material prosperity is understood to mean getting married, buying a big car, getting a good job, donating large sums of money to the church and living in good health.⁴⁴ The meaning of the name of the church, that is, Zoe, itself, reflects what the church stands for. It means abundant life and power provided by God. Their emphasis are on the here and now life – that is, the practical gospel that is accompanied by God's healing power. They therefore believe and teach that God's children must prosper because their God answers their prayers. They teach that God promised a land full of milk and honey to Abraham and his descendants. The basis of the prosperity and the healing message is positive confession of what God can do for his people. To advocate for prosperity they use Luke 6:38 which encourages generous giving. Great and generous givers are promised prosperity and multiplication of what they have given in faith. Some people therefore end up joining Zoe for these material blessings or benefits. Majority of people end up rallying to join the church for material gain, while some believe that God begins to perform all sorts of miracles in response to their generous giving. They claim that the miraculous will result in the cancellation of their mortgages and debts at the bank. They also teach that those who give to the work of God or to the man of God, will have huge amount of money deposited into their bank accounts. While this becomes the source of attraction of multitudes to these services, many orthodox Christians question the authenticity of these miracles, as they believe that they contradicted the scriptures.⁴⁵

The Role of the Traditional Healers Versus the Pentecostal Healers

No aspect of African culture has received so much criticism from Pentecostals as the practices of traditional medicine. The main objections to the therapy of the traditional healers, or witch-doctors as they are derisively called, are based on the false assumption that African medicine relies exclusively on magic, witchcraft, ancestors etc. Pentecostals made no attempt to verify the relationship between African medicament and disease. They also hold the view that the traditional healer deceives his patient with mysterious incantations and dispenses his medicines. People are called to keep their distance from

⁴³ Ibid.

⁴⁴ Interview with Zwile Mbulawa, one of the key founding members of Zoe, in 1996.

⁴⁵ Interview with James Amanze, Department of Theology and Religious Studies, University of Botswana, 5 January 2015. He rejects the claim of some of these churches to heal HIV/AIDS.

traditional medicine in their efforts to appear civilized and not to be mistaken for backward savages.

Pentecostals further argue that the functions of the traditional healer are not limited to the diagnosis of diseases and the prescription of drugs. The traditional healer provides the needed answers to the adversities imposed on the community by outside forces that are beyond the comprehension of ordinary people such as curses, charms, evil spirits, witches and aggrieved ancestors. On the other hand the traditional religions see the traditional healer to be very knowledgeable in the medicinal uses of local plants, and do employ such herbs for far more uses than for the treatment of diseases. The traditional healer is the one who provides charms and prescribes the rituals to neutralize the effects of the enemy's charms, ward off evil spirits and intercede between the community and the ancestors. He/she is also consulted for advice on misfortunes and the intractable problems encountered in ordinary life. The traditional healer provides special medicines to protect private property, recites incantations, and offers sacrifices to appease the spirits of the deceased ancestors.

The traditional healer does not only stop at providing medicines for the cure of diseases. He/she also deals with the underlying curses and their causes which he/she must also remove. The concern of a traditional healer is, therefore, not only with diseases and healing strategies, but also with the provision of charms to intervene in almost all aspects of life. It is he/she who advises the people to embark on community purification rituals in order to remove the burden imposed on them for the contravention of the society's norms and taboos. Since there are no written instructions from the ancestors, it is the healer-priest who keeps the channel between the deities and the community open.

Conclusion

This essay has indicated that while the traditional religions and Pentecostal churches are guided and ruled by different religious beliefs, there are striking similarities between their healing practices. Their religious beliefs are responsible for the differences that exist between them. From the beginning both the traditional religions and the Pentecostal churches have laid great emphasis on health and healing. The essay has shown that healing practices in both the traditional religions and the Pentecostal churches have confirmed that African conviction is that spirituality and healing belong together. They both revolve around religious protection and were consulted because they were believed to deal with spiritual forces to reverse misfortunes and heal a wide range of diseases and infirmities. The major attraction for both Pentecostalism and traditional religion is their emphasis on healing. A Pentecostal pastor, like a traditional healer, is accepted as the religious specialist and seen as a man of God anointed by the power of God to heal the sick.

Both the traditional religions and the Pentecostal church practices have shown that there is a strong connection between religion and healing. Religion seeks to alter the way people perceive and process their experiences. This, in turn, can alter the course of a disease because of the significant influence of people's attitudes and physical well-being. In traditional religious systems, as well as in Pentecostalism, it's normal to attribute physical improvement to the supernatural action. Finally, healing practices do not only address personal challenges but also serve to heal the social disorders and problems of the community.

REFERENCES

Amanze, J.N., (1994), *Botswana Handbook of Churches: A Handbook of Churches, Ecumenical Organizations Theological institutions & other World Religions in Botswana*, Gaborone: Pula Press.

Amanze, J.N., (2002), *African Traditional Religions and Culture in Botswana*, Gaborone: Pula Press.

Burnnett, D, (1992), *Unearthly Powers: A Christian's Handbook on Primal and Folk Religions*, Nashville, Oliver Nelson.

Byaruhanga-Akiiki ABT, & Kealotswe, OBN, (1995), *Healers, protective Medicine in Botswana*, (Department of Theology: University of Botswana, Gaborone.

Fako, T.T., "Traditional medicine & organizational issues in Botswana, Working paper No 20, University of Botswana, July 1978.

Kealotswe, O., "Healing in the African Independent Churches in the Era of AIDS in Botswana", *Missionalia*, Volume 29:2, August 2001, pages 220-231.

Gelfand, M., (1964) *Witch Doctor: Traditional Medicine Man of Rhodesia*. London: Harrill Press

Mackenzie, J., (1871), *Ten Years North of the Orange River*, Edinburgh: Hodder & Stoughton.

Mbiti, J., (1990) *Introduction to African Traditional Religions*, London: Heinemann.

Nkomazana and Lanner (2007), *Aspects of the History of the Church in Botswana* and Amanze (2003) *African traditional Religions and Culture in Botswana*, Pietermaritzburg: Cluster Publications.

Nkomazana, F., & Tabalaka, A., (2009), Aspects of Healing Practices and Methods Among Pentecostals in Botswana, Part 1, *BOLESWA Journal of Theology, Religion & Philosophy*, 2(2), 137-159.

Omenyo, C.N., (2002), *Pentecost outside Pentecostalism: A Study of the Development of Charismatic Renewal in the Mainline Churches in Ghana*, Uitgeverij: Boekencentrum.

Ramocho, PM., (1999) 'An Analysis of Healing Methods within Pentecostal churches: Focus on Goodnews Church Fellowship', Diploma in Pastoral Theology, Theology & Religious Studies Department, University of Botswana, 1998/99.

Schapera, I., (ed. 1960), *Livingstone's Private Journals, 1851 – 1853*, London: Chatto & Windus.

Setiloane, G.M., (1976) *The Image of God Among the Sotho – Tswana*, Rotterdam: AA Balkema.

Togarasei, L, et al, (2008), *An Assessment of the Capacity of Faith – Based Organizations for HIV Prevention in Botswana Report*, University of Botswana.

Togarasei, L; Mmolai, S.K.; & Nkomazana, F; (eds), (2011), *The Faith Sector & HIV/AIDS in Botswana: Responses & Challenges*, Newcastle: Cambridge Scholars Publishing.

Church's Role in Prevention, Care and Management of HIV and AIDS in Western Kenya: Case of Vihiga and Busia Districts

Sussy Gumo-Kurgat and Susan Mbula Kilonzo¹

Abstract

The mandate of this essay is two-fold. First, it pays attention to the role of the Church in the care of persons living with HIV and AIDS and the affected. Secondly, it examines the efforts of the Church in prevention and management of HIV and AIDS in Western Kenya. The strategies used by the Church in achieving these two facets therefore forms the basis of the discussion. The viability of these approaches has been discoursed analytically as a basis for providing suggestions that might inform the church leaders and members to rethink the strategies relevant in responding to HIV and AIDS. The discussions are framed under the concept of holistic care and development for humanity. Primary data is sourced from two purposively sampled districts: Vihiga and Busia in Western Kenya. 52 randomly sampled churches provide the sample size from which examples were drawn. As a way forward, given the numerous challenges that the churches face while responding to HIV within communities, we advocate for an integrated approach where churches can borrow strategies that work best from their counterparts.

Introduction

In his book "Breaking the silence on HIV and AIDS in Africa", Byamugisha (2000), from surveys done in Uganda about people's sexuality, acknowledges that "there is much more sexual activity happening in our families and communities than we are often

¹ Sussy is Professor in the School of Art and Social Sciences at Maseno University, Kenya. Email: suguku@yahoo.com. Susan is Senior Lecturer in the Department of Religion, Theology, and Philosophy at Maseno University, Kenya. Email: mbusupa@yahoo.com.

prepared to accept.” The spread of HIV must therefore be high. HIV and AIDS has drastic implications for a country’s economic life in general and it affects the most productive section of the population. It also has an impact upon the country’s education and security sectors as it knocks out key personnel in these sectors (Khamalwa, 2006:83). The control of HIV and AIDS is greatly challenged by a variety of issues, some of which include moral challenges as well as cultural factors. It has therefore been the endeavour of different sectors to contribute towards reduction of the spread of HIV. We show that the Church as a community and institution have the vantage position of reaching the infected and affected at the community’s grassroots level. It is in a position to devise models for care, prevention, and management of HIV and AIDS. In partnership with other stakeholders, the Church can enhance an integrated approach to combat the pandemic. We use the term Church to mean universal Christian institution, and in this sense borrow examples from different Christian churches and groups to extrapolate the (ir)relevance of the institution in the response to HIV. This essay consequently explores the prevention, care, and management mechanisms used by the Church in enhancing viable control to the spread of HIV and AIDS. Though most of the examples of the Church’s response to the pandemic are drawn from the Catholic Church, other Pentecostal churches that proved to be engaged in responses to HIV are also highlighted.

An Overview of the Guiding Concept

The role of the Church in responding to HIV remains at the centre stage. A collaborative study carried out by the Uganda Christian AIDS Network (UCAN) and Pan African Christian AIDS Network (PANACET) in 2013 shows that the Church and other faith based organizations are in the lead in helping families cope with HIV and AIDS by providing care and support to the sick, the widowed, orphan and vulnerable children. The Church is also promoting constructive behaviour change as they join in the campaigns towards zero infections. The research however hastes to point out that the Church and other faith-based organizations need support and equipping in order for their efforts to effectively and sufficiently reach significant population of the affected and infected.

There are a number of institutions and bodies that are involved in empowering churches and theological institutions in responses to the HIV and AIDS pandemic in Africa. One such institution is the Ecumenical HIV and AIDS in Africa (EHAIA). Chitando (2008:103) explains:

The Ecumenical HIV and AIDs initiative in Africa (EHAIA) brings “different skills and assets of different partners together” to confront the HIV pandemic. EHAIA brings together the African churches, ecumenical organizations, northern churches and agencies, and the World Council of Churches (WCC). Having been set up in 2002, its major goal is to ensure the emergence of “HIV competent churches” in Africa. This has meant empowering African churches to be actively involved in prevention, care and support programmes... Through its project coordinator, regional coordinators and theology consultants, EHAIA has mobilized churches and theological institutions to provide leadership in the response to the pandemic.

The Church's social action is believed to be built upon the Biblical concept of holistic development which derives its meaning from the teachings and lifestyle of Jesus Christ (Kamanzi, 2007:17). When it comes to HIV and AIDS, the Church can be said to be concerned with the lives of people living with HIV, hence, 'the response of churches must be everywhere in Africa, a declaration of commitment to saving humanity' (African Jesuit AIDS Network, 2005:12). This discussion is based on the idea that the Church is not just concerned with humanity's spiritual life but also their physical and material welfare. The Biblical principle of salvation is holistic, all embracing and a gift of healing and liberation for the whole creation (Matthew 25:42-46; and Isaiah 58:6-7). There is therefore a need for churches to deepen theological reflections around HIV and AIDS and expand the religious ethos of compassion and solidarity, keeping human rights and dignity at the centre; rejecting stigma and discrimination of persons living with HIV (PLWH); and addressing the growing impact of the epidemic on women and children so often fuelled by gender inequality and lack of social justice (African Jesuit AIDS Network, 2005:13; Russell, 1990:121).

The Study Area

The primary data for this essay is sourced from field survey in Busia and Vihiga Districts² of Western Kenya from which broad studies were carried out on Church and Development/Social change between August 2003 and December 2006. The research was done in Community Health Care Centres, churches and hospitals. This discussion is strengthened by examples from 52 randomly sampled churches in both Busia and Vihiga districts of Western Kenya to illustrate how the churches are involved in the care, prevention and management of HIV and AIDS. To gather data, we used unstructured questionnaires, interview guides and focus group discussions. The data generated was mainly qualitative. The District Development Plans of both Vihiga and Busia districts indicate that HIV and AIDS is one of the key challenges to development. More than 50% of bed occupancy in the district hospitals and other health facilities in the two districts are by patients suffering from HIV-related infections (Ministry of Finance & Planning, 2002-2008:19). In both districts, there are more females than males infected in the younger age groups.

HIV and AIDS Statistics

An estimated 6.2% of Kenyan adults between the ages 15 and 49 were living with HIV as of December 2011. In total, in a population of about 40 million, 1.6 million Kenyans are living with the virus (NASCOP, 2012). There is considerable geographic variability in the burden of HIV in Kenya. Provincial HIV prevalence ranges from a high of 13.9% in Nyanza Province to a low of 0.9% in North Eastern Province – a more than 15-fold variation (Kenya National Bureau of Statistics, 2010). Nyanza Province alone accounts for one in four HIV-infected people in Kenya. This region is located in what is generally referred to as Western Kenya presently, and it presently leads in the prevalence rates.

² Before the current Counties, at the time when this study was carried out, Kenya was divided into eight provinces that were further sub-divided into districts. Vihiga and Busia districts were in Western province.

Despite the strategic plans that have been put in place to provide a sound policy and institutional framework for a multi-sectoral response to HIV and AIDS, the evaluation of the various plans (2000-2005, 2006-2010) still shows minimum decrease of HIV prevalence rates. This conclusion was partly drawn after examining the HIV and AIDS prevalence statistics in Vihiga district. An oral interview with the District AIDS and STD Coordinator (DASCO)³ revealed that the HIV prevalence was still very high though there was a noted slight reduction since 2001, the prevalence was 12% and the 2005 prevalence was 9%. In 2011, the prevalence is 6.2%. However, the national prevalence conceals the geographical specific challenges and as shown in the statistics, certain geographical areas are more affected. It is from this background that the efforts of the Church which has a holistic concern to redeem humanity are needed.

A Contextual Understanding of “The Church as a Community”

The term Church has been used theologically in the context of this work to refer to the universal body of Christ. This body is presupposed to take care of those living with the AIDS virus as well as the affected-including orphans, caretakers and widows/widowers. Hence, *“because we are one Church with universal interests, we need to find out what it means to open our hearts, to be concerned for humans everywhere in the world, and as Christians, to meet human needs”*(Nicolson, 1996:79-80). Russell (1990:142) corroborates this view and shows that the true Church should be a church in which the word is truly preached and sacraments administered. It should be a Church where healing and forgiving is maintained. The Gospel in this Church is seen in the perspective of HIV and AIDS, and Christians manifest God in the social action - love to those living and those affected by HIV.

Why the Church should have Special Concern for the People living with HIV – some theological considerations

The Church is probably one of the most trusted institutions with regard to helping the poor. It could be argued that the church is in many cases near the people who are marginalized and thus know their pains as well. It seeks to bring reconciliation between God and humanity and to meet human needs, recognizing the inseparable physical and spiritual nature of humankind (U.S Agency for International Development; 1996:130). HIV confronts Christians in various churches with many difficult questions. For instance, how should churches respond to their own members who are living with or affected by HIV and AIDS? Should churches promote non-faith based messages to limit the spread of HIV? How should resources for care, prevention and basic research for sustainable management be distributed? How can conditions which favour the spread of HIV be corrected? What is the individual responsibility of Christians in this area?

Wherever the image of God is promoted, the Church should be present to enhance the effort (Howlands, 2001:279). In approaching the challenge of HIV, Christians are motivated by urgent imperatives passionately felt: to show Christ's love for neighbour, to save lives, to work for reconciliation, to see that justice is done (WCC, 2002:47). These motivations are highly triggered by the social responses of fear, denial, stigma and discrimination of people living with HIV. Followers of Christ ought to imitate Jesus'

³ Oral Interview with Jael Olubero, the coordinator of HIV and STDs in Vihiga district, on 24/11/2005.

example by interacting with people living with HIV and embracing the vulnerable and contingent members of our society (Nicolson, 1996:79-80). Jesus calls the church to be moved with pity for those who are suffering and rejected on account of HIV and AIDS; to reach people living with HIV, orphans, widows and the affected. HIV and AIDS has in many instances been viewed with shame in the family and society at large and in this way has led to the neglect of the infected and the affected people. The Church therefore holds enormous influence over the cultural norms that guide individual and community behaviour and that affects how information about HIV is interpreted (UNAIDS, 2002:11-2). By sharing in the multiple pains of people with HIV and AIDS in their physical and mental distress, in their social exclusion and personal depression - while striving to overcome those pains as far as possible, Christians are helping to transform sheer human tragedy into possibility of new life and love (Bujo & Czerny, 2007:45). The Church is called upon to administer service to people in their cultural contexts and in their present life milieus. Church members, priests, deacons, lay leaders and concerned organizations should heed this call and contextualize the gospel to have a greater influence in response to HIV and AIDS challenges (Slattery, 2004:110).

Church's Strategy for Care, Prevention and Management of HIV & AIDS

The manner in which the churches and their members respond to people living with HIV is an indication of the degree of seriousness with which they follow Biblical notion of love. Jesus' response was that of love and compassion and open-arms: a response that is demanded of God's people. It is a command expressly given by Jesus to his followers. The Church's approach should consequently be a concern for the infected, neglected and the affected in the community. Based on our findings, the churches in Vihiga and Busia districts have subsequently applied the following approaches in an endeavour to contain the spread of HIV, as well as take care of people living with HIV.

Use of Church Small Interest Groups (CSIGs)

Small interest groups are clusters of church members with a binding interest which helps them draw their objectives and work towards the achievement of those objectives. In the care, prevention, and management of HIV and AIDS, members of CSIGs are held together by the belief that their undivided effort can work best not only for the infected and affected members of the Church but also the community at large. Our survey revealed that these groups, among others, include youth clusters, women groupings, men groups, and Home Bible Classes (HBCs) and /or small Christian communities.

Youth Clusters

In Busia District, the study found out that, AIDS awareness programmes have been initiated through the Catholic Youth Movement (CYM), a movement found in all parishes. The aim is to train youth leaders who can in turn reach their own peers and become their own advocates on sex education on HIV and AIDS. Adolescents face sizeable risks with regard to promiscuous and unprotected sexual activity. These include HIV and AIDS, STDs and unwanted pregnancies (Aylward and Onyancha, 1998:93). UNAIDS estimates that up to 60% of all new infections of HIV are among those between the ages 15 and 24 and this age set is no different in Kenya (NAS COP, 2011). This means that many HIV and AIDS patients above the age 24 contracted HIV when

they were within above age group (PANUS AIDS, 1996:1). The church youth groups are therefore essential in the church's commitment in the responses to end this pandemic.

Through organized workshops and seminars, the youth are trained and counseled to become more responsible for their behaviour, life and health and for the people infected and affected by HIV and AIDS. Lessons on how to care for the people living with HIV and AIDS are given during these seminars and workshops. Through these, the youth are sensitized on the dangers of engaging in risky sexual behaviour that may expose them to HIV infections. Some of these groups carry out HIV and AIDS campaigns for awareness. An example in Vihiga District is the *Agape youth group*. This group consists of thirteen active members mainly from Church of God-Kima. Two members were from Word of Faith Church and Friends Church respectively. The area around Kima and Vihiga is rocky. This youth group seemingly uses the conspicuous rocks to do graffiti that communicates HIV and AIDS messages that are educative to both the young and the old. They use both Swahili (national language) and Lunyore (local language) to reach out to a wide audience. It was however noted that there is need for professional personnel in the training of the youth to carry out effective campaigns. The survey revealed that some of the campaign awareness methods used by the untrained youths have encouraged stigmatization and discrimination of people living with HIV. Some of the graffiti messages showed lack of sensitization on the language to use in educating people on HIV. For instance "Ukimwi ni kifo", Swahili for HIV and AIDS is death, which do not auger well with sensitization on HIV care and prevention.

Women Consortiums

Unlike men, women spend much of their time looking after relatives or family members living with HIV. This care includes nursing them, washing their clothes, cooking and accompanying the patients to the hospital among other things. From such a backdrop, women in the churches have formed various organizations which among other things provide relief to the infected and affected in societies. Some of these organizations provide food, clothing and other basic necessities to families and people living with HIV (Aylward and Onyancha, 1998:121). Our study show that the Catholic Church in its initiative of empowering women on care and prevention of HIV and AIDS, has reinforced women capacity in domains of education and training in matters related to HIV and AIDS through various Catholic Women Associations (CWAs) formed in every parish.

At Butula Parish in Busia District, the sensitization of women in dealing with the challenges related to HIV have led to the formation of unions within the CWAs. An example is the Hope Mothers Union that takes care of orphans in the community. With a total of 22 women, the group has established an orphanage that takes care of 93 orphans. They make contributions every month to feed the children and ensure that they attend school. They have also been organizing and conducting fundraising to help with the children's fees. The CWA organize and run awareness courses on HIV and AIDS which brings contact between groups in the different parishes to help and strengthen the affected and infected. Through these organizations, seminars and workshops are organized to discourage women on some cultural practices that may expose them to HIV infection. For example levirate and widow inheritance practices, which are prevalent in the area, have been discouraged through these associations. Peninah⁴ observed that sensitization is created on the dangers of these practices. In the 52 churches randomly

⁴ Oral Interview with Peninah (pseudonym) on 4/4/2005 at Mundika Parish in Busia district.

sampled in the two districts, statistics showed that 48 of them had women groups that dealt with various development issues as well as informal education on various life issues including HIV and AIDS.

Field data showed that churches are using women groups to enhance campaigns against HIV and AIDS. Florence, the HIV Director at the Church of God at Emmabwi in Vihiga coordinates HIV campaigns to help incorporate the HIV infected women into the wider community. This means that there is a lot of capacity building and sensitization that encourages people to accept those infected without any form of stigmatization.⁵ Jane, a member and partner of CoG Child Care Centre in Majengo - Vihiga, that has been established by the same church attested to the unity of women and observed that there is much that the community members can do, through the help of the church, to take care of those infected and those affected by HIV.⁶

Care for Widows and Orphans as a Healing Strategy

Leaders in different churches noted that most of the widows are HIV positive. The churches since the year 2002 started educating the members openly about HIV and AIDS. Some of the widows, through the help of other church members, have started a ministry for the destitute and orphaned children. The leadership of Emuhaya Redeemed Gospel Church in Vihiga district noted that they were taking care of 60 orphans, who though not residents at the orphanage, are given food and medical attention as well as fee subsidies. The senior pastor explained that they do not have any donor support but entirely depended on the generosity of the church members who conducted '*harambees*'-Swahili for fundraising, to help the orphans. The pastor also explained that the members would donate food (mainly maize and beans) and clothes for the orphans. The children would also receive spiritual counseling from the senior pastor, his assistant and church counselors.⁷

Churches have trained personnel to take care of those living with HIV and the orphans as well. The pastor in charge of the Maragoli ACK deanery, that has seven parishes, remarked that the deanery has six orphanages. These centres were pioneered by the church, which later sort for help from donors. The pastor noted that the church recruits the needy from the community then attaches the orphans to donors who send in their help either in cash or kind (goods).⁸ The Egyptian missionary at the Miyekhe Coptic Church said that the church takes care of more than 250 orphans in its nine branches in Vihiga. These are total orphans whose relatives are not able to cater for. The orphans become members of the Coptic church and are fed regularly. They are also educated at the primary school level and those that excel are sponsored fully for their secondary education.⁹

Men groups

Research findings showed that men were passive parties in the formation of development groups and were less involved in the HIV and AIDS campaigns. In the few churches that had men's groups like Butula Catholic Church, Mbale Deliverance Church

⁵ Oral interview with Florence (pseudonym) at Emmabwi Church of God on 03/2/2006.

⁶ Oral interview with Jane (pseudonym) at Emmabwi on 03/2/2006.

⁷ Oral interview with the senior pastor of Emuhaya Redeemed Gospel Church at the church premises on 13 February 2006.

⁸ Oral interview with the Rev. Pastor in-charge of the Maragoli ACK deanery on 18/6/2006.

⁹ Oral interview with an Egyptian missionary at the Coptic church in Miyekhe on 19/5/2006.

and PAG in Nyang'ori, the membership of these groups was very low and consequently very little or no significant activities were in place. This poses a challenge to the men and the male-dominated church leadership. They need to strengthen men's groups or form non-gender based groups especially designed to fight HIV since it affects all people indiscriminately.

Home Bible Classes (HBCs) as Small healing Communities

Home Bible Classes are small groups for both men and women that are formed at the community level by members of similar Christian denominations for purposes of bible readings, spiritual sharing and prayer meetings. They are believed to be a basis of uniting members of the same locality. The groups meet at least once a week to pray. 95% of the churches visited attested to having these prayer groups. This practice strengthens their spiritual and moral lives. This is a step towards containing the spread of HIV and also towards fighting other vices in society. Religious education is further emphasized during clubs and sports where the youth are able to share information on the dangers of HIV and AIDS. These activities are meant to keep the youth busy and engage them in alternative ways of socializing.¹⁰ This goes further to hinder social behaviour that encourage the spread of HIV. HBCs have been used by the Church as healing communities in which members are encouraged to visit and pray with the infected and encourage them on the importance of attending spiritual meetings.

Specific to the Roman Catholic churches are small Christian communities (SCCs). These are communities used for Christians' interpersonal relationships and a sense of communal belonging for the members. The priests in charge of the Chamakanga Catholic Church in Vihiga and Butula Parish in Busia observed that SCCs make it easy for priests to understand the real needs of specific individuals in the community, through the leadership of the SCCs. Giving an example of Chamakanga, the priest in charge indicated that there are over 3000 Catholic members in the church, though some members were not quite active.¹¹ The church had therefore divided the population into eleven SCCs to facilitate interpersonal communication and sharing. During some group discussions held with two of the SCCs at the church premises, the members indicated that women were the most active in these groups. They also enumerated the advantages of the communities-especially for the women: they were running income generating projects among the members, they would meet two times in a week and pray together, they were able to take care of the needs of the vulnerable within the groups. Through the SCCs, those living with HIV or affected (widows and orphans) would get help from the members, and where necessary the very needy cases referred to the priests for help.¹²

Morality as a Preventive Measure

Moral education is transmitted through films, videos, pamphlets and posters to educate the masses. Various churches have held workshops where resource persons, mostly professionals, Church ministers and people living with HIV gather to share information and experiences. HIV and AIDS education and counseling is given to all the attendants of the organized seminars using Biblical principles, which encourages marital sex and discourages pre-marital and extra-marital sex. The churches maintain that sexual union in

¹⁰ Oral interview with Titus (pseudonym) on 5/11/2006 at Kima Church of God.

¹¹ Oral interview with the priest in charge of the Chamakanga Catholic Church in 08/9/2006.

¹² Focus group discussions held with two SCCs at Chamakanga Catholic Church on 08/9/2006.

marriage was uniquely designed by God for exclusive enjoyment. This explains why adultery, incest, prostitution and fornication were forbidden as depicted in Leviticus, 19:21; 20:10; and 1 Corinthians 5 and 6. The condemnation should be enhanced by action-oriented duties (Dortzbach, 1996:16; Shisanya, 2001:60). The seminars organized by the churches also provide moral teachings that discourage vices such as prostitution, drug abuse and irresponsible sex which may expose people to HIV infections.

Sharing Christian love and compassion is also encouraged in accordance with Jesus' teachings on love and compassion for suffering neighbours. The various churches encourage people living with HIV to visit voluntary counseling and testing (VCT) centres for advice and to receive antiretroviral therapy (ART). In Busia's Redeemed Gospel Church, among other churches, the leaders have openly talked about HIV and AIDS, and educated people on the importance of VCTs and ART. We learned that in Vihiga District people living with HIV are using all kinds of visible strategies and messages to warn people about the risks of irresponsible sexual behaviours. Most of the rocks and trees have inscribed messages on the seriousness of the scourge. These messages are placed strategically on roads where most people are able to read. They are presented in Swahili, and local languages for many people to be reached. Some of the messages includes: "*jikinge wmenyewe and unao wapenda*"-protect yourself and those that you love, "*jua hali yako*"-know your status, "*tumia mpira*"-use a condom, among others. Besides the messages on warnings about the risks of irresponsible sexual behaviours, there are also messages encouraging people to avoid stigmatizing and discriminating people living with HIV.

Healing through Ministerial Care and Counseling

Part of the concern for the church in the prevention and management of HIV and AIDS is to give pastoral care, especially counseling services to people living with HIV (Tinkansiimire 2005:166-7). As Tinkansiimire notes, this encourages people living with HIV to have a positive attitude towards oneself and others too. The counseling strengthens the people living with HIV and gives them a hope for positive living. Guidance and counseling empowers people psychologically and socially, so that the afflicted can lead a normal life and the social impact of the disease can be alleviated (Shorter and Onyancha, 1998:83). The churches have embarked on pastoral counseling offered by individual counselors or group counselors. This is taking place both in the churches and at people's homes. Examples of churches where we recorded counseling services include: Church of God at Kima, Ebusiekwe Redeemed Gospel, PAG and Friends churches in Vihiga; and, Mundika and Butula Catholic churches in Busia. The Church counselors make appointments with individuals who are infected or affected to have one-on-one or group sessions of counseling. The group counseling mostly happens with those who have publicly declared their positive status and are ready to form groups for material, spiritual and moral support that are identified by church leaders and church members. The churches have also taken the initiative to empower some volunteers with counseling skills and knowledge to enable them reach out to both the affected and infected. Those undertaking counseling programmes from the churches understood it to be a way of providing information, support in identifying and resolving issues of integration, care of social needs and psychological support.

Apart from the guidance and counseling to ensure that those living with HIV accept their conditions, the church has been helping the patients acquire Anti-retroviral drugs.

They introduce them to hospitals that supply such drugs. A priest at Mundika Parish in Busia explained that one of the sure ways that the church was ensuring that those living with HIV got medical attention, was to work with the government and NGOs that would provide qualified personnel to provide the services needed. Guidance and counseling is also ensured on other areas that affect human sexuality.¹³ The Roman Catholic, exemplified by the Butula and Mundika Catholic churches in Busia, are known to be against the use of artificial methods of family planning. They however give guidance in family life education on how to use natural family planning.

The Role of the Church in Capacity Building for HIV and AIDS Management

Capacity building is the process of enabling people to be aware of the capabilities within their access by use of the locally available resources. It is the way in which people are sensitized to affect their capabilities. The churches in their campaigns are strengthening the capacity of the infected and the affected by creating an effective communication network, facilitating the exchange of ideas and experiences, mobilizing existing resources for effective response, devising common policies and intervention strategies. Through these awareness programmes, seminars are held regularly to empower communities to give quality care to HIV cases in a sustainable manner and to increase their awareness of HIV and AIDS management. An example is the Coptic Church in Luanda - Vihiga, which operates a nursing home clinic that has a VCT component. This facility has enhanced training and sensitization of the community members. It provides VCT services free-of-charge and collaborates with the government to ensure that anti-retroviral drugs are accessible to those living with HIV.

The Catholic Church in Busia District for example, has embarked on campaigns by the different church groups/organizations at all social levels, starting from the Small Christian Communities (SCCs) extending to the diocesan level. Sensitization and awareness is further enhanced among community based health care workers who come from various SCCs. These volunteers are later trained with necessary skills and knowledge on counseling. They become instrumental in assisting the church in dealing with the growing number of people living with HIV. Their role is to identify both the infected and affected at the grass root level. The identified group of people are therefore counseled and provided with the relevant skills and education on coping mechanisms. Through this form of capacity building, they are made aware of their potential to manage their conditions. The limitation of the campaigns though is the stigma that is still within the communities, lack of exposure by those carrying out the campaigns, and poor planning that does not engage all the stakeholders, including other churches.

The Church as a Partnering Community in the Prevention of HIV and AIDS

Churches have partnered with community initiative programmes that receive donor funding so as to counteract this challenge and discharge their services to the community. One of these organizations is Christian Health Association of Kenya (CHAK), which helps the churches to hold numerous training workshops on AIDS awareness. The Norwegian Church Aid (NCA) has developed the "Partnership in Community" approach for community education and training, using communities themselves to design HIV

¹³ Oral interview with a priest at Mundika Catholic Church on 23/3/2006.

programmes. The NCA's approach is a bottom-up initiative. They learn from the communities about the realities of those living with, or affected by HIV, and transform the lessons into action by involving communities to come up with solutions. One of the examples cited by the Pentecostal Assemblies of God Church at Nyang'ori is the method through which NCA reaches out to those who have been discriminated against because they are infected.¹⁴ They approach the church leaders, who, through the church members are able to identify the root causes of discrimination and as those who are related to the discriminated to reach out to them and connect them with the Church and in the end the NCA. They are then attached to health centres near them for health care and treatment.

Our study established that within Busia District, the Catholic Church is working hand in hand with two NGOs: the Rural Education Economic Programme (REEP) and The Aids Orphans Rehabilitation and Support Organization (TAORASO) to combat the spread of HIV. In Vihiga district, the churches are working hand in hand with AMREF, AMKENI (Swahili word for wake up), Engender Health (EH) and World Vision Kenya (WVK). These NGOs have been giving financial support to enhance organization of seminars.¹⁵

The Church has also partnered with Community Initiative programmes established by various individuals and organizations as well as to take care of the immediate needs of the community members. An example of these efforts was noted in Vihiga District at the Church of God in Kima, Emuhaya Division, and the Friends Church at Kaimosi, Tiriki East Division. Whereas the Church of God has partnered with Kima Integrated Community Initiative, The Friends Church has been collaborating with Rural Service Programme (RSP), which in itself is a church initiative funded by donor organizations to benefit the community at large.

Home Based Health Care, as care and support given to patients at the grassroots level without essentially attending health centers, is done by home based health care workers who are mostly trained community volunteers. Government community nurses or public health workers train volunteers on how to take care of patients at local levels. The NGOs have also sponsored the churches/community to purchase home-based health care kits to attend to people living with HIV. Most orphans are supported through the partnership of churches and faith based NGOs. Examples of those cited in this endeavour are, Compassion International, Christophel Blinden Mission, Friends in Germany and Bread for the World. Compassion International supports 85% of all Community Development Centres (CDCs) in Vihiga district.¹⁶

Inter-denominational Unity as an HIV and AIDS Alleviation Mechanism

Through networking and collaboration, various church groups have been able to implement strategies that can help alleviate or manage HIV and AIDS; dispatch information in regard to sourcing for funds; training community based workers as counselors; produce HIV and AIDS information material and pamphlets; disseminate information to community members; access health care centres; show love and compassion for the people living with HIV as one community and educate people on behaviour change. This has indeed been a milestone as it has contributed to cut across

¹⁴ Interviews with pastor in charge of P.A.G, Nyang'ori in Vihiga district on 17/12/05.

¹⁵ Oral interview with the Priest in charge of Mundika Parish, Busia district on 12/3/06.

¹⁶ Oral interview with Joshua (pseudonym) at Church of God in Kima, Vihiga on 21/8/06.

denominational boundaries in prevention and management of HIV and AIDS. However, there are churches that have separated themselves from such form of unity with a sole reason of protecting their doctrines.

Weaknesses of the Church's HIV and AIDS Preventive and Management Measures

Despite the noted and commendable efforts of the Church in the response to HIV and AIDS scourge, there are areas that the Church needs re-awakening so as to strengthen its approaches. The research showed that the churches in Busia and Vihiga districts cannot reach to all the infected and affected. There are pockets of the community that reported not seeing any transformation with regard to HIV and AIDS. This was mainly attributed to challenges of poverty. A number of church leaders explained that they could not be able to reach all those in need of material, medical and psychological support. They also noted that the churches entirely relied on members' and donor support and the help they received was limited to enable them take care of all the needs of community members living with, as well as those affected by HIV.¹⁷

Some churches have responded negatively to people living with HIV out of self-righteousness kindled by fear. There are cases whereby the churches have refused to administer matrimonial sacraments unless the would-be couple goes for an HIV test to prove their "purity" and declare it publicly. This makes the Church, which is supposed to protect its faithfuls, lose its trust and mandate. Besides this form of harassments, there are cases where churches have discriminated against widows living with HIV from taking part in church activities, and children living with HIV in Sunday schools.

It is obvious that some of the church leaders' actions have led to loss of trust of the church members in the church and church leadership. Immorality and irresponsibility have time and again been leveled against some church leaders. Once this trust is abused, broken and betrayed, immorality is bound to spread among the church members. The churches that are able to deliver promises within their means to those living with HIV have been able to retain their credibility. This view came up from the group discussions held with different church groups including youth, women, and men. Their argument was that it is better to promise little and provide it than set ambitious goals that the churches cannot meet in as far as reaching out to those living with HIV. The church members detest leaders in the churches who seemed to care more about their material wellbeing at the expense of the sick and vulnerable in the community.

The use of condoms for HIV prevention was an issue that was displayed as still very controversial in the churches during the research. The argument, especially from the Catholic churches in both Busia and Vihiga districts is that sex should just be a preserve of married couple and that advocating for condom is a way of encouraging immorality, as well as artificial family planning, which the Roman Catholic Church remains strongly opposed to.¹⁸ Literature that corroborates this view indicates that the churches advise against the use of condoms because it increases immorality especially among the youth and unfaithful partners (Williams, Ng'ang'a and Ngugi, 2005). In the nine interviews held with nine different Roman Catholic priests in the two districts, only one priest was quick

¹⁷ Oral interviews held with several church leaders in Busia and Vihiga between 24/5/2006 to 4/8/2006.

¹⁸ Oral interviews with various Roman Catholic priests in both Vihiga and Busia on the position of the Church with regard to the use of condoms for HIV prevention.

to indicate that there were times he had been forced to choose the “lesser evil” rather than obstinately condemn the use of condoms and the disapproval costs someone’s life. He leniently advocated for the use of condoms when one cannot avoid the temptation. Though the mainstream Protestant churches may presumably have no doctrinal objections to the use of condoms at least for the married couples, they are opposed to the promotion of condom usage among the young and the unmarried. Generally, the churches have discouraged the use of condoms and this contradicts and derails the efforts of other concerned bodies. Despite such a measure, the churches are unable to completely enforce the choice of abstinence as a tool to control HIV.

In an effort to carry out HIV and AIDS awareness campaigns and sensitization, the church’s small interest groups have unknowingly used methods and messages that encourage stigmatization and discrimination of people living with HIV. Such methods include use of placards and posters with human skeleton and skull drawn on them. Such messages in as much as they warn people of the dangers ahead, they may be interpreted to mean HIV and AIDS is a death sentence, which should not be the case. As Pattison (1990:28) explains, the Church should do good to people, learn from them and build them up, not make people who are already having a bad time feel worse.

Inter-denominational and inter-faith collaboration has been a challenge in different religious groups. The church leaders interviewed on this issue noted that it is not easy to have churches collaborate on social and development issues whereas they scramble for member to join their different churches. To a great extent, the lack of such collaboration can be blamed on the church leadership in an effort to protect doctrinal stands and loss of membership. Though such collaboration can result in realization of positive contribution in the prevention of HIV and support of those infected, there were no realizations towards this endeavor in the study area. This consequently has an effect in the response to HIV and AIDS since the cooperation is minimal.

With these weaknesses and challenges, we suggest a form of integration of all viable approaches towards the curbing of HIV and AIDS as a way of providing variety of choices to the users. The different churches, even with the dilemma of collaborations in response to the HIV pandemic, could borrow from each other’s efforts and integrate as many approaches as possible in their social service work of helping those living with HIV. There is the need to use professionally trained personnel who can provide informed choices to those infected or affected. We reckon the challenge of the government in ensuring availability of CHWs and distributing them equally so as to benefit the very affected communities. However, if more efforts geared towards church-government partnerships, then capacity building at the local level will be built to ensure the services and help delivered from the community level meets the standards required in responding to HIV. In the same vein, there is need to advocate for justice and human rights, women’s empowerment, training of counselors and creation of ‘safe places’ where people living with HIV can share their stories and testimonies. Along with this is the need for the churches to empower men to get involved in HIV and AIDS awareness campaigns and other HIV church-social related activities. Similarly, the Church leaders should build trust and confidence among their members. This will ensure a strong spiritual hold among the members, reducing instances of immorality that greatly contribute to the spread of HIV and AIDS. Church leadership should be quick to provide education on alleviation measures in case abstinence is not observed.

Church leadership should explore the possibilities of ecumenism and dialogue in health issues that cut across the community, irrespective of one's denomination. In so doing, challenges of drug abuse, commercial sex activity, child prostitution, as well as the root causes of destitute social conditions such as poverty, all of which favour the spread of HIV and AIDS should be dealt with. Participatory action research, which involves all the stakeholders propagating the mechanisms to curb the spread of the virus, should be well executed. This will enable the stakeholders analyze the issues and problems raised by HIV and develop actions which foster prevention and care.

Conclusion

The study was anchored on the biblical interpretation on the holistic concept of human development. This principle depicts the word of God as an all embracing and a gift of healing and liberation for the whole creation. The spiritual nourishment and hope giving which are important facets mostly neglected by the secular bodies, have been a relevant contribution of the Church and consequently a holistic approach. Of major concern to the discussion has been the approaches used by the different churches to curb the spread of HIV and AIDS in Vihiga and Busia districts.

From the discussion, it is evident that the churches have employed various tools in their effort to help the HIV and AIDS infected and affected people in the society. Among other strategies the churches have used women and youth groups, community volunteers, awareness campaigns, as well as capacity building to positively improve lives of people living with HIV and the affected by educating the community at large. The major challenge of the Church in an effort to respond to HIV and AIDS has been financial constraints and lack of qualified personnel. However, the churches have tried to partner with different organs, for example, the government, community initiatives, NGOs and CBOs so as to curb the spread of HIV and AIDS. In such partnerships, the Church has been a very important organ in mobilizing the community for capacity building. However, the survey realizes the need for grassroots ecumenism, not with an aim of sorting out doctrinal issues, but mainly to address health issues that cut across all boundaries, including denominational boundaries. This will be a milestone in helping the younger churches, which are limited in their capabilities to mobilize significant community groups for campaigns and capacity building. The study also realizes the need for integration of all viable methods of responding to and preventing the spread of HIV. Of great importance is participatory action research for propagation of relevant mechanisms in the response to HIV. With concerted efforts of ensuring and enhancing these approaches, greater change will be realized through a decrease in the prevalence rates-both at national and district levels.

REFERENCES

African Jesuit AIDS network (2005). *AIDS and the church in Africa*. Nairobi: Paulines Publications Africa.

AMECEA (1989). *African ecclesial review*. Eldoret: Gaba Publications.

- Belshaw, D. (2001). *Faith in development*. California: Regnum Books International.
- Dortzbach, D. (ed.) (1996) *AIDS in Africa: The church's opportunity*. Nairobi: MAP International.
- Byamugisha, G. (2000) *Breaking the silence on HIV/AIDS in Africa: How can religious institutions talk about sexual matters in their communities?* Tricolour designers & printers. Kampala.
- Chitando, Ezra (2008). The Ecumenical HIC and AIDS Initiative in Africa (EHAIA) and the Mainstreaming of HIV and AIDS in the Theological Programmes. In Chitando, E. (Ed). *Mainstreaming HIV and AIDS in Theological Education. Experiences and Explorations*. WCC, Geneva.
- Howlands, S. (2001). "The social mission of the church: Its changing context?" In Peter C. (ed) *The gift of the church: A text book on ecclesiology in honour of Patrick Grenfield O.S.B.* Collegeville: Liturgical Press.
- Kamanzi, M. (2007). Solidarity, a new categorical imperative, in, Benezet Bujo and Michael Czerny (eds.) *AIDS in Africa, theological reflections?*. Nairobi: Paulines Publications Africa.
- Kanyandago, P. (2005). Is God Africa?: Theological reflection on the AIDS scourge. In, Nahashon Ndung'u and Philomena Mwaura (eds): *Challenges and prospects of the church in Africa: Theological reflections of the 21st century*. Nairobi, Kenya: Paulines Publication Africa.
- Kenya National Bureau of Statistics (2010). *2009 Kenya Population and Housing Census: Volume 1A*. Nairobi: KNBS.
- Khamalwa, W. (2006). Religion, traditional healers, and the AIDS pandemic in Uganda. In Chepkwony, A. (ed.) *Religion and health in Africa: Reflections for theology in the 21st century*. Nairobi, Kenya: Paulines Publications Africa.
- McDonald, E. (1994). *Theology in a time of AIDS*. Ireland: Irish Theological Quarterly
- Ministry of Finance and Planning (2002). *National Development Plan (2002-2008)*. Nairobi: G.O.K Printers.
- NACC & NASCOP (2012). *The Kenya AIDS epidemic update 2011*. National AIDS Control Council. Nairobi: NASCOP.
- NASCOP (2004). *National HIV prevalence in Kenya: Report of a technical group harmonizing, 'sentinel surveillance' and 'Kenya demographic and health survey', HIV prevalence estimates*. Nairobi, NASCOP, 2004.
- NASCOP *National HIV prevalence in Kenya*. Nairobi: NASCOP, 2003.
- Nicolson, R. (1996) *God in AIDS?* London: SCM Press Ltd.
- Odundo, p. & Owino, W. (2004). *HIV & AIDS scourge in Nyanza province: Culture, poverty and behavioural change*. Nairobi, Kenya: Regal Press Kenya.

- Orobator, A. (2005). *From crisis to kairos, the mission of the church in time of HIV & AIDS refugees and poverty*. Nairobi, Kenya: Paulines Publication Africa.
- Otaala, B. (2003). *HIV & AIDS: Government leaders in Namibia responding to the HIV & AIDS epidemic*. Windhoek, Namibia: University of Namibia Press.
- PANUS (1996). AIDS Briefing no. 4.
- Pattison, S. (1990) "The judgment of AIDS" in Woodward James (ed.), *Embracing the chaos: Theological responses to AIDS*. London, England: SPCK.
- Russell, L. (ed.) (1990). *The church with AIDS; Renewal in the midst of crisis*. Louisville: Westminster Press.
- Shisanya, C. (2002). The impact of HIV & AIDS on women in Kenya' In Getui, M. & Theuri, M. (eds) *Quests for abundant life in Africa*. Nairobi, Kenya: Acton Publishers.
- Shorter A. & Onyancha E. (1998). *The church and AIDS in Africa: A case study-Nairobi city*: Nairobi, Kenya: Paulines Publication Africa.
- Singh C. (2004). *HIV & AIDS: Social and ethical issues*. Delhi, India. Lt. Col A Banerjee.
- Slattery, H. (2004). *HIV & AIDS: A call to action; Responding as Christians*. Rensend Edition Nairobi: Paulines Publication.
- Tinkansiimire, T. (2005). Prospects and challenges for the Catholic Church in the 21st century. In Ndung'u N. & Mwaura P. (eds) *Challenges and the prospects of the church in Africa: Theological reflections of the 21st century*. Nairobi: Paulines Publications.
- UCAN & PANACET (2010). Situation Analysis of Church Response to HIV/AIDS in Uganda. A collaborative study done by Uganda Christian Aids Network (UCAN) and Pan African Christian AIDS Network (PANACET), http://pacanet.net/newsite/wp-content/uploads/2012/10/Uganda_Report.pdf, accessed 18 January 2015.
- UNAIDS (2002). *Report on the global HIV & AIDS epidemic*. Geneva: UNAIDS.
- U.S agency for international development (1996). *AIDSCAP/family health international, socioeconomic impact and policy implications*, USA: Family International AIDSCAP.
- Wamue, G. (2002). "Women and AIDS in Kenya: Some general observations" in Getui, M & Theuri, M. (eds) (2002). *Quests for Abundant Life in Africa*. Nairobi, Acton Publishers.
- WCC (2002). *Facing AIDS: The challenge; the church's response*. Geneva, Switzerland: WCC Publications.
- Williams, G. Ng'ang'a, L. and Ngugi, J. (2005). Youth to youth: HIV prevention and young people in Kenya: Strategies for hope. Vol. 13.
- Woodward J (ed.) (1990). *Embracing the chaos: Theological responses to AIDS*. London: SPCK.
- Wolf, L. (2001). *Ethical dimensions of HIV & AIDS*. San Francisco: University of San Francisco.

Healing Culture, Healing AIDS¹: A Review of some African Cultural and Religious Beliefs and Practices in Contexts of HIV and AIDS

Lovemore Togarasei²

Abstract

This essay sees culture as a two-edged sword in HIV and AIDS response. It argues that while scholarly attention has mainly been on how certain cultural practices facilitate the spread of HIV and stand in the way of prevention, treatment and care, there are some ethno-cultural and religious beliefs and practices that can be used for positive HIV and AIDS response. The essay thus identifies and discusses some ethno-cultural and religious factors that contribute to the spread of HIV with the aim of 'healing' those that fuel the spread of HIV and promoting those that can be used for positive response.

Key words: HIV and AIDS, ethno-cultural and religious beliefs, healing

Introduction

The HIV and AIDS pandemic breeds in certain socio-cultural and religious beliefs and practices throughout the world. In a study on the male psyche with respect to reproductive health, HIV, AIDS and genders issues in Zimbabwe, Chiroro, Mashu and Muhwava (2002) found out that the culture and legal system in Zimbabwe provide a fertile ground for the propagation and perpetuation of adversarial sexual beliefs, gender role stereotypes and high-risk sexual behavior among men and male youths. Culture, more often, prescribes specific behavior patterns for women and men that put them at risk of HIV and AIDS. The Centre for the Study of Violence and Reconciliation in South Africa (Berner-Rodoreda 2006), for example, has identified a township culture that prescribed many sexual partners as a mark of manhood. But socio-cultural and religious

¹ This title is influenced by Ezra Chitando's (2009) chapter 2 title, 'Healing Culture: Inculturation theology and HIV.'

² Lovemore is Professor in the Department of Theology and Religious Studies at the University of Botswana. He takes interest in research in the areas of the Bible in African Christianity with special reference to the New Testament, Pentecostal expressions of Christianity in Africa and the public role of the church in Africa. He has led several research projects and consultancies in the area of church and public health especially HIV and AIDS. Email: ltogarasei@yahoo.com.

beliefs and practices do not only pose risk to the spread of HIV and AIDS, they can also be used to respond positively to the pandemic especially in prevention, care and solidarity with the infected and affected. For example, some cultures and religions emphasize sexual ethics that can be used to respond positively to HIV and AIDS. Weinreich and Benn (2004), note the Muslim, Jewish and Christian teachings on pre-marital abstinence and lifelong marriage faithfulness that can be used for HIV prevention. In cognizance of these two realities: that socio-cultural and religious beliefs and practices can fuel the spread of HIV and AIDS; and that these factors can also be used for positive HIV and AIDS response, in this essay I intend to identify and discuss some factors that contribute to the two scenarios with the aim of 'healing' those that fuel the spread of HIV and promoting those that can be used for positive HIV and AIDS response. As the world seeks healing of HIV and AIDS, traditional cultural and religious beliefs and practices need serious attention. This is because it is through them that people perceive the world and make sense of it.

I approach the discussion from my own social location. A social location is an individual's place or location in society (Dube 2003:101) from which s/he understands, makes judgments, values and thinks (Randolph Tate 2006:340) thus determining actions. One's social location is made up of many factors: family, work, church, neighbourhood, education level, gender, nationality and so on. In discussing one's social location Mary Tolbert (1995:305-317) identifies two categories of issues on social location: issues of bread (economic issues) and issues of blood (biological issues). I shall not give a comprehensive description of these two issues of my social location but simply to mention few issues that directly affect my discussion in this essay. My social location will therefore be limited to my gender, age, geographical location, profession and religious/church inclinations. After this brief description of my social location, I will outline and discuss factors that tend to fuel the spread of HIV and AIDS. In the third section I outline and discuss factors that can be used as anchors for positive HIV and AIDS response. Lastly, I will then reflect on how the Church³ and all those who want to respond to HIV and AIDS can learn from these ethno, socio-cultural and religious factors in developing tools and programmes for positive HIV and AIDS response in the areas of prevention, care and support.

My Social Location

I am a man of forty years, married with two children, a boy and a girl. I am a Zimbabwean by nationality, living and working in Botswana. I am an academic, teaching and researching at the University of Botswana in the area of theology and religious studies. I am also an ordained minister of the Church of Christ. Apart from teaching theology and religious studies, I have conducted research in the area of HIV and AIDS. I have led several research projects on religion and HIV and AIDS and in one of these projects we developed a strategy for HIV and AIDS response by the faith sector in Botswana under the auspices of the Ministry of Health. I therefore address issues of ethno-cultural factors and HIV and AIDS from my social location perspective. Much of

³ The Church in Africa is a significant player in HIV and AIDS response (see Dube 2008, Igo 2009, Parry 2013 on the Church and HIV and AIDS response). I also focus on the Church here since I consider it better placed to deal with issues of cultural and religious beliefs that have an impact on HIV and AIDS response. During the missionary period, it is the Church that condemned African religious and cultural practices. The Church may consider reversing this attitude in this post-colonial and HIV and AIDS context where certain cultural practices can help in HIV response.

what I say in this essay is therefore based on my experiences as a man living in Zimbabwe and Botswana, privileged to impart wisdom to others (in church, at institutions of higher learning, to government policy makers etc). My social location also allows me to be able to compare and contrast what I have experienced, what I have learnt from my Shona⁴ culture with what I know of other cultures through travel, research and reading.

Socio-cultural and Religious Beliefs and Practices that fuel the spread of HIV and AIDS

A number of African traditional beliefs and practices have come under fire in this era of HIV and AIDS (PACANet 2011). It is therefore not possible for me to exhaust them in this section. I select a few for discussion, exposing why they could be risky beliefs and practices in the context of HIV and AIDS.

Stigmatisation

Despite many years of education, people infected or affected by HIV and AIDS remain stigmatized. A number of people, especially in churches, continue to associate the condition with immorality. The level of HIV and AIDS stigma is seen in that very few church leaders have publicly declared their HIV positive status. Very few churches also provide an environment that allows people living with HIV and AIDS (PLWHA) to come out in the public and declare their status. In the Church of Christ, I am not aware of anyone who has declared his/her positive status among laity and clergy despite the fact that in Zimbabwe the HIV rate stands at 15% and in Botswana it stands at 17.5%. Pastors also tend to avoid the topic as it is possible to go for a whole year without hearing a sermon addressing HIV and AIDS.⁵ We all act as if the Church is full of people not infected or affected by HIV and AIDS.

Bride wealth

Most African societies practice the payment of bride wealth or *lobola*. Traditionally understood to be a sign of appreciation of the man to his wife's family, *lobola* seems to have lost its symbolic meaning in contemporary settings. In Zimbabwe there are many cases of parents who ask for luxurious items such as cars, expensive cell phones, large amounts of money, etc for *lobola*. In Botswana, some ethnic groups ask for as many as eight herds of cattle, three goats and a sheep over and above some other monetary charges. In cases where the woman has fallen pregnant before marriage, 'damages' are charged resulting in the *lobola* prices doubling in some instances. This has made marriage very expensive resulting in many young people settling for cohabitation rather than marriage. The ability of marriage to stop the spread of HIV and AIDS has been questioned (Parikh 2007; Chirau 2006; Bruce and Clark 2004), however it remains the second most efficient method of HIV prevention after abstinence especially when the married are not infected and remain faithful to each other.

The problem with cohabitation is that it is not socially binding as the two just stay together without informing their relatives. As a result the cohabiting partners often break up and get new partners exposing themselves and their new partners to the risk of contracting HIV. Apart from making marriage expensive and promoting the risky

⁴ The Shona make up the largest ethnic group in Zimbabwe.

⁵ I have experienced this in the church I attend in Gaborone.

practice of cohabitation, *lobola* brings about gender imbalance in a marriage relationship. S. LaFont (2007:1-19) is right when she argues that today *lobola* is more often seen as payment for a bride, meaning that the husband and his family have purchased the woman, including her future domestic production and children. This practice therefore, right from the beginning of the marriage, appears to relegate the woman to an inferior position. It tends to put her in a powerless position that may promote sexual and physical abuse and also limits her ability to negotiate safe sex even when she knows her husband's unfaithfulness. In their study, Chiroro, Mashu and Muhwava (2002:16) found out that over 80% of Zimbabwean men believe that payment of *lobola* means that a woman becomes a man's property, "just like his bed, goats, cows, chickens, and so." They report that in one of their focus group discussions, one man challenged them, "Would you allow your goat to challenge you and decide what it wants? If women want equal rights, they should also pay *lobola*" (2002:16). I have heard similar views even among Christians. Some men strongly feel that payment of *lobola* declares them masters over their wives and therefore women cannot make decisions for them.

In Zimbabwe, the payment of *lobola* leads to many other cultural practices that have been condemned for the spread of HIV and AIDS. *Chiramu*, *kuzvarira*, *kugadzwa mapfwa* and *kugara nhaka*⁶ all are connected in some way to payment of *lobola*. *Lobola* entitles a man to *chiramu*, a practice whereby brothers-in-law are allowed to sexually play and touch young sisters-in-law in the confidence that they too are wives. Often it ends up in sex and in some families I have been informed that when the son-in-law visits the in-laws without his wife, he is given a sister-in-law to 'entertain' him over the night. This is a risky practice in the era of HIV and AIDS. Related to it is *kuzvarira*, which is a practice where a poor family marries a daughter, often an underage one, to a rich man in exchange for goods. More often than not, such a man would already be married to one or more wives. The practice leads to abuse of young girls and to their exposure to HIV and AIDS. The practice has the same effect as *kugadzwa mapfwa*, which is a practice of marrying a young girl to a son-in-law in the event of the death of his wife. I discuss *kugara nhaka* separately below.

Kugara nhaka (Levirate /Widow inheritance)

Levirate practices (*kugara nhaka* in Shona) are strongly connected to the payment of *lobola* as I argued above. The Zimbabwean (or generally African) understanding of marriage is that a woman marries the family not only her husband. As a result, traditionally all family members made contributions for the *lobola* in one way or the other. Although this has slightly changed for working class men who can raise the money to pay *lobola* for their wives, unemployed men and those in rural areas still depend on their parents or on bride price paid for their sisters to raise *lobola*. The woman is therefore not only married to her husband but to the whole family. This explains why when the husband dies, the woman is expected or even forced to marry someone in the family. Among the Shona people, this is either a brother or a nephew. This practice poses high risks of HIV infection both to the widow being inherited and to the one inheriting her.

Dangerous Masculinities

By dangerous masculinities here is meant ideas/conceptions of manhood that expose man to HIV and AIDS. Virility is a common expression of masculinity as Chiroro, Mashu and Muhwava (2002) studying Zimbabwean male psyche found. Their study

⁶ These Shona terms cannot be directly translated into English. I therefore explain them below.

established that generally Zimbabwean men think of sex as an activity that should result in optimal satisfaction for the man. The language that some men use in describing sex shows its close association with violence. I remember our adolescent sexual discussions describing sex by a language of violence. To have sex was referred to as *kutema* (to cut), *kubvarura* (to rip), *kurova* (to beat) and such other terms of violence. As a result manhood is characterized by having multiple partners. Even being infected with a sexually transmitted infection (STI) is given a masculine commendation: *nzombe inorwa inoonekwa nemivare* (a fighting bull bears scratch marks). This mentality results in no use of condoms, sexual coercion for women and even rape. This kind of masculinity finds it normal for men to have multiple partners as well, thus exposing themselves and their sexual partners to the risk of contracting HIV.

Anti-condom

The anti-condom attitude is taken both from religious and even non religious points of view. From a religious perspective, condomisation is seen as promoting unfaithfulness. In a study of faith based organizations (FBOs), Togarasei, et al (2008) found out that nearly all faith organizations in Botswana were against the use of condoms, especially outside marriage. Respondents found it incompatible for a Christian to carry a Bible and a condom at the same time. In the early 2000s, Pastor Noah Pashapa of the Baptist Church in Harare, raised a controversy when he suggested distributing condoms in the church and went on to keep some in his office at the University of Zimbabwe where he was a part time lecturer. The general public perception was that the pastor was promoting fornication and adultery. I remember a certain lady raising the topic of the use of condoms by married couples at the Church of Christ annual conference in Harare in 2009 in a couples' meeting. She raised the question as a complaint and a report to church pastors that there were some young women who were asking their husbands to use condoms when they come back from migrant employment.⁷ It soon emerged that the issue had earlier been discussed in the women's fellowship groups and an agreement was reached by senior women that such women were not being 'submissive' to their husbands. Condoms are so shunned that there is a strong belief that they should not be used even in marriage. This is also coupled with the fact that there are many Christian organizations that are against the use of contraceptives.

From a non-religious perspective, condoms are shunned on the basis of people's understanding of sex. For those against condoms, sex with a condom is like 'having a shower with a raincoat' or 'eating a sweet in its wrapper'. In their study, Chiroro, Mashu and Muhwava (2002:25-29) found out that many Zimbabwean men (over 90% of their respondents), had a negative attitude towards condoms describing them as causing HIV, itchiness, many other diseases especially with prolonged use, as denying sexual pleasure, as providing false sense of security and as showing mistrust especially for those with a long term relationship. From our study in Botswana (Togarasei et al 2008), the attitude towards condom use from a non-religious point of view seems to have improved especially for casual sex with first time partners. The problem arises when relationships are long term and people get to 'know' and 'trust' each other.

⁷ Since 2000 Zimbabwe has seen many young men leaving the country to seek employment in neighbouring countries like South Africa and Botswana. Many of these young men leave wives behind and some of them come back ill, often, with HIV and AIDS. It is these wives who, on noticing that the husband might be infected, ask for use of condoms.

Sex should be practiced but not publicly discussed

Concerning the secrecy that shrouds sex among most African people, Chitando and Togarasei remarked, “Were it not for the children born, couples would never disclose that they have sex” (2008:4-15) Yes, African traditions shroud sex such that we grew up being told that children are bought from the hospital. A number of people, both in and outside the church, are uncomfortable talking publicly about sex. I remember the last time we would publicly talk about it was when we were adolescents. Thus, although people practice sex almost ‘daily’ they rarely talk about it publicly. This is true even between parents and children. This is because the subject of sexuality is often associated with shame and guilt. Many of us have learnt about sex from peers. Never would parents directly address the subject except to tell you of the dangers of contracting HIV and AIDS. Even parents find it difficult to address the topic. When should I start introducing the topic? Should I open up and talk about use of condoms? Is it not that when I introduce the topic I am telling him/her of the existence of the practice? Should I continue assuming that she/he is not aware of it? These are some of the many questions parents encounter in trying to talk about sex to their children. Failing to get answers, many parents often realize too late the need to have introduced the topics earlier.

In Church the subject of sexuality is even more difficult to discuss publicly. Amanze (2007:36) sees this as a result of the negative theology of sex and human sexuality that has been the hallmark of Christian ethics from the apostolic age to the present day. The Church limits sex only to those who are married. This is despite the glaring truth that very few in Church live by this moral standard. This is evident from the fact there are many unmarried people who get pregnant or make others pregnant in the churches. Many youths have premarital children. Some of them end up getting married and rising to become church leaders. These are clear indications that many Christians are not able to abstain from sex.

Women cannot initiate sex, their No means Yes!

It is only recently in Zimbabwe that cases of women raping men have been reported (*The Herald*, 6 October 2010). In the majority of cases, women are the victims of rape by men. Cases of women rape are so high that in 2002 Caroline Dempster of the BBC reported that South African women have high chances of being raped than of learning how to read (<http://news.bbc.co.uk/2/hi/1909220.stm>). The high rape cases have a lot to do with cultural beliefs, for example, that women do not initiate sex.⁸ I remember our older adolescent peers telling us that women will never tell you that they want sex. Even when they want they will pretend that they do not. The belief was that the mere fact that she has accepted your love proposal is enough to tell that she wants sex. Thus men ‘force’ women to have sex assuming that even when they say ‘no’ to sex they are just following the cultural expectation not to openly accept. Because of such beliefs there are some women who have their first sexual encounters through rape. The belief also makes women even in marriage relationships vulnerable. In their study, Chiroro, Mashu and Muhwava (2002:20) found out that Zimbabwean men believe that there is no rape between people who know each other, are married or are in love. As they write:

They (men) argued that agreeing to a relationship means that the woman has given the man the right to do whatever he wants with her body, including sexual

⁸ The high rates of rape in Africa referred to by Caroline Dempster are also a result of criminal rape cases. However, I am of the opinion that there are many other unreported cases of men forcing their girlfriends into sex.

penetration... In their view, no married woman can be raped by her husband because marriage means the woman can comply when the man wants 'to have it'. One man retorted: "How can I be told that I stole that which I bought, its mine to use whenever and whatever way I want!"

The belief that women do not consent to sex leaves women not empowered to decide on safe sex. It also does not give the perpetrators the chance to put on condoms. This often happens in what Cowan (2000) calls 'date or partner rape.' The following is a description of what happens to most women for their first sexual intercourse, what Cowan calls date or partner rape,

"Claire and Steve had been dating for a year and were planning to be engaged. Claire had told Steve that she did not believe in having sexual intercourse until after marriage, and Steve seemed to understand. One Friday while at their favorite lookout, Steve and Claire began kissing. Soon the kissing escalated and Steve threw her down on the seat and pinned her arms down with one hand while he ripped off her clothes with the other hand. Claire cried "No," but Steve overpowered her and had sexual intercourse with her" (Cowan 2000:812).

The description above suits what our older adolescent peers told us about having sex with your girlfriend. There was no belief that this could be called rape. "Women do not consent to sex, even when they want it they will appear to resist," were the words of our older peers. The belief was that only prostitutes can openly talk about and consent to sex.⁹

Polygamy and its modern forms

A number of both ethnic and Christian communities in southern Africa, e.g. in Zimbabwe and South Africa, practice polygamy. Apostolic churches lead the pack of Christian communities that practice it. The relationship between the practice of polygamy and HIV and AIDS is, however, contested (Saddiq, Tolhurst, Lalloo and Theobald 2010:146-151). Whereas some think polygamy exposes people to HIV and AIDS, others think it is a solution. Some members of the Johane Apostle Church of God in Botswana (otherwise known as Bazezuru) believe that it is not polygamy that poses a risk to HIV and AIDS but promiscuity by the monogamous. One member of the church, Nomsa Tatenda, said the following about polygamy, "I would say it's much safer to have two or more wives legally than to have several illegitimate partners." Be that as it may, polygamy raises the risk of HIV transmission since if one of the many partners is infected chances are high that it will be spread among the other partners. But Nomsa Tatenda's observation has been confirmed by a number of studies. For example, Saddiq et al (2010:150) concluded from their study in Nigeria that, "it is not polygamy/monogamy per se that shapes vulnerability to HIV and AIDS; but the ways in which women and men experience different types of marital union, which in turn is inextricably linked to religious discourses and gender roles and relations." It is mainly modern forms of polygamy in the form of multiple partners, so-called 'small houses,'¹⁰ that pose high risks of HIV transmission. A number of men in southern Africa are in

⁹ These are obviously the claims of men. Women's agency in sexual relations requires investigation.

¹⁰ 'Small house' is a term used in a number of southern African countries such as South Africa, Zimbabwe and Botswana to refer to the practice of having other sexual partners apart from one's wife or husband.

the habit of this practice, where they have one woman they are legally married to and several other women they have sexual relations and/or children with. Often those who practice it believe they have enough money to look after more than one wife as my story below testifies: Some years ago, I caught a lift from one gentleman from Masvingo to Harare. This is a 300km distance. On our way we started discussing various topics. I soon learnt from this man that he was coming from spending the weekend with a girlfriend. I enquired as to why he was doing this in this age of HIV and AIDS to which he responded by expressing his disbelief that I did not have a girlfriend. I explained to him that I am a God fearing man who loves his wife that I would not cheat on her. He had one last response, “Young man, you still do not have money. When you have it, you will get one and remember me!”

In Botswana, apart from polygamy, the practice of multiple partners is also sometimes promoted by cultural practices like concubinage. Nkomazana (2007:66) has it that traditionally women were not supposed to have sex when they were still breastfeeding. During this time (which could last up to two years) the man was free to seek a concubine if he was not a polygamist. There was also a belief that a man is shared like a calabash of water or an axe and as a result should not be asked where he has been or where he slept (Dube 2003:91).

Need for children especially, male children

Many Africans value children and see the birth of children as the primary purpose of marriage. In most of the southern African societies which are patriarchal, it is not only the need for children, but for male children. Problems arise when a couple fails to have children or when they fail to have male children. A childless marriage is therefore risky in terms of contracting HIV and AIDS. Often men (and in rare cases, women) will go out to ‘test’ themselves with other women. This exposes them and their wives to HIV and AIDS. The need for children also leads people to practice what is called *kupindira* in Shona. *Kupindira* is a practice in which a brother secretly has sex with his sibling’s wife if it is believed that the said brother cannot make the wife pregnant. Often the husband of the wife will not be aware of the arrangement which is usually made by elder members of the family. Again this poses high risks for the spread of HIV.

Anti-gays, lesbians and bi-sexuals

Except for South Africa, all other African countries do not recognize same sex marriages or the free association and sexual expression of gays, lesbians and bisexuals.¹¹ In some countries like Botswana, the law even criminalizes such acts. Human rights activists, however, argue that this contributes to the spread of HIV and AIDS. Discussing in a programme called Law Matters on 28 October 2010 on GABZ FM (a Botswana radio station), the director of Botswana Gays, Lesbians and Bisexuals of Botswana, mentioned that a study they had conducted two years earlier among men who have sex with other men pointed out that of the 120 men who participated in the study, 17% were HIV positive. They attributed this to the society’s non-acceptance of these people which results in them practicing unsafe sex. She pointed out that some of these men were married as a result of social pressure and thus were involved in multiple concurrent partnerships, heterosexual and homosexual.

¹¹ These are just official positions. There are many Africans who confess that they are gay, lesbian, bisexual or other sexual orientations. Thus in Zimbabwe, for example, the Gays and Lesbians Association is an active association advocating for the rights of sexual minorities. In Botswana Lesbians, Gays, Bisexuals of Botswana (LEGABIBO) is fighting for official recognition and registration as an association.

Other myths and misconceptions about HIV and AIDS

There are also many other ethno-cultural and religious beliefs that fuel the spread of HIV and AIDS. Such myths and misconceptions include the belief that God is in control of everything and therefore even cures HIV and AIDS. This myth has led some people to discontinue anti-retroviral treatment (ART) believing that they only need the power of God for healing. The danger here is that such people will get ill or pass on the virus to others thinking that they have been cured. Closely related to this misconception is what Togarasei (2009) calls blind faith. This is the belief by Christians that since God is in control of everything, then individuals cannot control their fate. No effort is then made to abstain, test or seek medical help believing that God is control. Musopole (2006:10) also noted this among Malawian young people some of whom even cited Ecclesiastes, “to everything there is a time” In defense of blind faith. Other misconceptions include the belief that sex with virgins cures HIV and AIDS. In Botswana, Nkomazana (2007:66) says the misconception stems from the traditional belief that sex with a young woman rejuvenates the blood of a man. As a result, it is then believed that sex with such a woman, especially a virgin, cleanses HIV from a man’s blood.

Other myths include the rejection of Western medicine by some Christian groups. In Zimbabwe, the Johane Maranke¹² is one such church that is against Western medicine. This attitude means if their members are infected by HIV and AIDS, they do not enroll in ART. Kealotswe (forthcoming) also talks of many other misconceptions about HIV and AIDS in Botswana. He tells the practice among the Kalanga in northern Botswana where traditionally sexually mature girls were advised to have sex with sexually immature boys while sexually mature boys were advised to have sex with sexually immature girls to avoid pregnancies. Whereas such a practice was seen as a contraceptive traditionally, it presents high risks of HIV infection today.

The association of HIV and witchcraft also stands in the way of turning the tide of HIV and AIDS. Associated with stigmatization which I discussed above, many families do not accept that their beloved ones are infected by HIV and so attribute the illness to witchcraft. This results in people not taking responsibility of their health and exposing themselves to HIV and AIDS. Related to associating HIV and AIDS with witchcraft is also the belief that HIV and AIDS is caused by the curse of angry ancestral spirits or a violation of sexual taboos. Such misconceptions lead to the stigmatization of the infected and people’s lack of responsibility to protect their sexual partners.

Socio-cultural and religious beliefs and practices that can be used as anchors for positive HIV and AIDS response

The foregoing section has discussed ethno, socio-cultural and religious beliefs and practices that may spell doom for Africa. Some African traditions appear to be a source of death. This is not only true on issues of health but also on other developmental issues as has been discussed by other scholars. But this is not the full story of African socio-cultural and religious beliefs and practices. Eurocentrism is accused by some scholars of negatively contributing to the development of Africa. It is believed to be pushing aside African traditions leaving Africans with no identity. Chitando (2009:39-54), for example, reviews works by many African scholars who take this view. These scholars have noted that not all is evil and suicidal in African traditions and culture. Rather there are many

¹² This is a different church from the Johane Apostle Church of God in Botswana referred to above.

other ethno, socio-cultural and religious beliefs and practices that can be tapped for positive HIV response, from prevention to treatment and care. In this section I look at some of these.

Teaching against pre-marital and extra-marital sex

Sex is the most common way by which HIV is spread in Africa. It is therefore important to revisit the traditional and cultural teachings and beliefs on pre- and extra-marital practices. Both religion and traditional culture are well placed to address the pandemic. There is a strong belief especially among elders that HIV and AIDS is result of lax moral practices promoted by Westernization and urbanization. Like Christianity and Islam, African traditions also promoted abstinence and faithfulness in marriage. Virginity, for example, is highly valued in many traditions and religions in Africa. In traditional Zimbabwe, for example, on discovering that his wife was not a virgin, a man was allowed to return her to her parents and demand his bride wealth back. Not only was the virginity of girls checked, boys were also discouraged from pre-marital sex. There was proper sexual education through traditional family structures. In some communities in southern Africa, there were initiation schools for boys and girls. Christianity came and discouraged such schools and was not able to provide substitute institutions in its structures. In contexts of HIV and AIDS such cultural practices need to be revisited and strengthened.

Communitarianism

Despite the forces of urbanization and its promotion of individualism, most African societies, especially in the rural areas, still uphold the traditional African communitarian ethics and way of life. The communitarian concept sees an individual in the bigger picture of community. In the words of John Mbiti (1969:108) the concept can best be summarized and understood through the phrase, “I am because we are; and since we are therefore I am.” Although some thinkers like Jonathan Gichaara (2008:188-199) see the concept as leaving most African women in a vulnerable position in the negotiation for safe sex, the concept promotes care of the infected and affected. Because people see themselves linked in relationships, they take it to be their responsibility to provide care to those of their own who are ill. Coupled with the Christian teaching of neighborliness, African communities are caring communities. No wonder many people will trace their steps back to the rural areas when they get ill from HIV. African communities also allow for the care of orphans left by those dying of HIV. The extended family structure allows for the care of one’s relative’s children. Such reception and care of the orphans is not seen as a choice but an obligation. The neglect of one’s relatives is met with strong community criticism. Considering the number of people who have succumbed to HIV and AIDS, was it not for this communitarian concept that call people to take care of the children of their departed relatives, there would be uncountable orphans requiring state assistance in most African countries.

Religious compassion and concern for morality

Most religious organizations are known for their compassionate practices. In a rapid assessment study conducted in 2009 to develop a strategy for FBOs response to HIV and AIDS in Botswana (Togarasei, 2009), it was found out that most of the home based care programmes operating in different villages and towns were run by churches and religious NGOs. Generally, most religions and traditional cultures believe in the sanctity of life. They therefore attach high importance to the preservation of all life and they believe that serving God involves serving humanity through compassionate acts to all the suffering and the needy. Such beliefs and attitudes have led some of the religious groups

to be committed to the care and support of people infected and affected by HIV and AIDS through home-based care programmes, independent and organized home visits, hospital ministry, hospices, encouraging testing and enrolling in ART. In Botswana some churches are even involved in the provision of anti-retrovirals (ARVs) to migrant communities who do not benefit from the government programme.

Generally, most religions and traditional cultures teach love for the whole of humanity. This teaching should be adopted and emphasized to encourage care of the infected and affected. The same should also be done concerning religions and cultures' teaching of altruistic ethical systems. We have seen above that most of these ethical teachings, e.g. against pre-marital and extra-marital sex, contribute to reducing the spread of HIV. This is also true of religious and cultural teachings against alcohol and drug abuse, factors that are associated with the spread of HIV.

HIV as a violation of sexual taboos

The belief that HIV is a result of violation of sexual taboos can be utilized for HIV prevention. Most traditional African societies had a number of taboos that were meant to limit the practice of sex among the married. Some people in Botswana, for example, believe that HIV is a result of the accumulation of sperms in the womb of a woman who has had many sexual partners. This understanding discourages multiple sexual partnerships by women. There were also taboos that controlled promiscuity by men. Although there is need to correct the misconception of the causes of HIV, the teaching's discouragement of many sexual partners is a good starting point for teaching abstinence and faithfulness to one sexual partner. There is therefore a need to adapt this teaching in the era of HIV and AIDS.

Socio-cultural and religious beliefs and practices in times of HIV and AIDS: Reflections

In the foregoing section, I have looked at religious and traditional cultural beliefs and practices which are, from the outset, positive for HIV response. In this section I want to revisit some negative cultural and religious beliefs and practices and suggest ways by which they can be healed/adapted for them to 'heal' HIV and AIDS. It is my conviction that any attempt to contain the spread of HIV and AIDS and successfully mitigate the impact should take the people's culture and traditions seriously. Although African culture and traditions are changing with some waning with time, people still take pride in them. Culture is the sum total of people's life, from beliefs, food, the way they think/dress/behave etc. It cannot be completely abandoned. There is need to modify and adapt traditions and cultural practices for positive HIV and AIDS response. African church leaders who met in Nairobi in 2001 resulting in the formation of the Ecumenical HIV and AIDS Initiative in Africa (EHAlA) noted this need. However, as Chitando (2009:43) correctly notes, nothing much has been done. There is need to rethink such practices and beliefs and suggest ways of using them for positive response. The Church is a key player in this process as it was originally responsible for the denunciation of African culture (Amanze 1998). This is because so long as a people's culture is lambasted without an alternative being provided, such beliefs and practices do not die but simply go underground from which they even have more disastrous effects. Culture provides identity and should evolve naturally as the circumstances of the custodians of the culture changes. When it is forced to change, it often becomes stubborn and never changes. What I suggest below is what influenced the title of this essay, 'healing culture, healing

AIDS”. My reflections below are mainly focused on the Christian religion, being a Christian myself and living in predominantly Christian communities. Space does not allow me to discuss all possible ways of healing culture for healing HIV therefore I limit my reflections on polygamy, bride wealth, widow/widower inheritance, open discussion of human sexuality and the debate on the use of condoms.

Polygamy

There is a need to rethink polygamy in light of the reality that many men have more than one sexual partner in Zimbabwe. Of course this raises problems in view of the need for gender equality. Should women also be allowed to have many sexual partners? Many men who have many sexual partners argue that they do so because they are not sexually satisfied by one woman. In their study in Zimbabwe, Chiroro, Mashu and Muhwava (2002:24) say a common response by men was that, “because men need more sex than women, they have to sleep with other women to satisfy their sexual desires.” Others, however, cite the fact that generally women are more than men. In most of the African countries, women form over 50% of the total population. In Botswana, for example, Kealotswe (forthcoming) estimates that in some communities, the ratio of men to women is sometimes 1:7. What should happen to the rest of the women if society insists on monogamy? What about the many young women widowed by HIV and AIDS? Traditionally in Botswana, these were catered for through polygamy or concubinage. I have also referred above, to a study from South Africa that showed that having many sexual partners is seen as a sign of true masculinity. A study in Namibia (cited by van der Brug 2007:41) also found out that, “For many men, a relationship with only one woman would have a negative connotation and would be associated with poverty, a low status and weak masculinity.” Although there are also many cases of women who are having many sexual partners, more often the reasons given for such practices have to do with economic factors: money and gifts (van der Brug 2007:41, Weinreich and Benn 2004:28). Men also justify polygamy on religious grounds with Christians citing the many biblical cases of polygamy for the argument. Is it time the Church begins to rethink polygamy especially as studies in polygamous communities (Brempong 2007:82) and among Muslims who practice polygamy have shown lower HIV prevalence rates? There are some churches that accept polygamy but the majority of churches in Africa despise the practice.

Bride wealth

This is another cultural practice that requires healing. Elsewhere I suggest its total abandonment (Togarasei 2012). There are some churches (e.g. Jehovah’s Witnesses) that are against practice of asking for bride wealth. But in view of the need to respect cultural practices for positive HIV programmes, it would not be wise to do so. Possibly, the best way is for Africans to go back to the traditional meaning of bride wealth. Traditionally it was supposed to be simply a sign of appreciation. Perhaps the Church and other traditional institutions like that of the chief, should advocate for lower bride wealth as a step towards total abandonment of the practice or the bride’s family must also give some tokens of appreciation to the groom’s family so that he does not feel superior to the bride.

Widow/Widower inheritance

This is another practice that needs healing. The general aim of the practice is commendable. A widow’s children need a father figure while a widower’s children also need a mother figure. The widow or widower, especially those who will still be young

also have sexual needs. Cultural practice meant to cater for these needs are positive. The only risky and negative factors are forcing the widow/widower into unconsented sexual relationships and engagement in sex without having tested for HIV and AIDS. The Church and other traditional institutions should therefore call for disassociation of inheritance and sex. Widow/widower inheritance should be limited to providing security, psychological and material support to the bereaved family. The widow/widower should also be allowed to make their choice as whether they want to marry or who they want to marry. The Church, which for a long time has been teaching against these cultural practices, should therefore not condemn them *in toto* but rather should adopt and adapt them.

Open discussion of human sexuality

The pushing of sexuality into a little corner in the public discourse of the Church and society needs to be healed in order to heal AIDS. Amanze (2007:28-47) has already called for the need by the Church to construct a positive theology of human sexuality. The Church together with other traditional institutions should help parents open up discussion on sex with their children. Traditional African cultures such as the Shona, often placed this responsibility in the hands of aunts and uncles. The disintegration of the traditional family due to urbanization means the aunts and ankles cannot continue playing this role. The Church is better placed to take over this role. As Amanze (2007:39) argues citing scripture and Christian theologians, “human beings are required to enjoy sex, celebrate and treat sex and human sexuality with the utmost responsibility.” The subject of sexuality should be given urgent attention in the light of HIV and AIDS. It is through the public discussion of sex that dangerous masculinities discussed above can be tackled. It is also through public discussion of sex that women can be freed from the bondage of culture that silences them from initiating sex even with their partners and calling for safer methods of having sex. Treating sex as a taboo has really not been useful in our contexts of HIV and AIDS.

The Church has another compelling reason for it to quickly address the issue of sexuality. Traditionally, sexuality was also addressed through initiation ceremonies. The Church abandoned these and had nothing to replace them with. In a recent seminar, a respondent argued that the unprecedented problem of HIV in Africa is a result of Africans’ identity crisis. He said the condemnation of African traditional beliefs and practices by Christianity and Western cultures has left Africans with no culture to hold on to. This is true with respect to initiation ceremonies. It is time Church and society should reconsider the reintroduction of such cultural practices. The health community’s call for circumcision as an HIV preventive measure is a sign of the fact that not all cultural beliefs and practices pose danger to HIV and AIDS.

Condom debate

The condom debate continues unabated. Whether this is due to the Church’s theological rigidity or timidity/mediocrity (Chitando 2007:16), is not clear. Studies show that generally churches are against the promotion of condom use. This is very unfortunate and is therefore a religious belief that needs healing. It is very clear that there are many people who fail to live up to the moral standards required by the Church. Considering that the Church allows repentance, surely those who sin should live to repent. Condoms have proven to have a high protection rate against HIV. The Church should therefore encourage its members who fail to abstain or being faithful to at least ‘fail alive’ and have a chance to repent. This should be based on the sanctity the Church attaches to life. The

Church should also think of many ‘sinners’ outside the Church there who are its potential members. It should encourage them to protect themselves against HIV and AIDS until they are converted and be able to live by the ethical teachings of the Church. Doing the two in no ways promotes promiscuity. After all, those who proceed to get HIV through sexual immorality while members of the Church, would have sinned anyway, whether protected or unprotected.

Conclusion

If there is anything that many African countries have succeeded in doing in this era of HIV and AIDS, it is to make people aware of this pandemic. Billboards, televisions, radios, newspapers, films, drama and all other forms of communication have been used to promote HIV awareness. Sex education has been gradually integrated into the formal school system with all ways of mainstreaming HIV in curricular and workplaces suggested. Most of these awareness programmes and activities have sought to undermine religious and cultural practices that seem to promote the spread of the pandemic. Surprisingly, equipped with all the knowledge, people’s behaviours have not changed. Many people have decried the fact that knowledge has not translated into behavior change (Musopole 2006:12). What could be the causes of this reality? I have argued in this essay that one of the reasons could be the fact that HIV policy makers have paid too much attention to the negative impact of religious and cultural practices at the expense of those that can be used positively.

I have argued that religion and culture provide a grid of meaning and value systems for people and therefore should be taken seriously in HIV and AIDS response. Policymakers therefore need to design and implement policies that capitalize on the positive aspects of culture, while curbing the negative aspects. The essay has especially paid attention to those cultural practices which have for long been seen as promoting the spread of HIV, suggesting ways by which they can be ‘healed’ for positive HIV response. Instead of dumping all cultural practices into the rubbish bin, “Sensitivity to cultural attitudes is critical if there is going to be behavior change; otherwise people simply block the message, treat it as unacceptable and continue with their old ways of behaving.” (Musopole 2006:16).

REFERENCES

Amanze, James. N. ‘Stigma: The greatest obstacle in the fight against HIV/AIDS in Africa,’ in J. N. Amanze (Gen. ed.), *Christian Ethics and HIV/AIDS in Africa*, Gaborone: Bay Publishing, 2007, pp. 28-47.

Berner-Rodoreda, Astrid, *HIV and AIDS in Africa: A female epidemic requiring only a female response?* Stuttgart: Bread for Life, 2006.

Brempong, Osei-Wusu, ‘HIV/AIDS in Africa: Christian Ethics in Ghana,’ in J. N. Amanze (Gen. ed.), *Christian Ethics and HIV/AIDS in Africa*, Gaborone: Bay Publishing, 2007, pp. 70-85.

Bruce, J. and S. Clark, 'The Implications of early marriage for HIV/AIDS policy,' brief based on background paper prepared for the WHO/UNFPA/Population Council Technical Consultation on Married Adolescents, New York: Population Council, 2004.

Chirau, S. (2006) 'Till Death Do Us Part: Marriage, HIV and the Law in Zimbabwe,' The Berkeley Electronic papers, <http://law.bepress.com/expresso/eps/1419>.

Chiroro, Patrick, Mashu, A. and Muhwava, W. *The Zimbabwean Male Psyche with Respect to Reproductive Health, HIV, AIDS and Gender Issues*, Harare: Centre for Applied Psychology, 2002.

Chitando, Ezra, *Troubled But Not Destroyed*, Geneva: WCC Publications, 2009.

Chitando, Ezra, *Living with Hope: African Churches and HIV/AIDS 1*, Geneva: WCC Publications, 2007.

Chitando, Ezra and Togarasei, Lovemore, 'Woman, where are they?: John7:53-8:11 and stigma in the context of HIV and AIDS,' *Missionalia: Southern African Journal of Missiology*, Vol. 36:1, 2008, pp.4-15.

Cowan, Gloria, 'Beliefs about the Causes of Four types of Rape,' *Sex Roles* Vol. 42:9/10, 2000, pp. 807-823.

Dube, Musa W. 'Social Location as a Story-telling Method of Teaching in HIV/AIDS Contexts' in Dube, Musa W. (ed.), *HIV/AIDS and the Curriculum: Methods of Integrating HIV/AIDS in Theological Programmes*, Geneva: WCC Publications, 2003.

Dube, Musa W. *The HIV and AIDS Bible: Selected Essays*, Scranton and London: University of Scranton Press.

Gichaara, Jonathan, 'Women, Religio-Cultural Factors and HIV/AIDS in Africa,' *Black Theology* Vol. 6:2, 2008, pp.188-199.

Igo, Robert, *Window into hope: an invitation to faith in the context of HIV and AIDS*, Geneva: WCC Publications, 2009.

Kealotswe, Obed, *The African Independent Churches and Marital Problems in Botswana: A study of the African Independent Churches' solutions to marital problems as experienced in present day Botswana*, forthcoming.

LaFont, S. 'An Overview of Gender and Sexuality in Namibia,' in LaFont, S. and D. Hubbard (eds.), *Unravelling Taboos: Gender and sexuality in Namibia*, Windhoek: Legal Assistance Centre, 2007, pp. 1-19.

Mbiti, John S. *African Religions and Philosophy*, Nairobi: Heineman, 1969.

Musopole, Augustine, *Spirituality, Sexuality and HIV/AIDS in Malawi: Theological Strategies for Behaviour Change*, Zomba: Kachere Series, 2006.

Nkomazana, Fidelis, 'Christian Ethics and HIV/AIDS in Botswana,' in Amanze, James, N. (Gen. ed.), *Christian Ethics and HIV/AIDS in Africa*, Gaborone: Bay Publishing, 2007, pp. 48-69.

PACANet, *Ethno Cultural Factors and HIV and AIDS*, Kampala: Pacanet, 2011.

Parikh, S. A. 'The Political Economy of Marriage and HIV: The ABC Approach, "Safe" Infidelity and Managing Moral Risk in Uganda,' *American Journal of Public Health*, 97:7, 2007, pp. 1198-1208.

Parry, Sue, *Practicing Hope: A handbook for building HIV and AIDS competence in the churches*, Geneva: WCC Publications, 2013.

Pinielo, Isaac and Pini Bothloko, 'Botswana: Bazezuru, Polygamy and HIV/AIDS', *Mmegi online*, 8 March 2010.

Randolph Tate, W. *Interpreting the Bible*, Massachessets: Hendrikson Publishers, 2006.

Saddiq Abdullahi, Rachel Tolhurst, David Lalloo and Sally Theobald, 'Promoting vulnerability or resilience to HIV? A qualitative study on polygamy in Maiduguri, Nigeria', *AIDS Care* Vol. 22:2, 2010, pp. 146-151.

The Herald, 6 October 2010.

Togarasei, Lovemore, 'Paul and Masculinity: implications for HIV and AIDS responses among African Christians,' in Chitando, Ezra and Chirongoma, Sophia (Eds.), *Redemptive Masculinities*, Geneva: WCC Publications, 2012.

Togarasei, Lovemore, *Rapid Assessment Report for FBOs Strategy for HIV response*, submitted to Ministry of Health Botswana, Gaborone, 2009.

Togarasei, Lovemore; Jensen, Kipton; Nkomazana, Fidelis, Haron, Muhammed; Mmolai, sana and Sebina, Lucia, *An Assessment of the Capacity of faith-Based Organization to Prevent HIV in Botswana: a report*, Gaborone: Associated Press, 2008.

Tolbert, Mary Ann, 'The politics and poetics of location,' in F.F. Segovia and M.A. Tolbert (eds.), *Reading from this place: social location and biblical interpretation in the United States* vol. 1, Minneapolis: Fortress Press, 1995, pp.305-317.

Van der Brug, Mienke, *World and experiences of AIDS orphans in north central Namibia*, Leiden: African Studies Centre, 2007.

Weinreich, Sonja and Benn, Christoph, *AIDS- Meeting the Challenge: Date, Facts and Background*, Geneva: WCC Publications, 2004.

<http://news.bbc.co.uk/2/hi/1909220.stm>

Book Reviews

James L. Cox 2014, *The Invention of God in Indigenous Societies*. Durham: Acumen, x + 182 pp., ISBN 978-1-84465-754-4 (hbk), \$76.86; ISBN 978-1-84465-755-1 (pbk), \$24.05

This book examines the submissions of writers in both indigenous and non-indigenous religious traditions on indigenous religion as a religion in its own right. Thus the book sought to critique writers who seek to discover 'the Christian God in Africa' rather than to understand indigenous religions in their own right. The author presents four case studies in this quest: New Zealand, Zimbabwe, Australia and the Yupiit of Southwest Alaska. In addition, the book attempts to explicate controversies on the academic and theological study of religion. The book comprises an introduction, six chapters, notes, bibliography and an index.

The introduction provides a two-pronged definition of Religion: Substantive and Functional. The substantive delineates religion from other aspects of human behavior or alternate reality which believers enter into during ritual. The functional address the communal and social roles of religion. The author maintains that all religions are invented 'because religious authority is obtained from postulated alternate reality to which appeals are made to validate the power of transmitted tradition'. However the word 'invention' should not be construed as 'deceit' because all traditions are 'invented and legitimate'. Inventions are conscious efforts to link ancient traditions with recent religious innovations for purposes which suit the aims of those doing the inventing. Such inventions emanate due to two possible agendas: attempts to discover a 'Supreme Being among indigenous populations prior to extensive contact with Christian missionaries and Western patterns of thought' and 'motives of those who make contentions about indigenous deities as being commensurate with a High God or a Supreme Being'. A very important aim of this book is to 'expose the many agendas that inform a variety of interpretations of indigenous religious beliefs and to place them into historical, social and cultural contexts'. This in turn would show that the scientific study of religion is different/opposed to a theological study of religion.

Chapter One of the book examines the 'God Controversy' in pre-Christian indigenous Religions. Here the author asserts that the academic and theological interest in locating the Christian God in indigenous societies was fuelled by ideological presuppositions which pre-determined the interpretation of data. Those who argued for primitive monotheism did so primarily for theologically inspired reasons, while the anthropologists, writing with anti-religious bias were to study the societies which they believed were doomed to extinction. For both groups, the interest of indigenous people and their right as worthy subject of research were not recognized. The author discusses

the varied contributions of scholars on the utilization of the Darwin theory in defining indigenous religion. These scholars include Eric Sharp, Herbert Spencer, E. B. Taylor, J. G. Frazer, Baldwin Spencer, F. J. Gillen, and T. G. H. Strehlow. He identifies similarities in traditions espoused by Carl Strehlow and F. Muller, which in summary states that 'the origin of religion can be traced to the human propensity to grasp or apprehend the infinite through finite objects or symbols'. The author noted the dispute between Baldwin and Carl Strehlow concerning different submissions about the Aboriginal peoples. These differences are premised on ideological assumptions which he categorized into two: Evolutionist/Anti-religious sentiment and Primitive/Christian Theological bias.

The author identified Primitive monotheism (also known as the European Debate) as an issue of debate with Evolutionists. A notable contributor to this debate was Andrew Lang, whose interest in religion was divided into two by Sharpe. One, the mythological period (1873-1897) in which Lang engaged in polemic discussions opposed to Max Muller's 'nature-mythological' school. Two, the period (1897-1912), when his interest centred on arguments about the universal God. This was instigated by the discovery of an 'All Father' Figure in southeastern Australia called *Baiame* as reported by the anthropologist A. W. Howitt. Lange raised two objections to show that the 'primitive' people of Australia had a notion of a universal God before contact with Christian missionaries. These were: one, the people did not offer gifts to their 'All Father' like the missionaries prayed to the Christian God and two, they only initiated men who knew the name and knowledge of the 'All Father'. The author mentions the report of Manning John, a settler who recounted how the indigenous people held belief in *Baiame*, who bore similarities to the Christian God; however, no missionary had any direct contact with Aboriginal people as of the time of Manning's report. This suggests that Manning's report may not adequately represent the position of the Aboriginal Australians on *Baiame*. Lang argues further that this existing belief in 'All Father' later degenerated into animism and that explains why the scholars who visited people like the Arrernte did not find the 'All Father' belief on ground. Lang concludes that 'belief in the Australian High God, the 'All Father' called *Baiame* is not the result of Christian influences'. The author of this book submits that Lang's position is theological at its root.

Next the author analysis the position of Wilhelm Schmidt, the German-Austrian ethnologist, linguist and Catholic priest on scientific evidences for the idea of primitive monotheism. This Schmidt attempted through the study of Semitic languages, especially the language and cultures of the German protectorate of Papua Guinea. Schmidt in his 1910 book *The Place of the Pygmies in the Developmental History of Mankind* claims to have demonstrated that the pygmies of Central Africa believed in a High God/Supreme Being. Further, he claims that the attributes of the primeval Supreme Being are consistent with the high monotheism of Christianity e. g. omniscience, omnipotent, eternal and creative power. Lastly, the author surveys arguments of Mircea Eliade on Primitive Monotheism. Eliade's reference to the first line of the Christian Lord's Prayer 'our Father who art in heaven' as the 'most popular prayer in the world' is taken as a reference to primitive monotheism. Also, the author notes Eliade's version of the

degeneration theory which stressed that the original state of humanity is characterized by direct communication with God without need for mediators.

In sum, this chapter attempts an analysis of submissions by writers on controversies about the person, characteristics and names of God in pre-Christian indigenous religions. The author identified theological and anthropological agenda as roots that instigated some of the submissions. In addition, the author regards some of the 'scientific' evidences for linking God in pre Christian indigenous religion to Christianity as inadequate.

Chapter Two looks at the debate on the Supreme Being among the Maori of New Zealand known as *Io*. 'New Zealand foremost ethnographer' Elsdon Best provided the means for the wide acceptance that ancient Maori people believed in a High God called *Io* through his two Volumes titled *Maori Religion and Mythology* which was published in 1924. Further, Best submitted that the cult of *Io* is the highest form of Maori religious belief, the cult was secret and only a few could utter the sacred name. He described *Io* as a moral God. According to Best, creation and nature emanated from *Io* and *Io* is immanent in all things. Best concludes that this religion of the Maori and the cult of *Io* could not have been derived from Christian missionaries. Best had informants on Maori religion, the most prominent being Te Whatahoro, while another was Tutakangahau. In addition to the work of Best, the author identifies the important role of S. Percy Smith as custodian of some manuscripts, which were received from Te Whatahoro. Smith produced these manuscripts in translation as *The Lore of the Whare-wananga*, a very influential work, which was divided into two parts: 'Things Celestial' and 'Things Terrestrial'. The author submits that the works of Best and Smith had profound influence on Maori cultural revival of the mid-to-late 20th century which emphasized *Io* as a pre-Christian Supreme Being.

Other writers who contributed to the debate on *Io* as pre-Christian were identified and discussed by the author, including Rev. Maori Marsden who avers that *Io* brought the world into existence, and is the first cause from which all things originated. Also, Henare Tate, explained that the missionaries adopted the term *Atua* for Maori Supreme Being but indigenous Maori believed in *Io*, a name for God which predates Christian missionaries coming. He distinguishes the public use of the term *Io* and the *Io* tradition. Again, James Irwin published *An Introduction to Maori Religion* in 1984 where he discussed the ancient Maori belief in the Supreme Being *Io*. Then, Michael Shirres submits that *Io*, the Maori High God preceded contact with Christian missionaries and European powers. But from a theological frame, he summarizes his interpretation of *Io* as commensurate with the Christian faith.

There were arguments that the term *Io* was post European and post Christianity. Here the submissions of Sir Peter Buck also known as Te Rangi Hiroa subsist. He avers that some of the elements of the *Io* tradition could not have pre-dated Christianity. These included a cosmology of separating light from darkness, the waters from dry land and the suspension of the firmament. Also any reference to the righteous going through the 'east

door to ascend to supernatural realms and sinners through the south door to the underworld is contrary to the Maori and Polynesian concepts and too closely linked to the Christian teaching of Heaven and Hell' to have originated in indigenous Maori people. In the same vein, the author examined the position of Jonathan Z. Smith in the work *Imagining Religion: From Babylon to Jonestown on Io* as a post-European and post-Christian term. Smith questions the reliability of materials gotten from the text by Tiwai Paraone in the 1907 *Journal of the Polynesian Society*, with an English translation by Hare Hongi whose integrity, Smith found questionable. Smith concludes that these materials and others like them are 'made in passing without any critical reflection or ---obtained after exposure to Christian missionary influence'. Consequently he submits that *Io* as a High God is a post-European phenomenon probably developed around 1880s as a Maori parallel to the Biblical tradition.

The author also examined the possible impact of Whatahoro's conversion to Mormonism on his testimonies concerning the Maori *Io*. Whatahoro was an important informant on Maori tradition and narratives but also a convert to Mormonism and this may have influenced his submissions on *Io* traditions. The similarities between his narrations on revelation and creation among the Maori and the Mormon account on the same subjects were too close to be coincidental. If the principal source of information on *Io* as a pre Christian Supreme Being among the Maori can be proven questionable, then present narratives on *Io* as the Maori primordial creator crumbles. Moreover, the attempt to locate a pre-Christian Maori high God is not done for its own sake rather it is for veiled or superstitious purposes, such as ideological or theological reasons. Moreover, contemporary Maori Christians use *Atua* as the name of God in a new tradition, which is accepted by the majority of practicing Maori Christians.

Chapter three surveys the attempts at making *Mwari*, the Supreme Being among the Shona of Zimbabwe, Christian. The author utilizes oral traditions, historical records, linguistics analysis and cultural practices in this bid. To the Shona the Spirit world and the human social world are understood as parallel to one another with each influencing the other. There is however a difference between reactions from regions in Zimbabwe. The basic pattern correlating social and spiritual hierarchies persist to date among the Korekore of the northern and central regions of Zimbabwe but in the southern regions, the chiefs pay tribute at *Mwari* shrines, which are very famous. The most notable of such shrines is located at a hill called Matonjeni, in a cave from which *Mwari* speaks its oracles. Another submission on *Mwari* by D. N. Beach is that *Mwari* was specifically Rozvi High God, who was a combination of sky God and ancestral spirit. This submission by Beach is authenticated because to this day the traditional tribute system whereby the king received payment in exchange for ruling has been preserved in the *Mwari* shrines. Consequently the author concludes that *Mwari* was more like a fertility deity judging from the spiritual and social structures, as well as the traditional rituals for crop fertility throughout Zimbabwe for senior ancestor spirits (Mhondoro).

Furthermore, the author postulates that *Mwari*, the fertility deity and ancestor has been transformed to represent God the creator, the Father of Jesus Christ by

contemporary Zimbabwe Christians. The author examines three sources to emphasize this position: (1) the theory of Canaan Banana who was the first president of Zimbabwe. In his book *Come and Share* he sets out a theological argument for equating *Mwari* with the Christian God. He submits that the 'Shona people have a God by the name *Mwari*' and *Mwari* is composed of the noun prefix "mu" and the noun stem "ari" which translate as "He who is" similar to the God of Moses in the Bible who identify Himself as "He who is". Indeed, Banana bid to equate the God of Moses with *Mwari* culminated in his call for the Zimbabwe stories and myths to replace the Old Testament which led to controversies and the writing of articles from different perspectives in the Department of Religious Studies, Classics and Philosophy in the University of Zimbabwe in 1993. However, the author notes disparities in the presentation of the original myth by Kahari and the version by Banana. In Kahari's account it is apparent that *Mwari* is progenitor of a specific people, bound to a particular place and identified as being inseparable from ancestral traditions. These disparities to the author confirms that *Mwari* was originally a deity of fertility, who stood at the pinnacle of a long line of ancestors whose collective presence ensures the stability and preservation of the people; hence while Banana's agenda was theological, that of Kahari was social. It is noteworthy that the author describes Banana's submission on *Mwari* as an 'invention'. (2) The author notes three possibilities of the Shona language analysis as concerns the name of God. Firstly, the submission of the team of indigenous Biblical translators in Zimbabwe submitted that *Mwari* is a contraction of 'Mwari' which means 'to spread' suggesting that *Mwari* is the being that has put in world, everything we see. Secondly, in a report on findings of Biblical translators as related by N. M. Creary the team advocated for the use of *Mwari* for God where the text refers to God as creator and the use of *Muari* as God's personal name. Further, the team asserts that *Mwari* is derived from *Muari* rather than from *Mwari*. Thirdly, is the suggested interpretation by H. Aschwanden that *Mwari* is a contraction of 'mu' and 'ari' which means 'to be in a jar'. To the author, this confirms that *Mwari* is the God of fertility and this is supported by oral genres to the deity of fertility among the Shona.

Furthermore, the author examines the Roman Catholic theology and Death rituals on Shona *Mwari*. The historical background of the use of *Mwari* in Catholic theology has been marked by controversies as to the name of God being *Mwari* or *Yave*. But by 1963, *Mwari* was used almost everywhere among the Roman Catholics for God. The author explains how the Catholic Church accommodates Shona religious traditions into Christian liturgies. An example is the '*keurova guva*' which is intended to bring home an ancestor spirit about a year after a person's death. This is to enable the departed one assume responsibilities of guarding, protecting and caring for his or her descendants. The Roman Catholic Church renamed the practice '*keuchenura munhu*' meaning 'to purify the person'. The author asserts that this act of incorporation by the Roman Catholic Church is clearly a theology of 'invention'. Moreover, the decision of the Roman Catholic Church in Zimbabwe to equate *Mwari* with God, the Father and first person of the Trinity is based on a non-empirical theological interpretation of pre-Christian indigenous beliefs and practices.

Chapter Four focuses on the Rainbow Spirit Theology, a contemporary movement aimed at indigenizing the Christian idea of God in Australia. This theology is represented by the rainbow-serpent which was severally researched by Radcliffe-Brown. Radcliffe-Brown described the rainbow-serpent as a conception of the rainbow as a huge serpent which inhabits deep permanent waters and is associated with rain and rainmaking. It is a sort of 'guardian-spirit' and the Aborigines conceive of it as 'the spirit of water'. Other researchers who worked on this topic include A. P. Elkin on rock painting as historical record of Aboriginal belief system; W. E. Stanner who described the rainbow-serpent as Kunmanggur, a being of great size with superhuman powers. Also, the works of Elkin, Hiatt and Warner & Berndt shows the possibility of the rainbow-serpent being bisexual. A germane question for the author is 'is the rainbow-spirit as presented in the rainbow-spirit theology the same figure described in anthropological literature as rainbow-serpent? He identifies three sources for possible answers to this question. One, the report of the consultations titled 'Rainbow Spirit Theology' which was first published in 1997, later in 1999 and revised in 2007. According to this report, the two terms are the same. Two, a book titled *The Rainbow Spirit in Creation* which shows that the two terms are the same because in seven of the ten drawings that the book considered, the central figure is a serpent; and three, an article by George Rosendale titled 'Milbi Dabaar' which identifies the rainbow-spirit as the same with the rainbow-snake. Another pertinent question for the author is 'How do the elders interpret the rainbow-serpent as being commensurate with the Christian idea of God?' The author infers from the responses of the rainbow-spirit elders that the rainbow-serpent is related to the land, and Christ is the incarnation of the rainbow-serpent. Also, there is reversal of theology because incarnation in Western thought is that God descends from above to the earth, to the land, and becomes human. But this is replaced with the rainbow-spirit theology where God emerges out of the land, from the earth and takes on human flesh, making Christ 'truly Aboriginal'. In addition, the suffering of Christ is taken as symbolic of the suffering of Aboriginals at the hand of white colonizers and missionaries. However, the suffering of Christ is not the end of the story for his resurrection symbolizes that all things can be made new. The author sums this chapter with the submission that 'the rainbow spirit theology is based on the assumption that God nowhere left himself without a witness and through the rainbow –serpent was busy preparing the Aboriginal peoples for his fullest revelation in Christ'.

Chapter five explores recent re-interpretation of indigenous culture among the Yupiit of southwest Alaska. Submissions by scholars reflect the Yupiit belief in a universal spirit-*Ellam Yua* but early missionary contact with the people show they do not have the idea of a pre-Christian belief in an omniscient and all powerful Supreme Being. The absence of belief in a pre-Christian Supreme Being among the Yupiit is further buttressed because references to such belief are generally absent from early description of indigenous traditions in Alaska. The author notes scholar's use of the term to refer to the people as a whole, the language, members of the group, their culture and social practices. The author provides a detailed description of Alaska historically and geographically. The submissions of some scholars were interrogated, these include, Angayuaq Oscar Kawagley on the Yupiit worldview in his 1995 work titled *A Yupiaq*

Worldview: A Pathway to Ecology and Spirit which engaged the attention of the author. Kawagley analyzed the term '*Ellam Yua*' to mean the spirit of the universe. He submitted further that an understanding of the multi-faceted term '*Ella*' is key to understanding the way the Yupiit traditionally unified all aspects of their lives. The term '*Ella*' epitomizes Yupiaq philosophy as a base word with numerous applications. Further, he presents the metaphor of the tripod whose legs represent three realms (natural, spiritual and human) as a demonstration of Yupik worldview. It is a coherent and solid framework that is threatened when the three supporting legs are not in proper balance due to breakdown in communication.

This framework is sustained in proper balance through the language, myths, legends and stories of the people. Again, the author examines the submission of Ann Fienup-Riordan on *Ellam Yua* and the eye of awareness. She submits that traditional Yupiit life was ordered by rules, which are often dramatized in rituals. Delineated rules govern every aspect of social relationships among traditional Yupik communities. Furthermore, is the centrality of understanding the symbolism of mask to the overall worldview of the Yupik, which is closely linked to the central role of the shaman 'whose role in linking the community with the world of spirits is critical. Again, she reports that *Kelek* is the ritual most associated with masks and shamans among the Yupiit. *Kelek* was performed 'to please the spirits of game yet to be taken to supply the needs of the living' In addition to the stance of these scholars, the author also considered the testimonies of some village elders and indigenous Christians on the pre-Christian idea of a Supreme Being. These testimonies present ways of life in old Yupik setting which correspond with many Christian teachings. But then, as observed by the author 'no major Christian theological works have been written that interpret ancient Yupik beliefs about *Ellam Yua* as equivalent with the Christian idea of God'. However, the Catholic Mass incorporates indigenous symbols into the liturgy, an example being the introduction of drumming and dancing into church services. But the author notes that though Catholic leaders in Alaska are making creative attempts 'to use culturally meaningful symbols in liturgical renewal, but by comparison, little effort is being made to reconcile pre-Christian cosmological ideas with Christian theology. Conclusively, the author submits that there is disparity between the ancient belief in a universal personal consciousness among the Yupik people of southwest Alaska and a Christian understanding of a creator prior to contact with non-Alaska groups and missionaries. However, the highlight on the ancient belief in *Ellam Yua* provides a way for indigenous leaders to restore pride in their own culture and values. Interpretations of the traditional worldview along Christian perspectives by Yupik elders suggest that traditions are dynamic, which confirms the author's stance on 'invention'.

Chapter six presents the author's use of the conceptual category of 'cultural hybridity' to interrogate the idea of 'invention of tradition'. He poses the question 'can case studies be generalized and applied more broadly to other 'inventions' of God in indigenous societies? He differentiates between syncretism and cultural hybridity and chooses cultural hybridity as a better suited term for the discussion in this book. Thereafter a summary of the major submission in the book is given. On the case of New Zealand, the

move in the past thirty to forty years fuelled by the assumption by Christian theologians, both Pakeha and indigenous that the Maori Supreme Being *Io* is the same with the Christian God. The primary source on which Christian theologians relied for this assumption was Te Whatahoro, and evidences were shown that his testimonies are unreliable. In Zimbabwe, missionaries and African theologians insisted on the existence of a pre-Christian idea of a God called *Mwari*, among the Shona. But Herbert Aschwaden, a Swiss medical doctor associates *Mwari* with a fertility deity and traditional rituals that address the family. Furthermore, Herbert's submission is favored by historical and ethnographic evidences showing that *Mwari* originally was a sky God associated with rain and fertility. In Australia, the rainbow-serpent was made into a counterpart to the Christian God who is the creator. The rainbow-serpent is a widespread symbol which was reported in many parts of Australia. However, although stories about the rainbow-serpent abound in many parts of Australia, the diverse ways in which it is conceived vary significantly in content and in relative importance. A. P. Elkin's research on cave paintings which was located in the forest river area in northwest Australia, suggest that the rainbow-serpent was associated with fertility and reproduction. This is clearly evident by the image of *wondjina* which was associated with 'making babies'. In Alaska, the Yupik people, local elders, villagers and academics formed a revival movement towards championing traditional values as a resistance mode to the dominant white population. *Ellam Yua* is construed by these groups as a universal consciousness that is on a level equal to the Christian God. Nevertheless, Michael Oleksa, a priest and theologian presents *Ellam Yua* as an anticipation of the incarnation of Christ, thereby making Yupik worldview subordinate to orthodox Christianity.

The author submits that the empirical evidences which he presents in this book demonstrates overwhelmingly that those who affirm the existence of primordial indigenous Supreme Being actually 'invented' those arguments for a number of reasons, including theological and anthropological reasons. Consequently, he argues that indigenous deities cannot be equated with the Christian conception of God unless firm empirical evidences can be found to support the alleged consistency between the two. Further, all assertions about pre-Christian religious beliefs must be subjected to close empirical scrutiny. But the author recognizes the need to always distinguish theological debates from academic research on this issue. Also, there is the risk of excluding the voices of believers from his interpretations of theological efforts to make the Christian God comparable with pre-Christian indigenous beliefs in Supreme Being as 'inventions'. He advocates that indigenous religions should be studied as traditions in their own right and not as preparation for Christianity or as a base on which all religious beliefs are constructed. Thus, 'the aim of the study of indigenous religions should be to understand the religious beliefs and practices of indigenous peoples, rather than to discover the Western God in indigenous societies'.

The age-long debate on the right relation between theological and academic study of religions surfaced in this book and provides the platform for ethical considerations in academic investigation. While the worldview of indigenous peoples remain novel but complex, academic research often times seek to super impose the reductionist paradigm

for agendas quite different from theological consideration. The interlock between the ambition of indigenous peoples to maintain originality and stay relevant to contemporary development also emanates in this discourse. In all, the author did justice to his stated objectives and challenged scholars of religion to pursue 'academic fairness' in the academic study of indigenous religion. The book is a must-read for scholars of religions, especially phenomenologists.

Oyeronke Olademo
Department of Religions
University of Ilorin, Ilorin, Nigeria
wuraolaanike@yahoo.com

Kumalo, Simangaliso, 2013, *Religion and Politics in Swaziland: The Contributions of Dr JB Mzizi*. Bloemfontein: SUNPRESS, 360 pp., ISBN: 978-1-920382-29-2, R375

This book is an anthology of a decade (1995-2005) of short and long essays by the late Dr Joshua B. Mzizi, a former Senior Lecturer at the University of Swaziland. Some of these papers were written for formal academic conferences, where they were delivered, but the majority of them were written for the two big newspapers in Swaziland, *Times of Swaziland* (www.times.co.sz) and *The Observer*. Mzizi was a dedicated liberation theologian and he used his knowledge and skills of this sub-discipline to reflect on the religio-political dynamics of his country of birth, Swaziland. His writings are a minefield of knowledge for those interested in the history, politics and religion of Swaziland. The book is a collection of pieces that were scattered mostly in newspapers, journals and books. By compiling these works Kumalo has not only produced a comprehensive volume on Mzizi's work but has also provided information on Swaziland, a country about which very little is known.

The book has five main sections. The first section concentrates on introducing Mzizi's works. Using a postcolonial theoretical approach to critiquing the historical and political developments of Swaziland, it locates Mzizi's writings into its proper context in this theological discourse. It draws from the postcolonial theories of Galati Speak, Homi Bhabha and Michel Foucault to reflect on Mzizi's writings. The rationale for writing the book is to share, preserve and pass on to future generations Mzizi's contribution to the struggle against the lack of freedom and rights experienced by Swazis under the monarchical government of King Mswati. Basic in this struggle is how the monarchy has used religion to justify its domination and claim for absolute power over the nation. This section argues that Mzizi's writings unpacked the misuse of religion by the system so that it can keep the ordinary citizens of Swaziland, who happen to be very religious, obedient to the government. According to Mzizi, religion was used to convince the Swazis that to be against His Majesty's government is to be against God.

With this background, Mzizi's own biographical story, the socio-economic, political, cultural and religious dynamics of Swaziland receive attention in the second section. Again the aim of this section is to bring to awareness the foundation of the unjust

political system. It introduces the reader to the way people experience life under the current system in Swaziland, showing how the government is structured and the implications of that structure towards people's rights and freedoms. The appropriation of religion to Swazi ethnic-culture and politics is adequately discussed in this second section. It is precisely concerned with analyzing what it calls the *Swaziazation of Christianity*, because it is concerned with how Christianity was co-opted by the monarchy and the ruling elite to serve their interests in the name of God. This started at the time of the late king Sobhuza II and was continued by the present monarchy. Mzizi's writings challenged the manipulation of the gospel, because he believed that it is no longer good news to the poor and the oppressed whom he referred to as 'the voiceless'.

The focus of the book then moves to the articles themselves. The third chapter focuses on Mzizi's reflections on religion, politics and the monarchy. His writings argue for religious pluralism and tolerance and warn against a civil religion which is exclusive of other religious bodies in the country. He also calls for the promotion of ecumenism and the freedom of religion under the law. He argues that more work has to be done if religion is going to add value to the political development of the country. Mzizi was a very controversial figure in Swaziland. His writings brought a new perspective to understanding religion in the country. Citizens responded in a variety of ways to his writings. For instance, those who come from the evangelical stream, which ironically is Mzizi's background, did not like his writings. As a result he was rejected by his church. However, those who came from the mainline churches generally accepted and embraced his prophetic writings. Another group that embraced him were those who came from the civil society and political movements as chapter four demonstrates. This chapter focuses on how Swazis responded to Mzizi's writings by drawing on the writings of six people who knew him in different capacities.

The final chapter deals with the legacy of postcolonial Swaziland. It describes Mzizi as an intellectual-activist, whose tool was liberation theology. It identifies the significance of liberation theology in a postcolonial African country and how it can be used by the progressive movements to campaign for democracy. Although this is much appreciated, Mzizi just like his contemporaries did not focus on how for example the Bible was used to justify the oppression of women in Swaziland. Yet it is obvious that women are marginalized through polygamous marriage among others. This omission demonstrates how patriarchy in Africa still remains a problem even after years of African theologians fighting for the liberation of African theologies and cultures.

Despite this shortcoming, this book is a voice of the voiceless against the powerful rulers who silence their cry for freedom. It is a voice that no committed human right activists, democrats and theologians can afford to ignore. The uniqueness of this anthology lies in the fact that it is written by a Swazi, who is addressing the issues faced by his country from his own experience and the experiences of those he was in dialogue with. It is a contribution to the world-wide concern for human rights and the democratization of the world's last absolute monarchy.

Rosinah Mmannana Gabaitse
Department of Theology and Religious Studies
University of Botswana, Gaborone
Email: gabaitser@mopipi.ub.bw

Elias Kifon Bongmba, ed., *The Wiley Blackwell Companion to African Religions*. Malden, MA et al: Wiley Blackwell, 2012. Xxi + 605 pp., ISBN: 978-1-4051-9690-1 (hbk), £129.00

The academic study of religion in Africa continues to grow, defying many challenges. One of the major stumbling blocks in the discipline has been the absence of scholarly literature. Whereas material on other aspects of religious studies, such as theory and method, has been developed in abundance, literature on the religions of Africa has been limited. The volume under review contributes significantly in this regard. It is a rich, informative and scholarly contribution to the academic study of religion in Africa.

One of the most satisfying dimensions regarding the *Companion* is its attempt to cover as many dimensions as possible. Part I of the book presents chapters that concentrate on methodological perspectives on African Religions. This includes essays on methodology in the study of African Religions (James L. Cox), postcolonial feminist perspectives on African Religions (Musa W. Dube) and religion and the environment (Edward P. Antonio). Chapters in this section provide helpful insights into some of the abiding challenges in the academic study of African Religions, alongside offering perspectives into emerging themes.

Part II, dedicated to interpreting religious pluralism, is equally informative. It includes chapters on “neo-traditional religions” (Marleen de Witte), Christianity in Africa (David T. Ngong), the Ethiopian Orthodox Church (Christine Chaillot), Pentecostal and Charismatic movements in modern Africa (Matthews A. Ojo), African Initiated Churches in the Diaspora (Afe Adogame), Women in Islam (Penda Mbow) and Hinduism in South Africa (P. Pratap Kumar). The section confirms that the notion of “the three religions of Africa” (namely, African Traditional Religions, Christianity and Islam) as monolithic entities is not sustainable. Africa is characterised by radical religious pluralism (to paraphrase Jan G. Platvoet).

Part III is more diverse, focusing on “religion, culture and society.” It has chapters that include a focus on the arts (Ile-Ife, Suzanne Preston Blier, and Sufi arts in Senegal, Allen F. Roberts and Mary Nooter Roberts), religion, health and the economy (James R. Cochrane), religion, media and conflict in Africa (Rosalind I. J. Hackett), gospel music in Africa (Damaris Seleina Parsitau), religion and globalization (Asonzeh Ukah) and religion and same sex relations in Africa (Marc Epprecht).

This volume is a sound and effective addition to the literature on the study of religion in Africa. It covers most of the significant themes, addresses some neglected dimensions (for example, same sex relations) and is written in accessible style. It brings together some of the leading names in the discipline and makes an important contribution to the field. Given the limited publishing opportunities that most black African scholars based in Africa (outside South Africa) have, it will be strategic for similar projects in future to include more from this category. In addition, the voices of black African women scholars need to be amplified. Despite these remarks, the volume remains timely, impressive and relevant to the academic study of religion on the African continent and beyond.

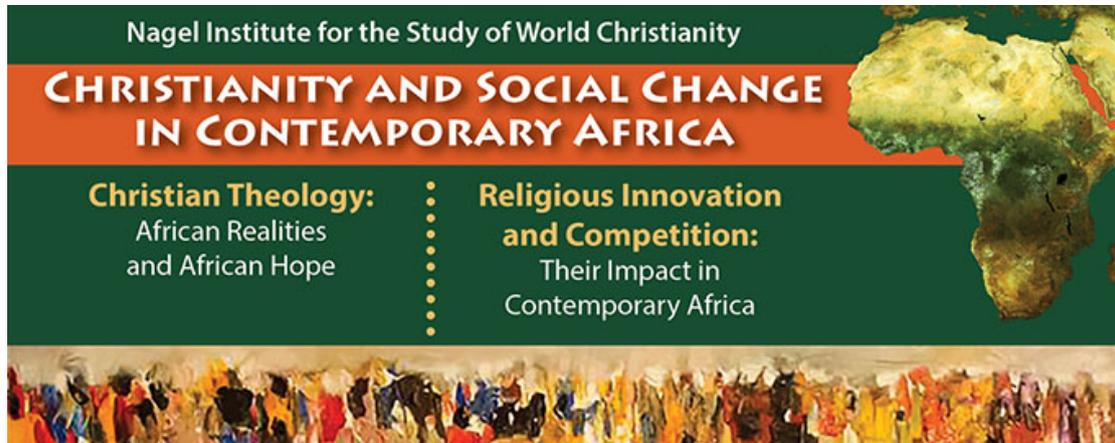
Ezra Chitando

Department of Religious Studies, Classics and Philosophy

University of Zimbabwe, Harare

chitsa21@yahoo.com

Research Opportunity



With generous support from the John Templeton Foundation, the Nagel Institute announces two research grants programs. One grants program will feature African theologians and the other will center on the continent's social sciences. These program's researchers will focus on African Christianity, one of the most dynamic forces in Africa today.

The grants for theologians will address how African modes of spirituality shape African Christianity today and how African values and virtues are embedded within a Christian context. Grants would enable theologians to consult with social scientists and humanities scholars and develop new Christian thinking that can be diffused among educational institutions and among pastors and lay leaders. Projects would seek deeper understanding of contemporary African realities on a variety of fronts, but emphasize agency and hope rather than victims and problems. What can theologians learn from research about African spiritual sensibilities and values? What theological themes will encourage and empower churches and help scholars in other fields see spiritual implications in their research?

The program for social scientists addresses contemporary African Christianity as a social force, focusing on its innovative and competitive character. Many social scientists still ignore or discount religion's social impact, while many Christian theologians regret African Christians' diversification and competitiveness. This program will ask, to the contrary, how might religious innovation and competition in Africa be contributing to social and theological renewal? The project will also put social scientists in touch with theologians in order to better understand the "religion factor" in contemporary African life. By these means they might develop a "capabilities" approach to studying African contemporary life rather than a "problems" approach.

Researchers are welcome to request up to \$20,000 for individual awards and to \$40,000 for team projects not to exceed 16 months in duration. We plan to make 12 grants in each program. There will be an initial research seminar for grantees, with leadership and guidance coming from senior African scholars. Each program will also produce at least

one book of grantees' articles, and there will be a summative public conference. These two programs will also interact. They aim thereby to promote appreciation for religious dynamics among African social scientists and to refresh African theologians' approach to contemporary life via new social research. The project aims to find, network, support and highlight the work of African scholars who are keen to emphasize African agency and African wellsprings of hope rather than African problems and victimization. We expect that they will develop a dynamic new emphasis in their respective fields and will have an influence on their peers.

Letter of Intent Submission Deadline	15 September 2015
Invitation for Full Proposal	15 October 2015
Full Proposal Submission Deadline	8 December 2015

For further details and application instructions, please visit www.calvin.edu/nagel/rfp



AASR

African Association for the Study of Religions

