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Seeing Through Our Eyes: Intimacy, Hope and Morality for HIV Peer Educators in Gaborone, Botswana

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Seeing Through Our Eyes: Intimacy, Hope and Morality for HIV Peer Educators in Gaborone, Botswana

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Honors Anthropology Project
Macalester College
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** Cover image: Center for Youth of Hope candle-lighting ceremony procession outside of Gaborone, Botswana **

Abstract

This ethnography focuses on the work of HIV peer educators at the non-profit organization of Center for Youth of Hope (CEYOHO) in Gaborone, Botswana. Drawing on Jarrett Zigon's theory of the moral breakdown and ethical demand, I argue that from a moral breakdown of HIV, intimacy can facilitate the ethical demand or motivation for developing new moral subjects. During this moral reshaping, intimacy is part of a process that involves practices of educated hope, trust, knowledge, and accountability. More specifically, intimacy through friendship and companionship between peer educators and clients allows them to hope together for an educated future that involves HIV prevention and the de-stigmatization of those living with HIV. Through testimonies given by peer educators about their experiences as individuals infected and affected by HIV, this ethnography aims to counteract dominant frameworks that continue to stigmatize those who are "infected" and rather "bring a face to HIV."

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At the core of this project, I would like to extend a huge thank you to the CEYOHO community. Thank you for sharing your stories with me and for the lessons you have taught me about resilience and hope. I dedicate this project to all the peer educators of CEYOHO and their pursuit for community education. Your work will continue to shape Botswana for years to come. *Ke a leboga.*

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Chapter 1

The Face of HIV

> We started under the trees. Back then, there was no money for HIV. There was no space for young people living with HIV. So, we started under the trees. We are telling people now that we are here, showing people that HIV is found in people. We are a face for HIV. ~ *Kesego Basha, June 2017*[1]

Middle-aged Kesego Basha sipped her cinnamon chai on a cool Gaborone evening in June, as she shared the founding of her HIV awareness organization about 17 years ago. Diagnosed with HIV as a young woman, Kesego belongs to a generation of individuals who remember a time when there was no hope for those living with HIV. She recalled that period of her life as, "the time that people were dying everyday. There was no treatment at that time." Even in a stable country with the wealth of diamonds, Botswana struggled to tackle and contain the epidemic. With the dominating influence of western prevention programs, HIV in this context remained shrouded in misinformation and sparked a wave of fear, stigmatization, and discrimination against the infected.

As a victim of this discrimination, Kesego sought to become a voice for those living with HIV in creating a network of support and hope. Along with a small group of other individuals living with HIV, this network developed into the grassroots organization of Center for Youth of Hope (CEYOHO). Reflecting on the early days of the organization, Kesego shared: "We would start by going door to door teaching people and encouraging them to test." While the availability of treatment now no longer makes HIV a death sentence, CEYOHO still stands as an organization of peer educators working

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[1] Audio-recorded interview in English with Kesego on June 28, 2017. All quotations from Kesego in this chapter draw from this interview.

to promote a future with increased prevention and the de-stigmatization of individuals living with HIV.

Having lived through realities "shaken up" by HIV, CEYOHO peer educators embody the resilience that grows from accepting an HIV status to live as healthy and responsible individuals. With the narratives from peer educators about their transition experiences, this project seeks to demonstrate how an HIV diagnosis is "not the end of the world." Rather, a diagnosis represents a transformative moment in time when individuals must choose to work towards a new educated and aware life with HIV. Although peer educators fill a gap of HIV treatment and support services, they expand beyond this role to provide their clients with the educational tools and motivation needed to achieve this hope of an educated future.

Relying on a theoretical framework rooted in an anthropology of morality, this ethnography seeks to understand how individuals are reshaped into new moral subjects after an HIV diagnosis. What are the apparent forces that are involved in this reconstruction? In defining an anthropological study of local moralities, Jarrett Zigon (2007) develops a framework that considers the relevance of a moral breakdown and its importance in shifting and rehabilitating an individual or societal morality. In turn, these moral breakdowns require individuals to reflect on their lives and face the ethical demand of taking responsibility for this new morality.

Drawing on Zigon's theoretical approach, I argue that from the moral breakdown of an HIV diagnosis, intimacy can facilitate the ethical demand necessary for the development of new moral subjects. During this moral reshaping, intimacy is part of a process that involves practices of educated hope, trust, knowledge, and accountability.

More specifically, intimacy through friendship and companionship between peer educators and clients allows them to hope together for an educated future that involves HIV prevention and the de-stigmatization of those living with HIV. Through testimonies that reflect the interwoven themes of intimacy, trust, and hope, this ethnography aims to counteract dominant frameworks that continue to stigmatize individuals who are infected and rather “bring a face to HIV.”

Peer Education in the Literature

Literature that addresses peer education is present across various realms related to learning and health. Ranging from diabetes support groups to sex workers participating in HIV prevention, the rising popularity of peer education addresses a collaborative, community oriented approach to behavior change and individual empowerment (Campbell & Mzaidume 2011; de Vries et. al 2014). Even with this increasing practice of peer education, Campbell and MacPhail (2002, 332) underscore that “our understandings of the processes and mechanisms underlying [peer education programs’] successes or failures are still in [its] infancy.” As an imprecisely defined strategy, peer education has been described as a “method in search of a theory” (Turner and Shepherd 1999).

The overarching definition of peer education incorporates the “teaching or sharing of health information, values and behaviors by members of similar age or status groups” (Milburn 1995). However, without a cohesive theoretical grounding, peer education appeals to various groups with differing objectives and goals (Damon and Phelps 1989). With these distinct and sometimes conflicting approaches, the question becomes: what is a peer? According to Tajfel’s (1981) concept of social identity, a peer is based in “the

knowledge that we belong to particular groups, together with the emotional and value significance of group membership" (cited in Campbell and MacPhail 2002). From this group belonging, Stockdale (1995) further acknowledges the influence of social identities in shaping and constraining socially negotiated phenomena such as health-related behaviors and sexuality.

Despite these influences of peer groups, Knibbs and Price (2009) underscore that peer education still remains "an unproven method" where educator "credibility cannot be taken for granted." The varying degrees of peer engagement along with diverse measures of quantifying knowledge acquisition and individual empowerment overall complicate an understanding of the peer education impact on behavior and social identity (Knibbs and Price 2009). Considering this nebulous approach, Campbell and MacPhail (2002, 333) argue that in the context of HIV peer education, it is not enough for peers to provide emotional empowerment, but rather they must also incorporate a "development of *intellectual* understandings of ways in which social relations contribute to the transmission of HIV." This perspective further engages with the Freirean (1993) notion of critical consciousness that allows for the "re-negotiation of collective identities...where learners are actively involved in formulating critical analyses and generating alternative ways of being" (cited in Campbell and MacPhail 2002).

The practice of critical consciousness in peer education is similarly reflected in literature regarding social and self transformation following an illness or diagnosis. In his ethnography *HIV is God's Blessing,* Zigon (2011) addresses such moral reconstruction in the context of a Russian Orthodox church rehabilitation program for recovered heroin addicts. Through discipline and therapeutic support, the church initiates an ethical

process for the creation of a new "moral personhood." In *Second Chances: Surviving AIDS in Uganda,* Whyte (2014) also conceptualizes the development of new personhood for HIV positive individuals through the availability of antiretroviral therapy (ART). Whyte demonstrates that individuals who have gained awareness and begun practicing ART are considered "enlightened" and thus given a "second chance" for living healthy and responsible lives. Second chances are heightened through personal connections and enable reflection on aspects of daily life often taken for granted.

While Livingston's (2012) ethnography does not focus on peer education in Botswana, it does provide insights into the importance of involving local practitioners in hospital care. Her study emphasizes the role of local nurses as expert "cultural brokers," in contrast to the international influence of scientific advancements and presence of foreign doctors in an oncology ward. Livingston challenges the traditional dichotomies of authority between doctors and nurses to highlight efforts to bridge relations between clients and health professionals that can improve cancer care and treatment.

While the previous literature incorporates the relevance of shared experience in providing education and bridging gaps of knowledge, this project expands on these ideas to acknowledge the importance behind relationships rooted in trust and intimacy. Even though peer education has been criticized for the lack of analysis on actual social interactions between peers, the focus on intimate connections between CEYOHO peer educators and their clients seeks to address these limitations (Knibbs and Price 2009). Specifically, CEYOHO peer educators go beyond a traditional medical model of expertise to demonstrate how the dissemination of knowledge better "sticks" through the sharing of individualized and relatable stories that peer educators call testimonies.

Along with the female voices that stand out in this project, this ethnography further contributes to a feminist perspective that underscores the value of personal and intimate approaches (Behar 1995). I privilege the stories primarily of the affected women to highlight the importance of the particular and avoid making generalizations or crafting a "universal women's experience" that Abu-Lughod (1991) warns may erase differences and power dynamics. This project, however, does not exclusively prioritize gender. Rather, I am careful to conceptualize my work in terms of *intersectionalities* between other identities such as race, age, socioeconomic status, and HIV condition (Bredström 2006). Although these varying aspects are integrated throughout different chapters, this approach of intersectionality allows me to explore how these characteristics mutually influence each other (Bredström 2006). In layering this work with often marginalized testimonies, my intent is not to erase my positionality in this project, but instead to remove an authoritative stance in my ethnographic writing. With these multiple and overlapping interactions, this ethnography seeks to "shake up the paradigm of anthropology itself by showing us that we are always part of what we study and always stand in definite relations to it" (Abu-Lughod 1991, 27).

Guiding Theoretical Frameworks

An Anthropology of Moralities

Within anthropology, limited agreement exists on explicitly defining the scope of morality studies. However, the general assumption that morality has been a focus of anthropology stems back to Durkheimian thought where societal structures promote social cohesion and contribute to "making the moral congruent with the social" (Zigon

2007, 133). However, expanding on this foundation, Joel Robbins (2007) theorizes that conscious decisions and choices are involved in moral reasoning. Foucault (2000) further addresses how moral subjects are not created through the following of rules, but rather by training oneself to develop certain moral capacities. While these two approaches appear to steer away from Durkheim's framework by providing agency to moral subjects, Zigon argues that these anthropological approaches to morality remain rooted in emphasizing the social harmony that morality promotes. Thus, to complicate the matter, Zigon asks: what happens when individuals "fall out" of morality? What happens when morality is shaken up? What allows individuals to "step back" into this morality or a new morality? (Zigon 2007).

The Moral Breakdown

To bring these questions into conversation, Zigon relies on the contributions of 20th century philosophers who have reflected on this rediscovery of morality. Specifically, Heidegger's concept of "being-in-the world," frames morality as the shared and familiar enactment of bodily and social dispositions that reflect what is good in the world. Considering the shared familiarity of these embodied moral practices, Zigon (2007, 132) emphasizes that they are performed "non-intentionally and unreflectively." Despite the reality of these unreflective moral dispositions within everyday life, "being-in-the-world" should not be viewed as static, but rather as dynamic and changing relationships. Again borrowing terminology from Heidegger, Zigon views this change as evidence of a *moral breakdown*.

While there is an acceptance and practice of moral expectations, a moral breakdown consists of bringing these realities into question. Zigon (2007, 136) explains

that a breakdown generally happens when practices that are considered "ready-to-hand become present-to-hand." Moral dispositions that are characterized as "ready-to-hand" are performances that are done out of habit and do not require reflexivity. However, in the moment of a moral breakdown that can arise from disagreement or conflict, these traditional modes of "being-in-the-world" are brought "present-to-hand" to reflect and address the reality of the situation. In this process of reflection, Zigon (2007, 137) argues that individuals are "stepping away" from these conventional frames of living in order to restructure their current morality.

In contrast to morality, a moral breakdown is viewed as an ethical performance or a moment that requires ethics to construct a new morality. Similar to Foucault's notion of problematization that highlights an individual's reflective state on traditional practices and cultural representations, the ability to "step out" of morality in a moral breakdown enables individuals to "work on themselves and alter their ways of being in the world" (Zigon 2007, 138). These alterations due to ethical reasoning thus not only contribute to the reconstruction of moral subjects, but also allow for their return into a changed morality that is again "ready-to-hand."

Returning to earlier literature, Zigon illustrates this concept of moral breakdown in the context of a Russian Orthodox church's drug rehabilitation and HIV prevention and care program in Saint Petersburg. Hinted by the title of his ethnography, *HIV is God's Blessing*, the diagnosis of HIV resembles a moral breakdown that places an individual in an ethical dilemma about how to proceed with this new reality. As Zigon (2011, 60) highlights, "the church views HIV as a blessing because the infection throws individuals into conscious awareness of their own bare life and mortality, making them

more open to changing their way of being in the world." Through HIV, individuals are forced to step out of morality in order to rethink and reshape themselves into new moral subjects. In the reconstruction of this morality, Zigon (2011, 95) ultimately argues that "a person does not overcome addiction; instead a new, un-addicted person must be made."

The Ethical Demand

For Zigon, a moral breakdown does not only consist of a performance of ethics, but it is also accompanied by an *ethical demand*. By relying on a conceptualization provided by Løngstrup, Zigon (2007, 137) argues that an ethical demand is the ethical moment within a moral breakdown resulting in the responsibility a moral subject feels towards the other. This demand of responsibility placed on moral subjects further highlights the interconnection of dynamic relationships that influence the reality of a moral breakdown. As Zigon (2007, 139) demonstrates, this interconnection between the self and other results in the response of the ethical demand because "one cannot live…in a state of permanent moral breakdown." Overall, the ethical demand serves as the motivation for individuals in a moral breakdown to restructure and return to a new moral framework.

In his article, "On Love: Remaking Moral Subjectivity in Post-rehabilitation Russia," Zigon (2013) offers the ethnographic example of how love has served as the ethical demand that motivates previous heroin addicts to restructure their moralities. Zigon (2013, 204) incorporates Badiou's conceptualization of love that demonstrates love as a "field of truth…around which a subject and a subjective life trajectory can be formed." Badiou's analysis further demonstrates that love or other forms of truth persist through a sustained fidelity towards the founding "event" that initiated the original

demand for love (Zigon 2013). As it applies to Zigon's analysis, the demand for love triggers an ethical response to develop a new moral subject. Through journal entries shared by previous drug addicts, their hopes of finding amorous love serves as the guiding principle or ethical demand that motivates them to stay sober and reconstruct how they live their lives. Through the demand for love and the actual act of loving, Zigon (2013, 212) highlights that "we shatter ourselves…and must struggle to remake selves capable of remaining faithful to the new subjective trajectory initiated through love's demand." In fulfilling and staying loyal to these responsibilities created by an ethical demand, moral subjects can return to the experiencing of morality as second nature.

While love can be an ethical demand, this project expands from Zigon's work to demonstrate how intimacy acts as an ethical demand contributing to the moral reconstruction following an HIV diagnosis. Unlike notions of unconditional love, relationships of "reciprocity" are necessary in formulating intimate connections (Jamieson 2011). As the following chapters will demonstrate, this intimacy is fostered through a process that interconnects hope, knowledge, and trust. In establishing bonds of trust with their clients, peer educators seek to disseminate the necessary knowledge about HIV treatment and prevention for an educated future. Unlike mere wishful thinking, this hope for the future acknowledges previous suffering and recognizes the importance of taking action in order to achieve social change for the greater community (Miyazaki and Swedberg 2017).

Crafting the Ethnography

Taking the combi[2] route 3 that stops at the Dithuto primary school in the village of Tlokweng outside of Gaborone, a dusted road lined with small family homes leads to the main CEYOHO community gathering center. Pink hydrangeas encircle the outside patio and a bolded red and green lettered sign stating "Welcome to CEYOHO" is planted at the entrance. I originally became connected with CEYOHO through my initial meeting with Ms. Kgoreletso Molosiwa, the Executive Director of the Botswana Network of People Living with HIV/AIDS (BONEPWA), a CEYOHO partner. Having arrived in Botswana in the middle of January for my semester abroad, Kgoreletso helped connect me with a grassroots organization to learn about local efforts towards HIV/AIDS treatment and care. "I will pick you up at the north entrance of the University and will introduce you to the group." Kgoreletso called to confirm our appointment for the following day. Driving up in a white pick up, Kgoreletso and her driver greeted me as we continued en route to CEYOHO. After a meandering drive through roaming cattle, we arrived just in time for the monthly CEYOHO gathering of peer educators.

At the center, Kgoreletso introduced me to the primary founder, Kesego and her peer educator team. Draped in a royal blue dress with her hair pulled back in a soft, braided bun, Kesego asked me: "What is your Setswana name?" Following my moment of hesitation, I recalled the name that I had been given after a home stay visit in Gabane. "*Ke bidiwa Go Po Lang* (My name is Go Po Lang)." Laughter erupted throughout the group. "This one speaks Setswana!" Although nervous that they would soon discover that

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[2] Combis are vans that function as buses. They are privately-owned and run varying 'routes' in and around Gaborone.

my Setswana was only a list of broken words and phrases, CEYOHO members began to tell their stories about how they joined the organization to become a peer educator.

My time and research with CEYOHO continued from the end of February until the beginning of July 2017. At the beginning, I served as an assistant helping in the organization and preparation of monthly community dialogues and workshops. In collaboration with other peer educators, we would select youth focused films to screen at the workshops and develop discussion questions to accompany the film. The short films were usually selected from "Steps for the Future (STEPS)," a collection of Southern African documentaries based on empowerment and human rights for youth and marginalized individuals of the community. In addition to assisting with these dialogues, I also served as liaison for the organization to the University of Botswana (UB) Health Outreach Group. I worked in collaboration with these two groups to begin the discussion of having CEYOHO assist with a UB campus club supporting students living with HIV.

Along with my role as an assistant, I shadowed peer educators at the respective clinics and schools where they perform community outreach and counseling for individuals receiving antiretroviral (ARV) treatment and therapy. I additionally accompanied these peer educators at community workshops and trainings organized by government programs such as the National AIDS Coordinating Agency (NACA) to keep peer educators up to date with important methods of teaching and statistics regarding HIV prevalence, policy, and care. With these wide-ranging opportunities, I gained insight into the differing perspectives and components that form CEYOHO, their work ethic, and overall organizational structure.

By incorporating these elements of *participant observation* into my research, I aimed to focus on the particular. In recognizing the specificity of these experiences, this project again stresses Abu-Lughod's (1991) understanding of culturally situated analysis rather than developing overarching theories regarding peer education. I hope that with this emphasis on the particular, this project can further shed light on how "there is no single face in nature because every eye that looks upon it, sees it from its own angle" (Neale Hurston 1990).

This relativity is reflected in the series of 38 semi-structured, one hour long interviews along with various informal discussions that I collected throughout my time with CEYOHO. For each of these interviews, I received verbal consent from my informants to audio record and utilize the data for my research. I interviewed 11 female and two male informants. These informants included 10 peer educators at CEYOHO, the two primary CEYOHO founders, and the Executive Director of BONEPWA. Out of these informants, one of them was 18 years-old, four were in their twenties, three were in their early thirties, and the remaining five were above 40 years of age. Although I was clear about my intent to anonymize the organization and my informants, the two primary founders of CEYOHO along with Executive Director of BONEPWA were explicit in having their names and the names of the organizations used in this ethnography. These individuals expressed their hope that this ethnography could be used as a tool in helping their organization and the work they do become more visible within their own community and across the globe. Before submitting this project for publication, I also had the two primary CEYOHO founders read over my draft and provide any commentary or

edits to ensure their full consent. The remaining peer educators are anonymized with pseudonyms throughout this work.[3]

Given my limited Setswana, most of the interviews were conducted in English. However, considering that most of CEYOHO's community events and counseling sessions were in Setswana, I remain indebted to my informants for speaking in English with me to teach me about their community. For informants who preferred to speak in Setswana, I had the interpreting help from a friend and classmate at UB, Galamoyo. While Galamoyo assisted in going over the interviews to ensure the most accurate representation of the narratives shared by peer educators, I am aware of the potential discrepancies between the original message and translation.

These interviews and participant observation opportunities were complemented by document review. Throughout my time in Botswana, I collected program brochures and evaluation reports from CEYOHO and their partnering clinics. When I returned to the United States, I also gathered information regarding the political and cultural history of Botswana. These additional documents and research were important in contextualizing the work of my informants and highlighting the specificity of the organization's location.

Throughout the course of my fieldwork, it became clear that most of CEYOHO's members were people living with HIV. While not excluding HIV negative community members, HIV status served as a shared experience between peer educators and clients associated with the organization. "We are an organization for and by people living with HIV," Kesego emphasized as we had our first chat at the Mugg and Bean cafe for late lunch. With this underlying source of connection between CEYOHO members and their

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[3] Although I anonymize all the peer educators that I directly spoke with, I quote one of the peer educators from a STEPS documentary that is found online and thus her name is not anonymized.

clients, I became aware of my own limitations in understanding the narratives and experiences shared by peer educators. While I listened with intent and searched for ways to connect my past experiences to similar ones described by my informants, I myself do not know the experience that accompanies an HIV diagnosis.

My challenges and shortcomings to fully understand informants' experience with HIV reminded me of the struggles described by Renato Rosaldo (1984) in his text "Grief and a Headhunter's rage: On the Cultural Force of Emotions." In sharing his initial difficulty with describing the reason behind why Ilongots head hunt, Rosaldo (1984, 180) noted how his "life experience had not yet provided the means to imagine the rage that can come with devastating loss." Just as Rosaldo lacked the words or experiences to explain this cultural phenomena, I similarly cannot put into words what it means and how it feels to be told that "you are HIV positive."

Along with this shared HIV status, most peer educators disclosed that they were secondary school graduates or had dropped out in the midst of secondary school. Considering the additional financial constraints of non-profit work, most of my informants identified as lower income. I was aware of my own positionality as a upper-middle class, Western educated *lekgoa* (of white European or American descent) and the need to learn from the expertise of peer educators and avoid adopting perspectives that have commonly exoticized poverty and disease. By this process of learning through experience, I hope that this project can further contribute to the "unsettling of boundaries that have been central to [anthropology's] identity as a discipline of the self studying other" (Abu-Lughod 1991, 26).

Road - Map

Chapter two of this ethnography contextualizes the work of my informants as peer educators in and around Gaborone. This chapter considers the cultural, historical, and political dimensions that contributed to the course of the epidemic across Botswana. The remainder of this chapter addresses the various actors involved in tackling the epidemic and how they influenced or contradicted cultural dynamics.

Chapter three addresses the association between concepts of youth and hope as presented within the title of the organization: Center for Youth of Hope. Although not all peer educators or clients can be categorized as youth, this section elaborates on the significance of youth as a symbol of hope and educated change for the future. This chapter continues to elaborate on how this educated hope is rooted in the trust that peer educators establish with their clients through relatability but also anonymity.

Chapter four of this ethnography explores how peer educators solidify the trust established with their clients through the sharing of testimony. While testimony can be used as a source of connection, this chapter also describes the ways in which testimony is used strategically. Chapter four continues to show how testimony extends beyond the personal to take on a more political stance that also incorporates the voices of those who are HIV negative. By highlighting the promotion of inclusivity, this chapter seeks to emphasize that while not all are HIV infected, the larger community remains affected by HIV.

While connections of hope and trust foster intimacy, chapter five discusses the role that intimacy serves in the ethical demand that motivates individuals in their moral reconstruction as individuals with HIV. Chapter five considers the cultural dynamics that

shape concepts of intimacy within Botswana and how peer educators counter these traditional ideas in order to promote an intimacy through friendship. Chapter five concludes by considering the foundations of intimacy through the exposure of vulnerabilities that play a central role in women's empowerment and moral reconstruction. While men are not excluded from the organization, CEYOHO is working to increase male involvement in this moral and social reconstruction.

Although peer educators establish intimate connections with their clients to work towards an educated future, chapter six highlights that it ultimately comes down to clients' decision whether to continue practicing prevention and healthy HIV interventions. Chapter six further deals with the influence of discipline and responsibility in this process of guiding individuals towards a future following an HIV diagnosis.

Tying the thematic ideas from the previous chapters together, the conclusion reconsiders this process of moral reconstruction following an HIV diagnosis. Despite the individual connections peer educators establish with their clients, this chapter concludes by demonstrating how the work of peer educators expands beyond individual moral reconstruction to contribute to a greater educated hope for the community.

Chapter 2

“The African Miracle”: Contextualizing HIV Amidst Economic Success

What was once one of the most impoverished countries post independence, Botswana has risen as one of the fastest growing economies in the world to become what Abdi Ismail Samatar (1999) has called an “African Miracle.” Unlike other African countries following independence that were plagued with corruption and failing infrastructure as a result of a lasting colonial legacy, Botswana throughout the last 50 years has seen a time of “hope, optimism, and progress” (Samatar 1999, 1). With minimal political corruption along with the discovery of diamonds in the early 70s, Botswana has had the resources to invest in infrastructure and higher education for the country.

Despite this success and miraculous economic growth, 1985 was seen as a turn for the worse with the first report of AIDS cases in Botswana (WHO 2017). Unlike countries such as Uganda that had faced years of political uproar with a larger and more heterogeneous population, Botswana as a country with a small population and political stability was expected to contain the epidemic (Allen and Heald 2004). However, from the mid-80s up until the early 2000s, AIDS-related deaths across Botswana skyrocketed with limited accessibility to effective treatment. With funerals almost every weekend, President Mogae chillingly declared: "We really are in a national crisis. We are threatened with extinction.”[4]

[4] President Mogae’s speech was cited in an article written by Anton La Guardia in *The Telegraph,* a British newspaper distributed on July 10, 2000. Title of article: “African President warns of extinction from AIDS.”

Furthermore, considering the lack of information or rather misinformation circling about HIV/AIDS and prevention methods, stigma surrounded those who were diagnosed with the infection. Although these numbers have steadily decreased with the introduction of free antiretroviral treatment, Botswana still remains the country with the third highest HIV prevalence in the world of approximately 22 percent behind Lesotho and Swaziland (UNAIDS 2017). While other countries may have larger numbers of those living with HIV despite a lower prevalence, the 360,000 individuals living with HIV in Botswana demonstrate the continual impact and gravity of this epidemic.

These contrasting and often paradoxical representations of Botswana serve to contextualize the work of my informants as HIV peer educators in and around Gaborone. As this next chapter will uncover, the historical context along with social structures present within Botswana play an influential role in framing CEYOHO and their mission. In this chapter, I outline a brief political and cultural history of Botswana to provide relevant background. This background offers a foundation for understanding the dynamics behind the HIV epidemic in Botswana and how it differs from other cases in Africa. Who were the local and international players involved in addressing this crisis? How were treatment and prevention initiatives implemented and received throughout communities in Botswana? Where do CEYOHO and their peer educators fit within this framework?

A Political and Cultural History of Botswana

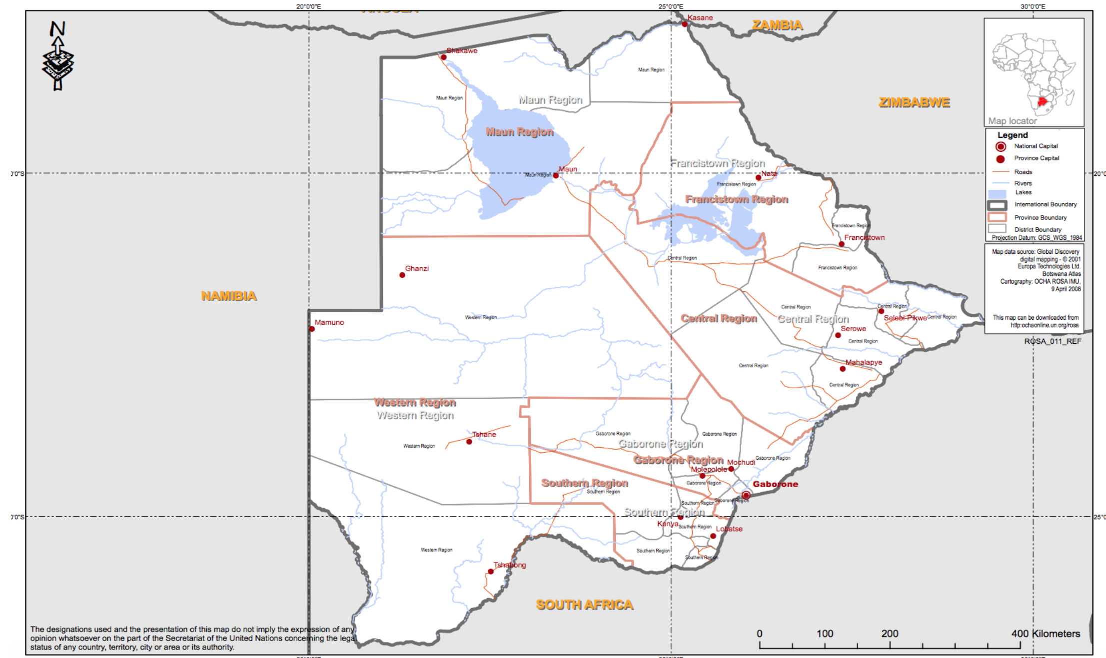

Figure 1. Map of Botswana[5]

The Republic of Botswana is a small landlocked country in Sub-Saharan Africa. With a population of around 2.25 million people, Botswana is one of the least densely populated countries in Africa. Although Botswana has traditionally maintained a unique pattern of mobility between agricultural lands and villages, the country has experienced one of the highest rates of rural to urban migration across Africa. Just between 1971 and 1975, Gaborone had an annual population growth rate of 15 percent (Bryant et. al 1978). However, prolonged periods of drought along with outbreaks of cattle lung disease resulted in diminishing opportunities of agricultural cultivation and cattle herding. These factors have made Batswana (people of Botswana) more reliant on economic opportunities in the city and in the mines both in Botswana and across other regions in Southern Africa.

[5] (United Nations Office for the Coordination of Humanitarian Affairs 2001)

The course of this social and economic landscape in Botswana has been shaped by the historical dynamics between Batswana and colonial powers. Even prior to colonization, Botswana had a hierarchical social structure. Traditionally, a *kgosi* (king) maintained the highest authority over a certain Botswana *morafe* (nation or society) across the region (Samatar 1999, 40). A *morafe* is further divided into structures that included the household (smallest unit), family group, *kgotla* (ward), and *motse* (village). Throughout time, these divisions have remained patriarchal and patrilineal in structure (Samatar 1999, 41). While Batswana identify with a *motse*, there is also plenty of internal movement to cattle posts across seasons (Hope 2001, 77). Cattle are considered a primary symbol of wealth originally controlled by the *kgosi* and utilized for *lobola* (bride-wealth).

As a result of the overall arid landscape of Botswana, cattle herding appeared to be the only viable economic activity and thus was not of interest to European colonial powers seeking to extract resources in the region. However, when the British became concerned that the Northern Road linking their interests in South and Central Africa was threatened by German and Boer powers, they declared Botswana (then known as Bechuanaland) as a protectorate in 1885 (Samatar 1999, 44). The *kgosi* were stripped of their power in the protectorate but resisted colonial rule and maintained their political authority over villages. Samatar (1999, 7) describes that this *kgosi* stronghold ultimately "sowed the seed of contemporary Botswana national identity."

While this dominance persisted until the early 1960s, college-educated chief Seretse Khama introduced a new political agenda by uniting members of chiefly and educated families across the region. In establishing the Bechuanaland Democratic Party (BDP), Khama and his party proposed a more capitalist project that would not jeopardize

the influence of *kgosi* families. Although these capitalist ventures served as the foundation for Botswana independence in 1966, they were also accompanied by hardships. After 80 years of colonial influence, Botswana was left as an impoverished society lacking in education, skilled labor, and extractable resources (Samatar 1999, 62).

With the discovery of diamonds in the 1970s, however, Botswana gained foreign exchange reserves from these exports and "meteorically leaped" from one of lowest income countries to a dynamic middle-income economy (Samatar 1999, 3). Overall, a combination of diamond wealth with the interwoven nature between the "old establishment" and "modernist elements" served as central factors in solidifying this future economic success for Botswana post-independence (Samatar 1999, 7). In describing Botswana as an African miracle, Samatar (1999, 8) ultimately summarizes that "it is impossible to clearly understand how the Botswana miracle was manufactured without appreciating the important function that the political and economic unity of the dominant class played."

Even in the context of Botswana as an African miracle, Samatar complicates this concept by highlighting that rapid economic growth favored primarily the dominant class and did not appear to trickle down into other sectors across Botswana. With the agricultural resources of cattle and land primarily held by chiefly families along with poor agricultural conditions, many Batswana turned to other labor opportunities in the city. However, a lagging rate of job growth relative to urbanization resulted in high levels of unemployment within the country (Jefferis and Kelly 1999). Despite the booming industry, diamond mining in Botswana only employed a small portion of the population. Due to the capital-intensive nature of work, mining companies like Debswana hired less

than 10 percent of the formal labor sector in Botswana (Meisenhelder 1994). In light of these conditions, at about the time of the 1970 census, close to 50 percent of the Botswana male population participated in temporary migration to South Africa to work in the mines (Lucas 1987). This migration to mining towns along with prolonged unemployment has contributed to the disruption of family structures and marital relations.

Traditionally, marriage in Botswana was negotiated between families and resulted with the transferring of *lobola* from the groom's family to the bride's father. Through marriage, men were granted legal rights over property and livestock while also gaining power over women's fertility. In contrast to male financial responsibilities for heading the household, the responsibility of women lay in this fertility and in bearing children. Although practices of polygyny have been outlawed in Botswana, it is still common for people to have multiple sexual partners. Specifically, if women were perceived to be infertile, men could father children with a surrogate. While male infertility was not usually addressed as a concern, Upton (2003) describes how women on birth control could be blamed for making men sick with "weak blood." Unprotected sexual intercourse with young girls or virgins was a prescribed cure for this "weak blood."

Although family and marital structures within Botswana have been fluid prior to increased labor migration, movement for mining opportunities has amplified the existence of multiple concurrent partnerships and thus has largely been associated as a factor in the spread of HIV infection (UNAIDS 2008). The extended periods of migration along with the cultural imperative of women to bear children has contributed to women having children with one or more men (Macdonald 1996, 1329). Similarly, considering that most men have moved to mining towns without their families, there has been

increased participation in prostitution (Musokotwane 2016). Even though sex work exists in various contexts, high unemployment in Botswana has also resulted in the greater commodification of sexuality and intimacy among both men and women (Honwana 2013, 89). While not typically identified as sex work, sexual intergenerational relationships[6] with "sugar daddies" or "sugar mamas" are common place in the absence of other economic opportunities in order to maintain livelihood (Honwana 2013, 95). The impact of this economic reality has corresponded to reduced marriage rates as individuals, primarily men, are unable to afford *lobola* and provide financial support for a family. Overall, these changing economic conditions that influence societal structures have been primary factors in facilitating the spread of HIV/AIDS across Botswana.

Addressing the Epidemic and Stigma

With the initial reports of AIDS cases across Botswana in 1985, the government of Botswana responded rapidly through a series of consecutive national strategic plans (NACA 2015). However, unlike epidemics that occurred in other African countries like Uganda where the virus's exposure was significantly higher before government interventions, Botswana's quick response preceded public alarm (Allen and Heald 2004). These strategic frameworks outlined primary goals focused on prevention through promoting behavior change and increasing accessibility to resources involved in treatment and care (BONASO 2004). The National AIDS Coordinating Agency (NACA) was established in 1999 to manage various stakeholders involved in policy development and treatment programs. Similarly, in 1999 Botswana began its ARV program with the

[6] Within this ethnography, sexual intergenerational relationships refer to those that are consistent with an exchange of intimacy and economic goods (gifts or money) between individuals of varying ages. I will be using this term interchangeably with that of sexual transactional relationships.

goal of putting at least 19,000 people on treatment (Allen and Heald 2004, 1146). Despite Botswana's status as a middle-income country, Botswana faced limited infrastructure in maintaining testing facilities and ARV supplies. ARV roll-out was also difficult because of the misconceptions associated with ARV treatment and a reluctance to test. This initial skepticism was elaborated on by Kennedy, an original CEYOHO member who assisted his wife, Kesego, in the development of the organization. As a middle-aged family man doing treatment literacy work with CEYOHO, Kennedy explained:

> When ARVs first came, they came with a lot of misconceptions. People were thinking, this is just the western strategy to kill us. The former president of South Africa, Thabo Mbeki actually refused, he gave an official statement: 'It is not HIV that is causing AIDS, it is poverty that is causing AIDS.'[7]

This underlying western influence in the implementation of treatment initiatives contributed to the initial skeptical perceptions of HIV treatment and care in Botswana.

At large, these western, particularly American, frameworks have cut across various dimensions of HIV prevention work carried out within Botswana and Africa more generally. As early as 1981, the Centers for Disease Control and Prevention (CDC) developed three primary behavioral strategies for reducing the risk of HIV through sexual transmission. This intervention initially arose to address the epidemic occurring in the United States primarily affecting men who have sex with men. These strategies included the reduction in number of sexual partners, the emphasis on protection to prevent body fluid exchange during sexual intercourse, and to increase awareness of sexual partner history. While these behavior changes were encouraged for men who have sex with men, abstinence until marriage was the main strategy initially promoted for male-female sexual relations across the United States (Su 2010). This model provided the foundation for the

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[7] Audio-recorded interview in English with Kennedy on June 3, 2017. All quotations from Kennedy in this chapter draw from this interview.

ABC campaign (Abstain, Be Faithful, Condomize) that served as an "amalgamation of various best practices from homosexual communities and Christian interest groups in the United States" (Su 2010).

As alluded above, the Botswana government's relatively quick implementation of these Western HIV preventive programs caused suspicion and offended Tswana "tradition and culture." Condom promotion went against values of fertility in disrupting the "flow of bloods" between sexual partners (Allen and Heald 2004, 1145). In breaking sexual taboos, condom promotion fueled suspicions that condoms were not a tool for HIV control, but rather the origin of HIV and its spread. While condom education was not implemented in Uganda until the mid-90s through a combination of institutional and civil society organizations, this early introduction of condom promotion in Botswana continued to heighten connections between immorality, condoms, and HIV along with stigmatization of those who were infected (Allen and Heald 2004).

Kennedy described this presence of stigma throughout the initial years of the epidemic. Following a brief pause to reflect, he shared: "Churches and priests would preach about HIV and would say, 'Look, if you sleep around, you are going to get HIV, you know.' So, those who got HIV, were viewed as those who slept around." This societal phenomena of linking HIV with immorality was further echoed in the narrative shared by Kesego.

> When HIV was first discovered it was taboo because most people found out that they had HIV through sexual intercourse. In our African countries it is taboo to talk about sex, because that is something that they do privately in the bedrooms. So when you are talking about somebody with HIV, it was as if someone was promiscuous.[8]

[8] Audio-recorded interview in English with Kesego on April 10, 2017. All quotations from Kesego in this chapter draw from this interview.

Along with the taboos associated with sexual activity, cultural imperatives related to reproduction were also impacted by the growing epidemic. In their qualitative research done about stigma in Botswana, Dolan and Upton (2011, 96) demonstrate that, despite the presence of HIV stigma, “fears of sterility overshadow fears of HIV/AIDS to the extent that the majority of individuals interviewed (in their study) would engage in risky sexual behaviors and practices despite their knowledge of the epidemic.” However, this study also noted that “individuals weighed the perceived risks of HIV positive status with a negative fecundity status” (Dolan and Upton 2011, 100).

The association between HIV and fertility issues has largely placed stigma on the shoulders of women. Considering the gendered responsibilities that women have in motherhood along with the patriarchal social structure, Schaan et. al (2016) highlight the difficulties many Batswana women faced in regards to using contraceptive methods like condoms. HIV has represented a barrier preventing women from disclosing their status for fear of partner abandonment and inability to fulfill expectations as a mother. In our discussion on stigma, Kennedy elaborated on the effects that the epidemic had on women. Aware of the patriarchal reality in Botswana, Kennedy highlighted:

> In the early days of the pandemic, women were accused of spreading the disease. You would find a man with HIV and it was like you are like a woman. All the blame was heaped on women. A lot of women succumbed to that pressure. They suffered some sort of mental shock, like ‘I am responsible for HIV.’[9]

Faced with the limited ability to negotiate their sexual experiences in the context of patriarchy, women in Botswana remain vulnerable and thus at greater risk for acquiring

[9] The HIV/AIDS epidemic has evoked widespread stigma. However, in contrast to Sub-Saharan Africa that placed stigma on women, in the United States, stigma was largely directed at the homosexual male population (Siegel et. al 1998). Although the homosexual population of Botswana also faces stigma, dominating patriarchal structures are a primary factor in this context that have burdened women with stigma and the greater risk of contracting HIV.

HIV. Considering that condoms have been linked with suspicions of HIV spread, women are caught between two realities of stigmatization. For women who may have insisted on using condoms during sexual intecourse, they are burdened with blame of spreading the infection, while those women who participate in unprotected sexual encounters suffer a higher risk of infection.

Although frameworks of the ABC campaign did not apply to sexual or cultural practices outside of the United States, the model was adopted by the United States President's Emergency Plan for AIDS Relief (PEPFAR) in 2003 as the designated curriculum for generalized epidemics (Su 2010). By 2008 however, PEPFAR adjusted their funding guidelines by stating that at least half of the funding directed towards HIV prevention must focus on advocating for practices that include abstinence, monogamy, and fidelity. Condom only projects would not receive funding and condoms were only recommended for high-risk populations. For a 93 million dollar budget allocated to Botswana in 2008, 24 million dollars were directed towards these prevention programs similarly emphasizing abstinence, fidelity, and as last resort condomization (PEPFAR 2011). Although the relative priority of abstinence as a practice of prevention has varied across administrations, the incorporation of this focus has impacted locally organized initiatives that require PEPFAR funding in Botswana.

In addition to PEPFAR, the African Comprehensive HIV/AIDS Partnerships (ACHAP) is another international partner influencing the implementation of HIV treatment and prevention strategies. With HIV prevalence at its peak in 2001 at almost 27 percent, the government of Botswana partnered with the pharmaceutical company of Merck & Co. along with the Bill and Melinda Gates Foundation to provide free ARV

treatment across the country (Ramiah and Reich 2006). While universal treatment coverage was only offered to Botswana citizens, this partnership enabled Botswana to become the first African country with a national HIV treatment program that has been sustained throughout the years (Allen and Heald 2004). Even though Botswana still faces difficulties with testing, the influence of a national treatment program has allowed for 83 percent of the 85 percent of individuals with known HIV positive status to access treatment across Botswana (UNAIDS 2017). With the new "Treat All" initiative implemented in 2016 that places HIV positive individuals on ARV medication regardless of CD4 count[10], Botswana continues to increase ARV coverage for those diagnosed with HIV (WHO 2017).

Although the Botswana-Harvard Partnership, Botswana-UPenn Partnership, and the Baylor International Paediatric AIDS Initiative are among other large contributors to a broad international support foundation in Botswana, many of these programs have reduced their funding due to Botswana's middle-income status. Specifically, PEPFAR has halved their funds from 84 million US dollars in 2011 to 39 million US dollars in 2015 while the Bill and Melinda Gates Foundation completely withdrew its funds from ACHAP in 2013 (NACA 2014; PEPFAR 2016). This reduction in funds from international donors has placed a greater burden on NACA's expenditures, which are expected to increase from $274 million in 2014 to $339 million in 2030 (NACA 2014). While this withdrawal in funds appears to reinforce Botswana's economic independence, the declining partnerships will continue to challenge the financial stability in providing national treatment and enhancing testing programs across Botswana.

[10] CD4 count is a measure of immune health. A CD4 cell is a type of white blood cell (T cell) that helps coordinate immune response. Without treatment, HIV weakens the immune system by destroying CD4 cells (NIH 2018).

The Civil Society Approach to HIV

Up until the early 2000's in Botswana, primary prevention initiatives continued to follow a top-down approach that impeded collaboration between the government, local councils, and civil society organizations (Allen and Heald 2004). While behavior change and prevention education were implemented by civil service and local councils working parallel to each other in Uganda, a multi-sectoral approach in Botswana was not addressed until President Mogae encouraged the greater engagement of civil society organizations such as church groups (Allen and Heald 2004).

Despite these initially disjointed efforts between the government and local communities, as early as 1991, Botswana launched the Peer Education HIV/AIDS Prevention Program (PEHAPP) at the workplace in accordance with Botswana's National Strategic Framework focus on prevention (Hope 2003). Initiated through the Community Health Services Division of the Ministry of Health, PEHAPP engaged co-workers to educate themselves and become experts on health issues regarding HIV/AIDS, safe sex, and prevention methods. Similarly, civil society organizations such as the BONEPWA also formed under the Ministry of Health have been important in disseminating information regarding HIV/AIDS prevention and care (BONASO 2004). Officially registered as an organization in 2000, BONEPWA focuses on the greater community response to HIV that engages those infected and affected by HIV to increase awareness about prevention and reduce stigma.

To learn more about this civil society oriented approach to HIV treatment and care in Botswana, I met again with Kgoreletso. Holding both a degree in nursing and a masters in public health, Kgoreletso has worked for several years within the Botswana

Ministry of Health prior to serving as the Executive Director for the non-profit of BONEPWA. Considering her passion for civil service and community work, Kgoreletso has additionally served as a board member for CEYOHO. As we met on a Wednesday afternoon in late June for tea at the nearest Wimpy's food chain within Gaborone, Kgoreletso began sharing this community-oriented response to HIV:

> Usually discussions are more about statistics, rather than how a person with HIV actually looks like. We are putting a face onto the HIV problem. It is important to have the locals, people living with HIV who are Batswana to be seen and known, that it is not only coming from foreigners, it is here with us.[11]

Civil society groups such as BONEPWA challenge the historically dominant western frameworks of treatment and care. The emphasis on Batswana voices highlights how civil society responses to HIV treatment and prevention are rather oriented towards the cultural dimensions and social factors relevant to various communities across Botswana.

These local HIV initiatives are also particularly relevant in the clinical context. Botswana has consistently faced a shortage of medical professionals with only 34 physicians for every 100,000 people (Mokone et. al 2014). Although Botswana has attempted to address this issue by training students abroad in the early 90s, few of these doctors have returned to the country to practice. Even with the opening of a Botswana medical school in 2009, still only 21 percent of doctors in Botswana are Batswana. As a result of this shortage of Batswana physicians, the work normally completed by doctors or nurses has shifted to training other health care assistants including counselors or peer educators from civil society groups to complete the necessary tasks within clinics and hospitals (Nkomazana et. al 2014).

[11] Audio-recorded interview in English with Kgoreletso on June 21, 2017. All quotations from Kgoreletso in this chapter draw from this interview.

This dynamic suggests the increasing "links between primary care and the community-based services" and reinforces the importance of peer education programs within the clinical setting (Nkomazana et. al 2014). As will be discussed in the following chapters, CEYOHO's "Staying Alive Project" represents peer education counseling carried out in various clinics across Gaborone. Through such initiatives, peer educators can conduct follow-up with patients on ARV medication adherence and assist medical professionals in ensuring that information is adequately conveyed to clients. These programs further demonstrate that the role of peer educators goes beyond simply filling a shortage gap to providing education and support to clients recently diagnosed with HIV in the clinical context.

Considering the focus of civil society and peer education groups on prevention and behavior change, it is important to understand how these components have been measured on a national scale. While the following statistics are interesting indicators of change, the scope of my research does not intend to draw correlations between these behavior changes and the impact of peer education in the realm of HIV work. The 2011 Botswana Progress Report on HIV/AIDS addresses these various elements of behavior change throughout the years of HIV intervention work (NACA 2015). For example, the report highlights that individuals between the ages of 15 and 24 with a basic knowledge of HIV transmission increased from 28.1 percent in 2004 to 43 percent in 2008. Furthermore, the percentage of young women and men between the ages of 15 and 24 that could correctly identify ways of HIV prevention and that rejected misconceptions about HIV transmission or prevention increased from 42.1 percent in 2008 to 47.9 percent in 2013 (NACA 2015). Despite these promising trends, the report also notes that

youth between the ages of 15 to 24 using condoms during non-regular partner sexual intercourse had declined from 78.4 percent in 2008 to 65.2 percent in 2013 (NACA 2015).

Although peer education through civil society organizations has served to educate the community on HIV/AIDS and prevention methods, the sustainability and implementation of such interventions in relation to its effect on behavior change still remains in question. Hope highlights the reality of this context:

> Peer health education is an effective tool for information dissemination and the changing of behavior among peers. Nonetheless, we need to wait and see how this translates long-term into the reduced rates of infection that have occurred in such countries as Senegal and Uganda (Hope 2003, 279).

While Hope's commentary underscores how it is difficult to draw causality between these interventions and Botswana's shift in behavior and knowledge, the following graph of new HIV cases over the past two decades appears to support Kennedy's claim that "something is happening" with regards to HIV prevention and care.

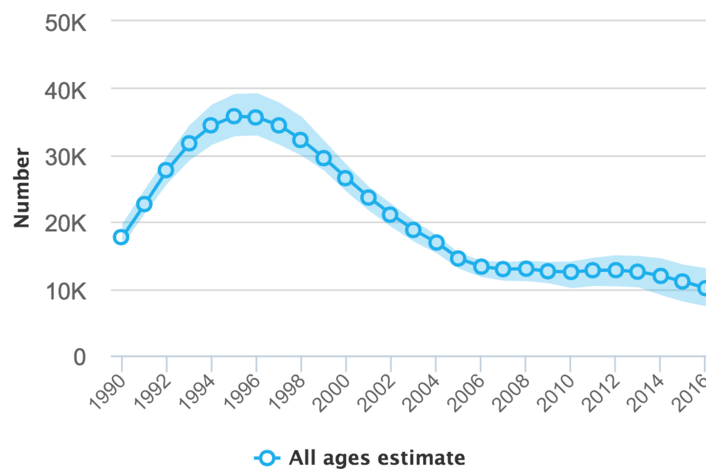

Figure 2. New HIV Infections for Botswana (all ages)[12]

[12] (UNAIDS 2017)

Overall, national statistics related to HIV show improvements in terms of reducing the number of new HIV infections, increased ARV coverage, and a declining rate of AIDS-related deaths (UNAIDS 2017). Despite these promising signs, the low rate of testing and later introduction of civil society initiatives in Botswana as compared with other African countries still appear to contribute to the higher HIV prevalence seen in the country. Acknowledging these limitations, Kennedy addressed improvements for the future. Having lived now with HIV for over 20 years, Kennedy contends: "people living with HIV are a resource that has not fully been tapped into. Change must come from us."

Conclusion

In the context of HIV, Botswana was considered to be a country that would stabilize and suppress the epidemic. Unlike countries such as Uganda that faced years of political upheaval and economic instability paired with a larger population, Botswana's small population and rapid economic growth were promising indicators of their ability to manage the spread of infection. Interestingly, Uganda has been remembered as the HIV success story[13] while Botswana continues to be plagued by a high prevalence of infection with low testing rates. As this chapter has demonstrated, the wealth of diamonds in Botswana did not appear to correlate with benefits for the greater Batswana population. Uneven wealth distribution, increased unemployment, frequent migration, and changing

[13] Although Uganda is often held in high regard to their early initiatives that resulted in a rapidly decreasing incidence rate of HIV, it remains important to problematize this "success story." Specifically, the 2011 AIDS Indicator Survey of Uganda highlights that over the last 8 years, the decline observed in HIV prevalence and incidence has levelled off (AIS 2011). The New York Times also published an article titled, "In Uganda, an AIDS Story Comes Undone" to point out that from a prevalence of 6.4 percent in 2005, prevalence has actually increased to 7.3 percent in 2012 (Kron 2012).

sexual partnerships have all contributed to the growing spread of HIV infection across Botswana.

By addressing the initial HIV programs adopted by the Botswana government, this chapter has highlighted the dominating western influence in the dissemination of knowledge throughout the country. The failure of Botswana to initially include local and culturally specific approaches has led to a legacy of suspicions and stigma around HIV and HIV prevention and treatment methods. This chapter also highlights more recent innovations that involve civil society in HIV work to give background and contextualize the work of my informants. Drawing attention to current factors of behavior change, I have tried to demonstrate where peer education falls within the larger network of HIV treatment and prevention work. With this background in mind, the following chapter will explore the demographic importance that CEYOHO places on youth. Specifically, how has the situation of youth in southern Africa contributed to CEYOHO's goal of educating youth in HIV prevention and treatment methods? How do youth symbolize an educated future that embraces HIV prevention and stigma reduction?

Chapter 3

Youth of Hope: Seeds for the Future

Youth as a concept in Botswana is constantly challenged and shaped by economic and cultural forces across the country. According to Deborah Durham (2004, 601) who has done ethnographic work on youth in Botswana, "claiming the space of a youth or elder...is an ongoing political struggle" largely tied into the state management of the population. In some cases, youth are defined as those individuals who have yet to establish independent households and in other circumstances, youth are people that are still in or could be in school. Even young individuals who have had children are still often considered youth due to their dependency on other family members to help them raise their own children (Durham 2004). Considering this varying definition of youth, the Botswana Revised National Youth Policy of 2010 defines youth as individuals between the ages of 15 and 35 (Ministry of Youth, Sport and Culture 2010).

Factors of high unemployment across Botswana have also contributed to this complex understanding of what is considered youth. Data from the World Bank (2017) suggests that unemployment in Botswana for people between the ages of 15 and 24 has increased from 25.4 percent to 33.2 percent within the years of 1991 and 2017. As a result of this economic situation, many youth lack a social support network allowing them to complete secondary school and gain marketable skills essential for employment (Baxter and DeJaeghere 2014). Without steady employment or income, individuals must often prolong time before marriage which is considered a marker of independent adulthood (Honwana 2013).

By prolonging time until marriage and in order to maintain a livelihood, youth participate in alternative economies that often include the commodification of intimacy and sexuality. Honwana (2013, 90) underscores that "young people use all the means available to them, including their sexuality, to gain access to consumer goods." The involvement of youth in these sexual economic opportunities points towards higher risk behaviors linked with the spread of HIV infection (Baxter and DeJaeghere 2014). Again when considering the wide ranging definition of youth, over one-fifth of Botswana's population remains at risk for HIV infection (Ministry of Youth, Sport and Culture 2010). While economies of intimate exchange are interconnected with these changing definitions of youth, for the sake of organization in this ethnography, this chapter will primarily address the different understandings of youth without engaging in literature regarding transactional relationships. I am aware of the intersectionality between issues of youth, HIV diagnosis, and gender, and will address these aspects in relation to intimacy and economic exchange in the following chapters.

Despite the instability and unemployment associated with youth across Botswana, CEYOHO centers their peer education work on youth as a symbol of hope for an educated and responsible future. Hope is the driving force and has been identified as such in the work of Paul Ricoeur (1970) and Ernst Bloch (1986). Ricoeur contends that "hope is an impulse that opens the system, breaks the closure of the system; it is a way of reopening what was unduly closed" (cited in Miyazaki and Swedberg 2017, 3). Hope as a moving power for action is reflected in Bloch's (1986) understanding of concrete utopian thinking. For Bloch, a utopia embodies an expression of hope through dreams of a better life and the process of reaching towards a transformed future (cited in Levitas 1990, 14).

But Bloch is critical of an abstract expression of utopia rooted in wishful thinking or a "dream" state for something better. While abstract utopia is driven by desire in the sense of wishful thinking, hope is only manifested in a concrete utopia directed towards will-full thinking and tangible change (Levitas 1990, 15). Bloch (1986) terms the hope connected to concrete utopia as *educated hope*. An educated hope is not ignorant of social suffering, but rather brings together frameworks of desire, intervention, and struggle to mobilize social transformation and change (Giroux 2002, 103).

Following an HIV diagnosis (either their own or the diagnosis of their client), peer educators strive to create this educated hope through disseminating knowledge on HIV prevention and treatment that will promote a better future with heightened awareness and de-stigmatization. Drawing on Bloch's notion of educated hope, this chapter seeks to understand how peer educators establish connections, particularly with youth, to carry on their mission of education and vision for the future. As educators, how do CEYOHO members work to impart their knowledge about HIV prevention and care to transform the social reality of those infected and affected by HIV? How instrumental is the concept of youth for CEYOHO's plan of action for future social change? Through the narratives of my informants, this chapter explores the interconnections of youth, hope, and the future to gain a deeper understanding of the relevance of knowledge and trust for CEYOHO's practice of an educated hope or educated future, terms I will use interchangeably throughout this thesis.

Knowledge for the Future

Following my afternoon class at the University, I skipped lunch and began to walk along the main road to the Gaborone Secondary School. "Come around 1:30 to the school, we will be speaking to the students," Lesogo had texted me earlier that morning to remind me. Arriving at the gated entrance of the school, I crossed the courtyard and headed to the counseling office. Sitting at the main desk in the office, Lesogo and Neo invited me in as they were finishing lunch before their presentation. Having worked with CEYOHO for many years as youth educators, Lesogo and Neo consider presentations part of their routine.

As the two were setting up their presentation in a neighboring classroom, a sea of thirteen year-olds flooded in and sat down. Once the whispers and giggles settled, Lesogo and Neo began by introducing themselves (and I briefly introduced myself as well) as youth educators working with CEYOHO. Neo then continued to turn on the projector to play the short STEPS documentary about a girl orphaned because of HIV: "Keitumetse's House." When the documentary finished, Lesogo stood at the front of the classroom and asked the students: "Put yourself in Keitumetse's shoes. What would you do?" Along with reflections on the film, Lesogo opened the floor to other health and wellness related questions. To allow for a more personalized discussion among the students, Lesogo added: "you can even ask me personal questions."

By reaching out to schools across Gaborone, CEYOHO emphasizes the organization's focus on youth. In describing this intended approach, Kesego exclaimed: "I founded the organization while I was just a youth with HIV, now I am grown up. As a person living with HIV, I was seeing that there was no room for young people living with

HIV."[14] Similarly, many peer educators further added that the emphasis on youth stems from the fact that "youth are the ones at risk." Although mother-to-child transmission has significantly decreased across Botswana, this heightened risk for youth results from a combination of structural issues that include inconsistencies in contraception access, multiple concurrent partnerships, and lack of formalized sexual education within Botswana school systems (Advocates for Youth 2008).

While these challenges still persist among the youth communities, Kennedy pointed towards a new reality where youth and a greater awareness of prevention methods can serve as the hope for reducing more HIV infection. To emphasize this hope for a better future, Kennedy reflected on the past where resources were limited and treatment as prevention[15] was an unthinkable solution. Following a long sigh, Kennedy reflected:

> We lived with hope, but we knew back then there was really no hope when there was no talk of ARVs compared to these days when there is hope, there is treatment. I get tested and I am diagnosed with HIV, I get treated. In those early days I was one of those people motivating others, asking people to test, though there was no treatment back then.[16]

Kennedy's narrative highlights the paradoxical nature of hope. Even during a time of lacking resources, hope rises from this suffering and struggle. Miyazaki and Swedberg (2017, 3) echo that hope "contains within itself its opposites such as fear, disappointment, and despair." Despite this negative reality, it is also this hope that pushes Kennedy to action in motivating others to test even when treatment was not an option.

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[14] Audio-recorded interview in English with Kesego on April 10, 2017. All quotations from Kesego in this chapter draw from this interview.

[15] Recent scientific evidence suggests that when HIV positive individuals correctly take their ARV medication, they are less likely to transmit the virus to others. This practice is often referred to as "treatment as prevention" (CDC 2017).

[16] Audio-recorded interview in English with Kennedy on June 17, 2017. All quotations from Kennedy in this chapter draw from this interview.

The drive for social transformation and change that is formed out of pain highlight the practice of an educated hope. Drawing back on Bloch (1988), an educated hope "is born out of and articulates this relationship between end and means, passion and reason, aspiration and possibility. It represents the transformation of wishful thinking into will-full and effective acting, the move from the dream to the dream come true" (cited in Levitas 1990, 20). Just as Kennedy works to motivate others in times of despair, peer educators equally carry on this mission of an educated hope. With the current availability of treatment and prevention methods, peer educators have the tools to initiate action and instill knowledge across the greater generation of youth.

This dissemination of knowledge regarding HIV treatment and care remains fundamental in sustaining an educated hope. In the search for knowledge and growth, Miyazaki and Swederg (2017, 10) highlight that an educated hope calls for a "continuous performative and interactive work of active commitment to knowing while recognizing the ultimate human capacity to know." This dynamic search for knowledge is present in how HIV prevention and ARV therapy came to resemble "a form of enlightenment, an indication of being modern and progressive...a new consciousness" (Whyte 2014, 15). This enlightenment through knowledge applies to the CEYOHO approach of educating themselves and others on the necessary prevention methods to embrace an educated future.

Chokchok experienced this interconnection between knowledge and hope through her own transformation of becoming a CEYOHO peer educator. I met Chokchok on a cool June afternoon during her lunch break. Standing by the chain-linked fence at the entrance of the clinic, Chokchok's golden weave glimmered with sunlight and her warm,

hazel eyes greeted me. “Welcome darling, did you bring me something to eat?” Sitting in her counseling office lined with stacks of client paperwork, the two of us sat, chatting over braai meat and a salad of sweet potatoes and cabbage. Diagnosed with HIV at the age of 22 and now in her early thirties, Chokchok reflected on her own HIV diagnosis. In her soft, yet confident manner Chokchok shared her own testimony with me:

> When I started my medication, I was drinking *bojalwa* (alcohol). Sometimes I forgot and would say, 'ah let me just forget about these things and move on with myself.' When you are on ARV treatment, if you want to live long, it is for you to quit drinking alcohol and substance abuse. Because when you are drunk, there are many bad things that you will do for yourself, sometimes you will not take your medication.[17]

The behavior changes described in Chokchok’s narrative connect to hope for a changed future that will positively benefit her life and contribute to the reduction of re-infection. Having lived with *mogare* (the virus) now for over eleven years, Chokchok’s increased awareness of her condition has served to inspire and educate others recently diagnosed or in denial about their HIV status. When asked what she likes about working as a peer educator for CEYOHO, Chokchok said: “It motivates others. People are sharing things and learning through our organization.” This calling to educate and motivate others is reflected in Mittleman’s (2009) understanding of hope as a virtue that can ultimately be “felt as knowledge and [serves] as an affirmation of something other than mere desire or wishfulness” (cited in Miyazaki & Swedberg 2017, 9).

Lesogo similarly expressed this responsibility of educating the community, particularly youth, in regards to behavior changes that promote prevention and reduce infection. Having been with CEYOHO for over five years, Lesogo found her passion for working with youth and serving as a mentor to students. As a young woman herself,

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[17] Audio-recorded interview in English with Chokchok on June 1, 2017.

Lesogo exclaimed, “I can understand what they are going through.” Lesogo and I met over dinner one evening at the Riverwalk Shopping Center to discuss her position as a youth educator and commitment to adolescent sexual education. Chatting over steaming bowls of chicken pad thai, Lesogo paused to reflect:

> I make sure that, indeed, I live what I am preaching. I make sure, I am living what I am saying, I want to be an example for them. I used to stay in Tlokweng, but they are telling me, 'why don't you go out for fun here?' I say, 'I cannot have fun here, I am working for the community of Tlokweng. I would rather go out to Riverwalk to have fun and come back home.’ I should respect myself and my community, so that they can respect me also when I am standing in front of them. It is making a person more responsible. I talk to the youth, every youth should see themselves like me behavior wise.[18]

As a role model, Lesogo embodies the hope of instilling knowledge about healthy practices that prevent infection and reduce stigma. As a young community member, Lesogo challenges conceptions that traditionally frame youth as dependent or without adult authority. In holding this position as a youth leader, Lesogo not only promotes accountability among her peers, but reinforces the ideology of youth of hope.

Connections of Trust

Returning to the introductory narrative with Neo and Lesogo, CEYOHO primarily receives funds through NACA to visit schools across Gaborone to offer counseling services and teach about sexual health. When discussing with various peer educators about the curriculum implemented in schools with regard to sexual education, many focused on abstinence. Curious about this approach, I questioned further, “Is that realistic?” Following a hesitant chuckle, Kennedy described: “You cannot go to a school and do a condom promotion campaign, they will stop you.” Considering that the

[18] Audio-recorded interview in English with Lesogo on April 20, 2017.

Botswana government prioritizes abstinence teachings over condomization in primary and secondary schools, CEYOHO also has incorporated this guideline into their lesson plan. Independent from having to follow government guidelines, Lesogo did consider the importance of incorporating abstinence into their curriculum. As we chatted at the CEYOHO center, Lesogo explained:

> The reason why we are promoting abstinence for youth is because we are trying to avoid re-infection. We found that people mostly get it through sex, so if you can cut the sex part out, at least we would have fewer people becoming re-infected. Re-infection is when you are already have HIV and then you are having sex with an HIV infected person. That person's HIV gets into contact with your virus, things can just go wrong, so it is best when we just say no sex.[19]

While CEYOHO remains a proponent of abstinence, peer educators are aware that this method is not always the solution to HIV prevention. Kennedy along with other peer educators admit that as a practice, abstinence "is not always realistic." As an alternative, Neo clarified that peer educators ensure that clients are made aware of safe practices. Although peer educators are unable to perform condom demonstrations or distribute them in classrooms, they organize workshops within the community and at the center for youth to attend and learn about alternatives to abstinence. Neo who had recently turned 18 and whose relationship with CEYOHO started when she was a child commented:

> If you are sexually active we do this condom demonstration so that you are on the safe side. Because if you are saying, ' I want to have sex, I want to drink alcohol, I want to have fun', we try to make you see the other side of the story, because obviously, if you are using drugs, alcohol, having sex, we need to show you both sides of the coin. Ok fine if you do it, do it on the safe side with safe measures. We do not want to lose hope, we just need to keep teaching because we cannot say that 100 percent of people are getting it.[20]

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[19] Audio-recorded interview in English with Lesogo on April 3, 2017.
[20] Audio-recorded interview in English with Neo on May 24, 2017. All quotations from Neo in this chapter draw from this interview.

The emphasis on abstinence along with the recognition of other alternative methods speaks of CEYOHO's established curriculum that allows peer educators to access youth communities within schools.

CEYOHO's most evident goal is to bring awareness to HIV prevention practices. Less evident but essential to peer educators is the objective of building trust and rapport with youth who are seeking advice and counseling. The dissemination of knowledge is key to how peer educators seek social transformation, but so is trust, which according to Miyazaki and Raffnsøe (2015) lies between the spectrum of knowledge and hope. The exchange of knowledge that peer educators encourage with their clients, contributes to the construction of more trusting relationships. Just as trust is rooted in knowledge, "hope emerges as a capacity to rest assured and embrace human uncertainty and powerlessness, as one entrusts oneself into another's keeping" (Raffnsøe and Miyazaki 2015, 185). The possibility of an educated future with HIV relies on the ability of peer educators to sustain their trust with clients and provide the hope and motivation that can shape positive behavior change.

Neo pointed out the importance of trust in their youth-to-youth approach to counseling in the schools:

> Counselors request us to come to the schools because in most cases it is better to tell a stranger your problems than to tell a person you see 24/7. So in that manner, the students feel free around us, because we do not spend that much time there, so they can open up to us and they cannot open up to their teachers, because most of the time, there are teachers who when I tell them my problems, I will be the talk of the town, all the school teachers would have to know that I have a problem. In that way it makes students pull back with their problems. But when we go there, students are able to open up to us and tell us how they feel about their lives or the problems they are facing.

This idea of placing trust in a "stranger" is echoed by Simmel in his essay *The Stranger.* Simmel (1950, 2) reflects on how the "stranger" is often received with openness because "[they] (the stranger) are not radically committed to the unique ingredients and peculiar tendencies of the group and therefore approaches them with specific attitude of 'objectivity.'" Simmel (1950, 2) shows that this objectivity serves as a source of freedom that enables the individual to not be "bound by...commitments which could prejudice his perception, understanding...and allow the stranger to experience...even his close relationships as though from a bird's eye view." Due to the stranger effect, peer educators are perceived as neutral and more approachable figures for students that are seeking someone to confide in about their issues.

Lesogo provides another example of the guidance peer educators offer; this one based on her youth counseling experiences when visiting a school in Gaborone. Strolling across the patio at the CEYOHO center, Lesogo explained:

> There was this young girl, she was just under self-stigma, she just wanted to know why out of all her siblings, she is the one living with HIV. Her sister is not living with HIV, her brother is not living with HIV, just her. She wanted to know who was going to accept her. During break time she came along and said, 'You are here for a week, and there will be no way to see you, so can you kindly refer me to someone that I can be open with.' I asked her if she was ok with her guidance counselor and she said, 'no'. So I was able to refer her.[21]

Lesogo's role as a peer educator who is also a stranger allows an openness to offer advice and referrals. Rice and Farquhar (2000) highlight the benefits of some confidential and anonymous resources in HIV youth education and prevention programs. Specifically, organizations that have utilized telephone hotlines to provide person-to-person services have demonstrated success in ensuring confidentiality and approaching young people

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[21] Audio-recorded interview in English with Lesogo on April 3, 2017.

about sensitives situations requiring advice and referrals (Rice and Farquhar 2000, 191). As strangers, peer educators and other confidential programs can ultimately evoke the trust required to share HIV knowledge and sustain the hope of an educated future.

The fact that peer educators remain strangers does not make them less approachable to clients. On the contrary, as strangers they can rely on a certain relatability that further facilitates a relationship of trust and rapport. Just as "the stranger...is near and far at the same time," peer educators maintain a dynamic of distance and closeness to heighten connections of trust (Simmel 1950, 3). Between two strangers or between peer educators and their clients, "commonness functions as their unifying basis" to motivate the trust necessary for achieving an educated hope (Simmel 1950, 3). This relatability between youth peer educators and students became evident in my conversation with Jack, the youth president of CEYOHO who is 21 years of age: "As youth we deal with different problems...most old people think we do not face problems...it is easy for me as a youth to talk to other youth about these things."[22] Neo also highlighted the significance of youth as a basis for trust.

> It is better when we get advice from our peers, because a 60 year old cannot talk to a 15 year old about sex or 'don't do this or don't do that', so basically it is easier when you get advice from your age mate and we do that by going to the schools and we start talking at the schools.

Jack and Neo convey that age can serve as a point of connection between peer educators and their clients. Through the commonality in age, peer educators bring a closeness that again allows for the necessary trust to impart knowledge and continue spreading awareness about HIV and prevention.

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[22] Audio-recorded interview in English with Jack on June 14, 2017. All quotations from Jack in this chapter draw from this interview.

Pedagogy of Hope

In finding commonality with their clients, peer educators embrace the collective sharing of knowledge embodied in Freire's (1987) understanding of participatory education. Freire (1987, 90) highlights that it is "impossible to teach participation *without* participation...it is impossible just to speak about participation without experiencing it." While HIV youth education has, "too often focused on...classroom-based activities with the teacher...lecturing about anatomy, risky behaviors," the Freirian framework suggests that "knowledge does not come solely from experts" (Rice and Farquhar 2000, 187). In contrast to this expert and authoritative model, "collective knowledge emerges from the group experiences and local knowledge of individuals in an effort to understand the social influences that affect individual lives" (Rice and Farquhar 2000, 187).

By following this collective rather than authoritative schema of education, peer educators and clients embrace their shared and connected experiences to construct an educated future. As a young woman often offering advice and counseling to other young women, Neo embodies the reality of this participatory approach. Weaving the tips of her straightened hair through her fingers, Neo recalled an earlier counseling experience:

> This girl, she is doing her form five and got involved with an older man. Then few months down the line, she decided to pull out and this man was then proposing to this other woman that he was staying with. But as he was proposing, the lady found out that this man was in a relationship with the girl, with a student in fact, so the lady threatened to kill her, come to school and beat her up in front of her classmates. I advised her, 'I think it is best that you tell your parents because, if you tell your parents the whole truth, they will be able to see you through. What is the use of lying to your parents while you are living with them and at the end of the day you are lying to them and then get up beat up by a lady at school - that is when the truth will come out.'

While Neo may not share the same experiences as this young girl, their youth still connects them. Rather than taking a dominating or judgemental stance, the

encouragement and support that Neo offers stresses the responsibility that peer educators have in "unveil[ing] opportunities for hope, no matter the obstacles" (Freire 1992, 3). Although Freire emphasizes a joint learning process, CEYOHO peer educators are responsible for enlightening clients about the opportunities that contribute to a growing awareness of HIV prevention and treatment. By offering this collective knowledge, peer educators emphasize a "learning process whereby...the crushed, the rejected teach that, through serious...determined struggle, it is possible to remake the world" (Freire 1992, 3).

The participatory education between peer educators and clients extends beyond the counseling sessions at the clinics or in the schools. Aware of some limitations in the classroom approach, Jack shared that sometimes in these school settings, students will "sit in the classroom but don't listen to what you are saying and can be ignorant of the information." Peer educator Liseho also reflected on the current context contributing to other limitations in accessing youth: "Things are different. There was no media, there is technology now too much. So we are supposed to take this situation and put it in a way that youth will understand it better."[23] In light of these changing realities, Rice and Farquhar (2000, 191) similarly highlight that "classroom course alone cannot be expected to change sexual behavior in a direction that is into opposition to the adolescent's sexual world."

To address these factors, CEYOHO has planned to integrate technology and social media based approaches to expand their teaching and outreach on HIV treatment and prevention practices. When discussing these technology driven plans for CEYOHO, Kennedy outlined the organization's goals:

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[23] Audio-recorded interview in Setswana (with English translation) with Liseho on June 1, 2017. All quotations from Liseho in this chapter draw from this interview.

> We want to scale up our treatment literacy activities, we want to do a short video project. Since social media is mainly used by young people, we want to do short videos talking about various aspects that can be shared on WhatsApp and you can watch them on the bus, at work, you can upload them via Facebook. So we know that this can impact the community positively, we know that so that they can see that through our eyes.

The incorporation of media into prevention approaches will expand the ways in which youth receive information regarding sexual health and HIV. In emphasizing the importance of "seeing through our eyes," Kennedy again highlights the collective rather than authoritative approach in educating the community. Including personal and shared experience into this strategy enables peer educators to build trust that strengthens and validates their knowledge and thus continues to motivate a hope for better education. Through a project for youth and by youth in the community, peer educators not only empower themselves through the application of their educational skills, but empower others through the greater dissemination of information via technology.

Empowerment through participatory education further enables peer educators to establish a critical consciousness among their clients. Freire (1993) emphasizes that a critical consciousness among a community develops "the ability to think holistically and critically about one's condition, with the belief that existing norms can be changed" (cited in Campbell and MacPhail 2002, 333). The HIV knowledge provided by peer educators across various educational platforms allows for clients and community members to gain insight into the conditions and factors that play into living with HIV. In gleaning this awareness, the community attains confidence to collectively change behavior that promotes prevention and reduces stigma for an educated hope.

Conclusion

The concept of hope for an educated future has been foundational for this chapter. Although youth across Botswana have faced a high burden of unemployment and risk of HIV infection, hope is embodied by youth who symbolize a new social-changing generation motivated by education for the future. For CEYOHO, the youth of hope represent both peer educators and clients working collectively to embrace this knowledge about HIV prevention and treatment methods. While an educated hope remains the primary goal of CEYOHO peer educators, this chapter has highlighted the role knowledge and trust have in stimulating this hope for a better future. By building trust through a position that evokes both distance and closeness in relationships between peer educators and clients, peer educators establish credibility in terms of knowledge.

Rather than practice an authoritative model of education, peer educators embrace a collective approach that allows for the contribution of shared experiences and struggles. In bringing attention to these challenges, peer educators establish a pedagogy of hope that serves to bring awareness and empower the community of infected and affected through HIV education. Beyond creating shared spaces of struggle, this participatory education contributes to the process of critical consciousness necessary for social transformation and change. While this chapter has discussed the importance that shared experience (through factors that include age and HIV status) has in establishing trust, the following chapter addresses how testimony is used to solidify the trust between peer educators and clients in order to sustain the flame of hope.

Chapter 4

Sustaining Hope: The Politics of Testimony

Testimony strengthens the necessary bonds of trust to motivate social transformation for an educated hope. In establishing this trust, the expression of testimony and personal narratives enable the creation of shared space where individuals can come together to understand their similar experiences (Levy 2005, 9). In that sense, CEYOHO peer educators offer their own testimonies of living with HIV to show clients that they are not alone in the challenges that come with an HIV diagnosis. Apart from using their testimonies to facilitate trust with clients, create community, and encourage reciprocity, peer educators utilize their personal testimony as a strategic device to foster behavior change for moral reconstruction aimed at achieving an educated hope.

While testimony may have its roots in traditions of Botswana oral history, peer educators privilege the use of the term and practice of testimony for its political implications. Unlike oral history that remains important in transmitting cultural events and traditions across generations, testimony seeks to convey a certain urgency regarding the struggle of marginalized people (Dobson 2011; Gugelberger 1996, 28). By standing openly as individuals living with HIV and willing to share their previous experiences of suffering, peer educators call attention to how they and their community have been disadvantaged or stigmatized because of HIV.

This call against prejudice highlights how individual testimony shared between peer educators and their clients extends beyond personal relationships to address society at large. When used as a political tool, testimony can "denounce systemic oppression and inspire social justice activism" (El Ashmawi et. al 2018, 71). With testimonies that resist

social marginalization and stigmatization, CEYOHO peer educators criticize HIV programs and policies that fail to include the voices and knowledge of those living with HIV. Even though these testimonies evoke powerful "I" statements voiced by individual speakers, testimony also often embraces a greater community sharing in struggle (Gugelberger 1996, 28). Considering that policy makers and other government officials "cannot see" through the eyes of those living with HIV, peer educators employ their testimony as this collective response to initiate the necessary social change for an educated future.

This chapter seeks to understand how testimony functions in different ways to foster community and to destigmatize HIV diagnoses. How does this collective sharing further reflect empathetic understanding? On a larger scale, how do peer educators mediate information between different actors to ensure adequate treatment and care for their HIV clients? How do peer educator testimonies go on to convey a political critique about current HIV policies to demand social change?

Entrusting Testimonies

My first conversation with Gouta was at her home village of Mmankgodi, about an hour outside of Gaborone. Before sitting down to talk, Gouta gave me a tour of her home showing me her chickens and the corn hanging in the sun waiting to dry. As we pulled two chairs under the shade of a tree in her yard, Gouta began to share her work as a peer educator in the clinics around Gaborone. Her counseling sessions incorporate not only teaching patients about ARV treatment, but also encouraging them to maintain important health practices that are essential when living with HIV. These practices

include adhering to medication, practicing safe sex, reducing alcohol consumption, and disclosing their HIV status to sexual partners.

Having started ARV treatment in 2002, Gouta relies on her own personal testimony as a platform to reach out and establish trust with her clients:

> People are still denying, people are still dying, and people are still defaulting at the clinic. People do not understand when the nurses tell them, 'ARVs, we take them for life.' When their CD4 count goes up, they leave the pills and that is why CEYOHO took us to the clinic to support them and to tell them stories about me, not somebody else. I am the first person to tell them, 'Do you see me, am I sick?' They look over me and I start to tell them my testimony. Because if you do not tell the testimony, there is no way you can approach the patient. But if I can tell them my testimony, they can be open.[24]

By disclosing her status with clients, Gouta privileges her identity as a fellow person living with HIV, rather than her position of authority as a counseling figure. This perspective incorporates the kind of empathetic understanding that Hollan (2008, 479) describes as a process "modeled on personal experiences that are homologous to the experiences and behaviors we are attempting to understand...One can only understand another's overwhelming grief by having been overwhelmed with grief."

The vulnerability that Gouta shares with her clients further allows her to initiate a relationship based on trust and understanding. In opening up about her personal struggles, Gouta seeks to establish a reciprocal exchange of testimony and experience (Raffnsøe 2015). More specifically, Gouta's decision to share her testimony is tied to expectations of also having clients accept their HIV status to enable the continual restructuring of their lives after the diagnosis.

The disclosure of vulnerability that facilitates trust and reciprocity is also experienced by Chokchok. Following a morning of counseling, Chokchok offered to chat

[24] Audio-recorded interview in English with Gouta on May 6, 2017. All quotations from Gouta in this chapter draw from this interview.

with me during her break. Sitting across from each other at her counseling desk, Chokchok rubbed the arms of her emerald velvet sweater for warmth as I asked her about the nature of her counseling sessions. "How do you connect with new clients?," to which she replied:

> The time I got infected with HIV, I used to have a friend who was doing sex work and we would go together. When she would meet with the clients, they would pass on to my side. The guy, I didn't know his status and then the condom blasted. That thing stressed me because I had a boyfriend at the time, maybe I was doing that because my boyfriend was cheating on me. So, she passed that one guy to me while she was busy doing sex work there and the guy was HIV positive. I did not know that.[25]

Discussing her HIV status in the first counseling session allows Chokchok to chip away at the stigma attached to an HIV diagnosis and to instead promote an environment of acceptance and normalcy. The admission of her own challenges to a client further enables Chokchok to participate in a shared empowering experience. Abdi and Simbar (2013, 1202) highlight that peer education programs aimed at behavior change "may simultaneously empower the educator and the target group by creating a sense of collective action." Through fostering an open dialogue based in a joint struggle, peer educators initiate a "moral contract" based on trust and reciprocity with their clients to collectively approach their moral reconstruction after an HIV diagnosis (Raffnsøe 2015, 206).

Chokchok elaborated on this collective response to HIV acceptance and awareness in the context of counseling her client and friend, Ruth. Ruth came to Chokchok after her HIV positive diagnosis. Frustrated and ashamed after having been infected by her husband, Ruth remained in denial about her status and did not properly

[25] Audio-recorded interview in English with Chokchok on June 8, 2017. All quotations from Chokchok in this chapter draw from this interview.

adhere to her ARV medication. Recognizing her situation, Chokchok invited Ruth to attend a CEYOHO support group meeting where both peer educators and clients come together to share their experiences and stories as individuals living with HIV. Chokchok recounted:

> Some of them [people at the meeting] were saying, 'ah if you are HIV positive, it is not the end of the world.' Another said, 'Ah, I got infected when...' Some people were sharing, and Ruth was sitting quietly, she was looking at those ladies sharing and then she went outside. I followed her and I asked her what was wrong. 'Hey Chokchok, it seems like these people are talking about me. But this motivated me, because I was not expecting to find beautiful ladies in this facility.'

The collective experience of sharing testimonies allows individuals to come together to work towards an educated and aware future. While testimony can reaffirm individuality in growth and transformation, the commonality between individuals establishes the connection with a group marked by marginalization and struggle (El Ashmawi et. al 2018, 71). Through this collective approach based on trust and support, clients are aware that they are not alone as individuals living with HIV.

These support sessions appear to mirror other support group meetings such as alcoholics anonymous (AA) in the sense that personal narrative is used as the foundation to connect veteran and new members of the group. In her ethnographic analysis of AA, Levy (2005, 20) found that, “storytelling by ‘old-timers’ provides control over which stories are told. The moral voice of these stories is that they tell about how life ought to be lived and how stories ought to be told.” The idea of ‘control’ should not be viewed in a negative way or as authoritative in style, but rather suggests how experienced members provide structure within such support group meetings and establish a sense of belonging for new community members. Through the initiation of personal sharing, peer educators

at CEYOHO establish a supportive foundation for clients to tell their individual testimonies among people who understand them and that can empathize. In creating a community of trust and acceptance, peer educators sustain a collective hope for HIV education and awareness.

Strategic Testimonies

While testimony contributes to building the trust necessary for an educated hope, testimony is also a strategic tool to promote behavior change during a moral reconstruction. Liseho is adamant about the significance of testimony in social transformation. But she is also aware of the power of relatability for clients to be able to identify and take advantage of learning experience through testimony. Liseho who is a young mother of two describes how she tries to achieve that needed relatability:

> When I come to group of elderly people, I put myself to their age, that is what I do, I become an older woman also so that it can be easier for them to talk to me and get along with me. That is what I do. When I get to children, I also become a kid, so that it can be easier for me, to work together. So that tool that I am using, it is helping me get what I want. Even when I get, I am not a drunkard, when I get a temper, and I want information from them, I try to be like them (the drunkards) so that they give me what I want. When I get out of church I become a Christian, so I adopt everything to get along, so it is easier to get along with me and get the information.[26]

For testimony to work, identification between peer educators and clients seems essential, to the extreme of embodying different personas, as Liseho does to develop the needed relatability with clients. Although relatability is always important in establishing rapport, this example points to how peer educators can strategically adopt the perspective of a target population to facilitate trust and behavior change.

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[26] Audio-recorded interview in English with Liseho on June 13, 2017. All quotations from Liseho in this chapter draw from this interview.

Not only is testimony used as this performative strategy for promoting behavior change, but it is also a means through which behavioral strategies of moral reconstruction can be conveyed. The role of guidance attributed to testimony is highlighted by Frank (1998, 53) who demonstrates that, "stories have to repair the damage that illness has done to the ill person's sense of where [they are] in life, and where [they] may be going. Stories are a way of drawing new ways and finding new destinations." Through their own personal experiences, peer educators can offer their clients strategies for new and healthy ways to live as individuals with HIV.

Gouta uses her testimony to share strategic lifestyle changes for others to follow:

> I have three kids and the first step for me when I was HIV positive was I was very open. I told my kids, I am positive. They were very young. Why was I telling my kids I was positive? I was told to adhere to this medication. What I know is that kids, even though they don't know the type, if you have already told them you are on a medication the kid will say to you, 'have you forgotten to take the pill?' to remind you. It was so hard when I told them, but it was my kids who were helping me adhere. The best way to adhere is somebody has to know about your medication, especially someone in the family.

Gouta chooses to be open about her vulnerabilities and the ways in which she has altered her habits in order to improve personal health. These experiences again reinforce the importance of healthy living when HIV positive and serve as encouragement for Gouta's clients to follow suit. In other words, peer educators become important motivators. They are among those "certain individuals from a given population which act as agents of behavioural change by disseminating information and influencing group norms in their community" (UNAIDS 1999, 6). By incorporating personal testimony, peer educators utilize their relationships of trust to promote behavioral change and improve their clients' knowledge in regards to HIV treatment and care. With this participatory approach, peer

educators initiate the process of moral reconstruction to ensure that their clients do not "walk the path" of previous struggle.

Political Testimonies

Despite the influence of testimony on behavioral change, CEYOHO peer educators still remain limited in the range of strategies that can be utilized to implement HIV care and treatment programs. As I spoke with Kennedy at the CEYOHO office in Tlokweng, he shared the obstacles that CEYOHO has often faced in the development of these new HIV prevention projects. Pensively stroking his stubbled cheek, Kennedy lamented:

> We have brilliant interactive ideas. But we cannot implement them, because the people that implement them cannot see through our eyes, they do not understand these ideas that we know would benefit people living with HIV. People who grant funding are not in that position, so they cannot appreciate our initiatives. I have been trying to advocate for treatment literacy for 10 years and no boost. People see these interventions later, but us people living with HIV we can see that we need to do this and that our fellow people living with HIV can make use of this information. I am HIV positive and I am designing programs for other people living with HIV. I am in their shoes.[27]

In highlighting the inability of government officials and policy makers to "see through the eyes" of those living with HIV, Kennedy underscores the barriers peer educators face in resource recruitment and promotion of improved treatment programs. While Kennedy's commentary does not directly address personal narratives, his emphasis on being "in their (others with HIV) shoes" hints towards the shared experiences of those living with HIV that cannot be understood by others without the same diagnosis.

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[27] Audio-recorded interview in English with Kennedy on June 17, 2017. All quotations from Kennedy in this chapter draw from this interview.

In this case, the testimony of peer education stands as an outspoken criticism of the absence in political will and empathy to make programs and policies that could benefit the HIV positive community. Peer educators transform the “personal into the political” (El. Ashmawi et. al 2018, 72). Just as peer educators resist the forces that silence the voices of those living with HIV, El Ashmawi et. al (2018, 75) argue how testimony highlights a “desire not to be silenced or defeated, to impose oneself on an institution of power...for social change.” By taking a political stance with their testimony, peer educators continue to advocate for those living with HIV.

The political importance of peer educator testimony also concerns the dynamic between clients and higher-up health officials in clinical settings. Many peer educators working at clinics described the issue of patients who “lie” to the doctors or nurses about why they are not adhering to their medication. Lesedi, a peer educator in her early forties claimed, “many will say that they did not have money for transport or that they did not have food to take with the medication.”[28] Considering her own previous financial struggles to maintain a good diet while on medication, Lesedi did acknowledge the validity of these claims. However, this lack of compliance with medication still contributes to the disconnect between medical professionals and their patients.

When I asked Kesego about the source of tension, she explained that, “they [the doctors and nurses] are from the government. The peer educators are from the community and live within the community.”[29] Kesego’s commentary suggests how testimony and shared experience can extend to social and cultural realities between peer educators and

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[28] Audio-recorded interview in English with Lesedi on June 15, 2017. All quotations from Lesedi in this chapter draw from this interview.
[29] Audio-recorded interview in English with Kesego on April 26, 2017. All quotations from Kesego in this chapter draw from this interview.

their clients. While the status of higher-up medical professionals is associated with the government and a sense of distance from the community that "cannot see through their eyes," peer educators remain connected through a shared social status and health condition as their clients. With this shared background, peer educators embody the empathetic connection that Hollan (2012, 71) describes as a "conscious awareness and engagement with other bodies and people." Spinrad and Eisenberg (2014) further highlight that an aware empathy is rooted in the "apprehension or comprehension of another's emotional state or condition."

The awareness and orientation towards shared testimony and experience allows peer educators to act as the translators of empathy for health professionals. This process of translation ensures that patients can express their concerns openly while still receiving the adequate information necessary for their HIV treatment and care. Gouta highlighted that part of this communication role involves easing the tension clients may feel in clinical environments with health professionals:

> If the client approaches the nurse and have some wound, they often cannot tell the nurse. They will say, 'I have a headache'. So the nurse just gives the patient a pain killer. They will stay for three months with that wound. But as a peer educator, sometimes I can say: 'I want to talk with you. I am Gouta from CEYOHO. I am here in the clinic to provide you information so that you can be treated. The best way to be treated is to say things out, not to hide things. I have been sick for so many years, even if you have something, just tell me. After you tell me, you go to the doctor or nurse and you say what you have said to me.' So that is how we cooperate with the patient. I am a friend to share things with.

The responsibility of peer educators is not simply to fill the shortage of medical staff in Botswana. Rather, peer educators are able to use testimony to facilitate the flow of communication between medical staff and their patients.

Gouta's vested interest in her client's well-being can be understood as a way in which testimony is "an opportunity to rally for solidarity" (El Ashmawi et. al 2018, 73). By combining their knowledge and empathy, peer educators become "allies in the struggle" advocating for the education and care needed by the HIV community (El Ashmawi et. al 2018, 73). The importance of testimony extends beyond individual counseling sessions to address the larger contribution that peer educators wish to have in improving Botswana HIV care and treatment. By resisting the dominating figures that "cannot see through their eyes," peer educators stand in solidarity to "bring a face to HIV" that can benefit the greater healthcare community.

Inclusive Testimonies

While peer educators promote shared experience through testimony, this approach does not exclude those living without HIV. CEYOHO emphasizes how everyone within a community is affected by HIV/AIDS even when they are not directly infected. This stance is reflected in the personal narrative shared by Keitumetse in a STEPS film.[30] A name that means happiness in Setswana, Keitumetse shared her story about growing up as an orphan: "I do not know what killed them, because at the time you could not speak to your parents about HIV/AIDS or sex. It was taboo."

Although Keitumetse is HIV negative and thus may not know the pain of having an HIV diagnosis, she still experienced stigma and discrimination for having grown up as an orphan of HIV parents and who had to care for her younger siblings. Keitumetse recalled that, "people looked down on us, it was very painful." In allowing for a space to

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[30] The following quotations from Keitumetse are cited from the Steps for the Future documentary, "Keitumetse's House" (2015).

share these experiences, CEYOHO brings together the testimonies of people living with HIV and those without HIV to build a larger, non-exclusive communal support network. As Keitumetse explained,"If it wasn't for my peer educators at CEYOHO, I would not be where I am right now...maybe I would be drinking, maybe selling myself as a prostitute, or having many kids or infected with HIV." This inclusivity ensures that individuals, regardless of their HIV status, know that they are not alone in their struggles against stigma and discrimination.

The inclusivity that CEYOHO encourages further ensures that peer educators share knowledge with the greater HIV negative community about HIV awareness and prevention strategies. Neo talked more about CEYOHO's outreach programs when we visited a relative at the Princess Marina Hospital, the largest government-funded hospital in Botswana. With the occasional background noise of janitors sweeping the brick floors or patients and doctors passing through, Neo spoke about her years as a youth educator visiting various schools across Gaborone. To my question, "What do you share with students?," Neo replied:

> I will tell students that I abstain from sex, alcohol, and drugs. I will tell them that I have been going to school, but I am not going to date, because surely you have to expect sex. I will tell them that I do not drink. Why? Because it is not good for my health or academics. I will tell them, really motivate them and show them that by not having a boyfriend, when you are not having sex, when you are not drinking, you can still do good. Most of them say that 'I need a boyfriend to help me with school'. But, I tell them that they can do this. So as a result, we get to talk to them and help them in preventing HIV/AIDS infection.[31]

Neo's awareness of the importance of a healthy lifestyle enables her to educate and motivate others, especially youth who are her same age. Although Neo does not explicitly recommend abstinence for everyone or expect all peers to follow her exact example, her

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[31] Audio-recorded interview in English with Neo on June 29, 2017. All quotations from Neo in this chapter draw from this interview.

narrative serves as a platform to show how healthy living can be practiced to prevent infection. The inclusion of testimonies from peer educators who are HIV negative like Neo, allows CEYOHO to educate the community at large. Peer educators rely on the trust built through these shared testimonies to increase the motivation needed to make a greater impact through education and awareness.

Conclusion

The shared experience of an HIV diagnosis serves as a central point of connection between peer educators and their clients. Although age and gender are also sources of shared experience, this chapter has delved into understanding how testimony is tied to trust. From these expressions of testimony, peer educators can continue to transmit the necessary education and awareness for a better future. While personal testimony is important in providing clients with knowledge and promoting behavior change, collective testimony is essential to political action. Peer educators employ this political stance to resist policies implemented by those "that cannot see through their eyes." With this approach, peer educators highlight that social change must come from those directly infected with HIV. However, the primary focus of providing voice to those with HIV does not exclude HIV negative testimonies. On the contrary, their inclusion highlights CEYOHO's objective of creating a dialogue about prevention and de-stigmatization that involves the entire community. While trust through testimony remains fundamental in sustaining a practice of educated hope, the next chapter will explore how intimacy is born out of these relationships of trust and how it provides the necessary ethical demand for moral reconstruction after an HIV diagnosis.

Chapter 5

Intimacy: The Ethical Demand

The concepts of intimacy and love are often used interchangeably. In discussing the moral construction of individuals, Povinelli highlights that, "in intimate love they (moral subjects) will experience a break, a rupture from their prior selves and experience a purer, truer form of self" (Povinelli 2008, 191). While such an example appears to reinforce the overlapping nature of these two concepts within the reconstruction of moral subjects, it is important to distinguish love and intimacy from each other.

Jamieson (2011) argues that love is often referred to as an emotion and can occur even when reciprocity is absent. In contrast, intimacy focuses on "interpersonal connections." Although love can contribute to strengthening intimacy, within intimacy, love is not always present. Jamieson (2011) notes that, "relationships between clients and professional caregivers or service providers can involve practices of intimacy such as self-disclosure without love." Gouta's "buddy" relationships with her clients in the clinic corresponds to this kind of self-disclosure without love.

Regardless of love, this process of mutual self-disclosure within intimacy occurs between "equals, revealing inner qualities and feelings, simultaneously generating a self-reinforcing narration of self" (Jamieson 2011). Given the context of Botswana where transactional relations of sex or other intimate acts in exchange for money or gifts still remain a prominent form of livelihood, peer educators seek to show clients that amorous relationships are not the only forms of economic and emotional support. This form of intimacy is instead revealed through friendship and companionship that are equally important in establishing common ground between people (Jamieson 2011).

I contend that intimacy or the demand for intimacy through relationships of mutual self-disclosure between peer educators and their clients can serve as an ethical demand in the reconstruction of moral subjects returning to a new order and morality in their lives. It is important to remember that an ethical demand establishes a moral contract between individuals and creates the motivation that allows for their moral transformation during a moral breakdown (Zigon 2007, 137). In this chapter, I examine how peer educators challenge traditional frameworks of intimacy that have placed individuals, especially women at a higher risk of HIV infection. Furthermore, I discuss the gendered concepts of intimacy and how this has contributed not only to vulnerability, but also women empowerment in the educated hope for greater HIV awareness and education.

Intimacy and Economic Exchange

In the middle of June, I took a taxi out to Manyana Clinic to meet with Gouta for a second time. About an hour drive from Gaborone, rolling hills and acacia trees lined the roads leading to the small village of Manyana. When I arrived, I peered around the compound looking for the IDCC (Infectious Disease Care Clinic) trailer where Gouta worked. The clinic was quiet and practically empty. Briefly worried that I had mistaken the day of our interview, I heard a call coming from behind me, "Go Po Lang! You came, my friend! I was just having lunch." The two of us walked over to the IDCC trailer and Gouta introduced me to the nurses on staff, "*Dumela, ke bidiwa Go Po Lang*." Amused by my Setswana name, the nurses greeted me back and each told me about their

individual positions at the clinic. Gouta and I proceeded to go to one of the filing rooms where she held her counseling sessions since the clinic had no space.

There we began to discuss the vulnerability of HIV contraction that women face compared to men. Gouta's explanation was:

> Many people, especially women, demand in men (economic and emotional dependence). If I am a lady, I am not working. The boyfriend is the one who is working. He comes with the money to give her. But by the time he does not give her the money, that is the problem. They (women) do not bathe, they do not eat. It's a problem.[32]

Gouta's narrative is similar to other accounts that appear in various scholarly works highlighting the exchange of sex for livelihood as a "means to economic survival, security, or maturity" (Kaufman and Stavrou 2004, 379). Although the nature and objects of exchange often vary, peer educator Keeya shared with me the common "triple C" of having a sugar daddy or blesser. As a young woman in her mid-twenties, Keeya went on to explain the components of this exchange: "It is the three C's...women will have a sugar daddy for a cell-phone, car, and cash...they will say 'hold on, my transport is calling.'"[33] While sugar daddies are often older, blessers are distinguished by their upper-income status. Geldenhuys (2016) further point out that the newer term of blesser has "nothing to do with religion or faith, but it has everything to do with what people are prepared to do for money." When reflecting on "blessers" as a source of income for young unemployed youth, Jack also highlighted that "money can be a blessing, it can help you achieve things."[34]

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[32] Audio-recorded interview in English with Gouta on May 29, 2017. All quotations from Gouta in this chapter draw from this interview.
[33] Audio-recorded interview in English with Keeya on May 18, 2017. All quotations from Keeya in this chapter draw from this interview.
[34] Audio-recorded interview in English with Jack on June 23, 2017. All quotations from Jack in this chapter draw from this interview.

Although a high unemployment rate and limited economic opportunities have contributed to both men and women becoming recipients in this gift exchange, Kesego again emphasized that, "women are the vulnerable ones. Women are coming from poverty and they are dependent on men."[35] With these underlying economic constraints and gender inequalities, women participate in livelihood alternatives that often include power imbalances with large age differences (Kaufman and Stavrou 2004, 379). Gouta expressed her concern that women involved with sugar daddies or blessers are at a higher risk of contracting HIV because they are often unable to request men to wear condoms. This unequal power dynamic is also mentioned in Kaufman and Stavrou's (2004, 387) research about the exchange of sex and gifts in South Africa where young men "felt that if a girl was to accept a gift just before sex, then she was denying herself the right to ask a man to use a condom." Although not exclusive to transactional relationships, these attitudes highlight the risky behaviors that are from limited agency in a patriarchal structure.

Despite these underlying power imbalances, the women as well as young men involved in these exchanges must not be seen without agency. Honwana (2013, 103) insightfully suggests that women involved in multiple sexual partnerships for gift exchange, "carve their sexual and financial independence by avoiding being controlled by any one man" and thus are not simply "victimized by the exchange." Rather, economic and social relations are interrelated and penetrate the dynamic of intimate relationships across Botswana (Livingston 2009, 665). Interestingly, Groes-Green (2013, 114) explains that, "contrary to the tenets of Karl Marx and Marcel Mauss, just because money

[35] Audio-recorded interview in English with Kesego on May 18, 2017. All quotations from Kesego in this chapter draw from this interview.

penetrates all spheres of life does not mean that morality has dissipated; it simply means that one is not tabooed to the extent it is elsewhere." This perspective suggests the normalization of relationships between intimacy and economic exchange as forms of alternative livelihood in Botswana and across Southern Africa.

These transactional social relationships represent an underlying factor in the spread of HIV. The importance CEYOHO peer educators give to economic independence in their counseling sessions acts as a source of empowerment for their clients and as a means to prevent increased causes of infection. Having faced economic vulnerability herself, Gouta often tells her clients:

> If you are a woman, you have to use your hands, you have to look for a job, any job. Even the nurses (at the clinic), you can ask them if they have washing, laundry, so that you can wash and then can get something with to buy, something you want, not depending on the boyfriend. I tell them, they have to spread themselves doing that, rather than just sitting here and waiting for a man coming and having money and giving you 100 pula every month and then he says, 'I do not want condom today' and you just give in...it is not good. But if you have a job and if a man says, 'I do not want condom', you just say, 'no', because you know you will get the money somewhere else.

Although peer educators are still limited by structural issues that reinforce patriarchal systems along with sexual transactional relationships such as sugar daddies and blessers, their counseling sessions seek to discuss alternatives that individuals, especially women, can attain as a way to counteract power imbalances. Even when money is not a direct issue for clients, peer educators hope that the promotion of economic independence will empower women to seek alternative income sources that are not dependent on their husband's or partner's as well as to have greater authority over their sexual lives.

To heighten the importance of stable and safe economic alternatives, CEYOHO is in the process of proposing a women's bakery initiative at their center. The project has

been undertaken by Liseho who is the CEYOHO community outreach point person. Liseho explained how the bakery could serve women who have experienced sexual and domestic violence to gain practical skills that will allow them to be economically independent from men who may also have been their abusers. Through this bakery initiative, Liseho hopes that "the abuse can be reduced, because they (women) can support their kids without those guys ordering them around."[36] With the personal narratives offered in counseling along with such gender oriented initiatives, CEYOHO underscores their objective of working against issues of structural violence that have often placed women in vulnerable and abusive situations. In doing so, peer educators not only remind women that they have agency, but also continue to promote prevention and the reduction of HIV infection.

Intimacy and Love

While the interconnection between intimacy and material exchange have contributed to societal structures that increase the risk of HIV infection, it is easy to forget that love and emotional care are still central factors within relationships, including transactional ones. Dahl (2015) underscores that it would be a "mistake to overdraw the distinction between material and emotional economies—love and care are equally expressed through giving things." In her research about the orphans at the Bathusi NGO in Botswana, Dahl (2015, 534) highlights that "orphans prioritized relationships with men both for love and in order to promote their self-fashioning as cared-for, beautiful, and socially-valued individuals." Dahl's analysis challenges stereotyped representations of transactional relationships based solely on the exchange of sex and gifts.

[36] Audio-recorded interview in Setswana (with English translation) with Liseho on June 1, 2017.

Along with economic independence, peer educators equally encourage the emotional independence of their clients to reduce further risks associated with HIV contraction. This emotional independence is not only a goal for clients involved in sexual transactional relationships, but also for those partnerships not explicitly defined as transactional. The importance of emotional independence in counseling became clear in a conversation that I had with Chokchok just after she had finished counseling a woman who had been abandoned by her boyfriend following her HIV disclosure. Heartbroken and hopeless about her future, the woman confided in Chokchok for advice. In response to her client's sadness and fear, Chokchok recalled her own experience of disappointment before she became a peer educator:

> I met a guy, he was dating me for about three weeks. That guy, I told him: 'There is something that you need to know about me.' 'Ok fine, Chokchok, what is it?' 'No, I will tell you in your house and when we are not in public.' He called me and said I should take a cab. When I got there, after eating supper, we were there and talking, I told that guy, 'baby, it seems that you are serious, but there is something that you should know about me...I am living with HIV, I have been living with HIV for eleven years, I tested in 2006.' 'Oh baby, why did you not tell me?' 'I wanted to see if you are serious or not.' He started crying. The guy in the morning was supposed to drop me at work, but he left money for the cab with a message, 'baby this is your money for transport. We will talk.' I sent the guy an SMS saying, 'baby you should be happy because I did not have sex with you and be happy that I told you the truth.' The guy disappeared, I deleted his number. Be yourself, because you are young and if that guy goes away, it is fine. Be happy that you told him everything about you. One day you will meet somebody and he will love you and listen to you. He will respect you. Forget about stress, focus on yourself.[37]

Based on her own experience, Chokchok shows the importance of maintaining emotional independence and self-confidence. Specifically in the case of women, Chokchok's message serves as a reminder that men are not necessary for a woman to have a sense of completeness and stability. Although her words of encouragement for her client include

[37] Audio-recorded interview in English with Chokchok on June 19, 2017. All quotations from Chokchok in this chapter draw from this interview.

meeting and being loved by a man someday, Chokchok seems to impart a sense of self-love and self-acceptance. Her narrative further points to the ways in which intimacy can be expressed beyond sexual relationships. Sharing her testimony is a matter of trust that creates an intimate relationship between her and her client. As the next section will discuss, intimate connections extend beyond traditional frameworks of love and exchange into the realm of friendship and companionship.

Intimacy in Friendship

The association between intimacy and livelihood is primarily addressed in the context of transactional relationships where gifts and monetary exchange are given for sexual returns (Honwana 2013). Although women are more regularly seen as the "vulnerable" and "dependent" ones in these dynamics, CEYOHO peer educators, particularly female peer educators, challenge this dynamic between intimacy and livelihood by highlighting the alternatives that can contribute to an independent economic and emotional livelihood from men. Although not excluding men, CEYOHO women peer educators demonstrate how counseling, a practice based on intimacy and empathy, serves not only as a job for economic support, but also provides a model for cultivating female independence and empowerment (Bemak and Chung 2002). While pay as a peer educator is still limited, Kennedy explained the economic and educational importance that these positions can have for women:

> If a young man comes here and a young woman and they are looking for one position...I know that there is a baby behind that woman. Whereas behind this man, there is nothing. So it is better when a woman is empowered. I would be damned if I said this in public, everyone needs to be empowered, but I am talking about who needs the help most. Because when the woman gets paid she will buy

> food for the child, whereas the man will walk to the nearest bottle store. So in this case, why not empower someone that can empower another person?[38]

Kennedy speaks to how CEYOHO views women as a greater source of human capital when compared to men (Becker 1962). By investing in the support and training of women, CEYOHO seeks to increase returns of education and empowerment benefiting the greater community.

This rationale comes through in Lesedi's narrative. Stationed at the clinic in Mogoditshane, Lesedi took time before her counseling sessions on a Friday morning to talk to me about the path that led her to CEYOHO. Sitting in her office before clients arrived, Lesedi explained:

> I was one of those monitoring CD4, but last year in 2016 they started this 'Treat All.' I went to Old Naledi Clinic and met with Masego (peer educator) who said it is time to start treatment. I said, 'I heard that with this tablet, you have to eat a lot, and I am not working, so where I am going to get the money to get the food?' So Masego invited me to CEYOHO, I was so stressed, because I have to take care of myself and two boys, who is going to provide now? When I got there, she introduced me, it was a community health talk. But the challenge I was having was money, to put food on the table. Masego always invited me, but it was one day after church she said, 'Lesedi, did you see the poster? They are looking for peer educators!' Mind you, I did not go to school for that, I just applied and I was called for the interview.[39]

Counseling can secure peer educators a form of income based on fostering relationships of intimacy and friendship with their clients. Not only does this model offer economic empowerment for the peer educators themselves, but serves to highlight the alternative forms of intimacy that can be cultivated for livelihood.

This alternative form of intimacy is expressed in the relationships that peer educators maintain with their clients. As referenced earlier, peer educators establish

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[38] Audio-recorded interview in English with Kennedy on June 9, 2017. All quotations from Kennedy in this chapter draw from this interview.

[39] Audio-recorded interview in English with Lesedi on June 10, 2017. All quotations from Lesedi in this chapter draw from this interview.

intimate connections with their clients through friendship rather than sexualized notions of love. Gouta emphasizes how she is “their (client’s) buddy. I am always checking up on them,” and Chokchok says: “I have so many friends in this facility. If I am not here, they always say ‘Oh Chokchok, where are you? We have missed you so.’” These friendships provide clients with the ethical demand or motivation in their process of developing new habits and healthy behaviors.

This expression of intimacy through friendship during counseling sessions extends into the broader activities organized by CEYOHO. Started during the early years of the organization, the young women’s football team serves as an example of promoting female empowerment through nurturing relationships of friendship and companionship. When I spoke with Kesego on the relevance of establishing an exclusively young women’s football team, she emphasized the importance of providing community activities that involve young women and help them in preventing teenage pregnancies and early HIV infection. Posters taped to the walls at the CEYOHO center with phrases such as “Sex can wait, football is my game!” reinforce the relevance of this objective. As a former team player, Neo shared her insight into the dynamics of the team:

> The football team’s main focus was young girls, because we find that young girls are very vulnerable...so we would organize a tournament within the village and afterwards we would go sit in the shade and talk about these issues. We hear the concerns, what are the needs, and if we see that some of them are having trouble pulling out of these issues, we refer them to other stakeholders that can help them like counselors, people who deal with drugs, rehabilitation centers. Through that we are able to reach a lot of people through the little CEYOHO football team.[40]

The intimate and supportive connections established between teammates is another example of how CEYOHO emphasizes the cultivation of friendships that promote

[40] Audio-recorded interview in English with Neo on June 7, 2017. All quotations from Neo in this chapter draw from this interview.

healthy activities and preventive practices. Although Neo no longer participates in the team since she is older, she still maintains contact and occasionally meets up with the other young women who originally comprised the team. These ongoing friendships point towards the underlying influence of such intimacy through companionship that contribute to sustaining healthy behavior practices and a supportive community.

While football is not often recognized as a women's sport in Botswana, the specificity of football in this context further shows the importance of establishing healthy relationships and self-care through friendship and teamwork. Neo offered more input on this point:

> In a team, there is a striker, there is a goalkeeper. Through those football terminologies, we use them into real life situations. We start telling them that as a goalkeeper, this is what you do, your duties are these and then we reflect them, we mirror them to the day to day life that we lead. So through the football team we are not only taught the football terminologies, but also how to reflect our life to it. So through that we are able to, like this is me, I am the goalkeeper, I should make sure that nothing goes through the net, nothing bad goes into my life. I make sure that I defend myself, I can strike very well.

Through the dynamic of a football team, CEYOHO offers a platform for young women to learn and practice healthy habits that involve self-acceptance and self-confidence. While participation in the young women's football team does not reflect intimacy as the ethical demand in overcoming an HIV diagnosis, team relationships offer the motivation for the young women and girls to remain healthy and aware of prevention practices. With these activities that are complementary to the counseling sessions offered through clinics and schools, peer educators solidify the alternatives available to women that often, as Gouta quoted, "demand in men."

Care Work and Empowerment

Expressions of intimacy in peer education counseling and other peer educator activities have an unavoidable connection to gender roles. It remains clear that overall, there are more women -- peer educators and clients. Although other groups such as members of the LGBT community also demonstrate higher risk of HIV contraction, the gender inequalities across Botswana fuel the high risk of infection for women. While CEYOHO appears to address these issues that impact women more heavily, men are not excluded from this discourse.

As I sat down with Kennedy, one of the few central male figures at CEYOHO, we discussed this disproportionate distribution of men and women involved in peer education work. Considering the strong presence of women throughout the organization, I found the more appropriate question to be: “Where are the men?” Kennedy shook his head and chuckled. With a brief sigh, he lamented:

> It is a national disease. If you look at all HIV/AIDS community work, women are always in the lead. I think the reason it is like that is because to a larger extent it calls for that aspect of voluntarism, it is not every time that you get paid doing something. There are some people that ask us to explain our experiences and you might not get anything from that, you feel good at the end of the day because you have empowered somebody, so most men do not want that, they want cash on delivery. That is why I find in most cases women take up this work.

Although peer educators are paid minimally, funding is often inconsistent and results in gaps where peer educators work on a volunteer basis. This dominance of women in volunteer work is seen across various HIV home-based care programs in Botswana and other parts of Southern Africa. The reality today demonstrates that young girls and women are still socialized into the role of a caregiver. This is echoed in Makina’s (2009, 310) piece on HIV care work that discusses how this socialization is rooted in the

Southern African “myth that women have a natural capacity and desire to care for others...reinforcing gender inequality both by disproportionately burdening women with unpaid work and on the other hand justifies employing them in low-paid care work outside the home.” Boris and Parreñas (2010, 10) further emphasize this genderization of care work by highlighting the traditional dichotomy where, “women give care, men earn money.” Although Kennedy himself appears to reinforce this binary by primarily hiring women for peer educator positions, his involvement in the voluntary work of CEYOHO suggests an attempt at changing this unequal dynamic.

While women peer educators may mirror conventional gender norms of care and intimacy within this affective labor, such positions actually place women at the forefront of HIV awareness and prevention. In discussing women’s involvement in community-based HIV support activities across South Africa, Susser (2009, 141) underscores the “effective, proactive strategies that allow women to collectively create spaces of autonomy and possibly even to move towards sources of collective knowledge, practical sense, and transformative activism.” Similarly, at CEYOHO both female peer educators and clients maintain a platform to promote awareness and expand the growth of HIV/AIDS knowledge and prevention. Within this context of community engagement, women are more comfortable than men in establishing intimacy and exposing their vulnerabilities, which is central to their moral reconstruction of becoming aware and educated individuals living with HIV.

Jack, another primary male youth educator working at a clinic in Gaborone, is also very aware of the gender dynamics at CEYOHO. Between cracking a joke here and

there, Jack described how gender plays out in the morning health talks he facilitates at the clinic before counseling sessions:

> We as Batswana men do not like to go to clinics and test. It takes a lot of effort for him to be seen at the clinic and testing. If you see that person, you know that he is very sick. Men are the most difficult people, women want to update their status, they want to know about their health...it is like we do not have enough men at CEYOHO, women are the ones who want to know what is going on. Even here, when I invite them for the dialogue, the women always respond more than men, they always give us the positive response.

Jack's commentary again emphasizes how women use the space within community health care talks to promote care for themselves and their families while men remain on the periphery. This limited male involvement is also examined in Mills et. al's (2012) work on the engagement of men in HIV/AIDS prevention and care initiatives. The difficulty in recruiting men to engage in these HIV awareness and prevention discussions often stems from how "sickness may be seen as a sign of weakness for many men…[or] men may feel that they have been caught in their hidden sexual behaviors."

This aspect of vulnerability in men or what Kennedy labeled a "national disease" is not a recent phenomenon, but rather remains engrained within the Batswana societal structures. Reflecting on the imbalanced participation between men and women Keeya summarized: "It has always been that way, we don't know it any other way." While this vulnerability in men has hindered their community engagement, for women it has resulted in a mobilizing force of empowerment. Butler (2016, 24) argues that the mobilization of vulnerability "can be a way of being exposed and agentic at the same time." In being open and essentially exposed through the sharing of their HIV diagnosis, women utilize their community participation as the ethical demand to reshape their moralities as aware and empowered individuals living with HIV.

Getting Men Involved

Recent CEYOHO initiatives show efforts to bring men into the sexual health conversation. Liseho taught me more about these initiatives through her outreach work in Tlokweng. Liseho was new to the position, but has had plenty of previous outreach experience working as a district director of HIV/AIDS for the United Nations Population Fund (UNFPA) in Botswana. Liseho has training in adolescent sexual health and condom programming, and has facilitated various community outreach activities including visits to bus rinks, shebeens, and churches to raise awareness on important sexual health issues. She brought her expertise to CEYOHO.

In mid-June, I accompanied Liseho to the local combi rink for a condom demonstration. Although male peer educators also participate in outreach events to connect with other men, Liseho has taken the primary responsibility of these activities considering her CEYOHO position. According to Liseho, the combi rink not only serves as a location where it is easy to find men to speak with, but also is a part of the HIV problem that needs to be addressed. In our meeting before her demonstration, Liseho elaborated on the combi issue:

> You see a combi everyday, even you, because we are using the combis everyday. You will see too many students in the combi and I have heard that these are the guys that are taking girls and boys to parties on the weekends, pool parties, sex parties, these guys are the ones who are transporting them. So if we focus on them, maybe it can help, maybe we can get something, because they are also involved in the problem. So we target the problem where it starts.[41]

The concern with transportation by combi as a risk of HIV infection was also stressed in the course "Demographics of HIV/AIDS" that I took at the University of Botswana where combis were described as a source of "sex parties" or "orgies."

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[41] Audio-recorded interview in English with Liseho on June 13, 2017.

With this in mind, I agreed to meet Liseho at the primary route three and five combi station area for the community outreach activity. Scrambling out of bed the next morning by 6:30, I ran to catch the next combi out to Tlokweng. “Good you are here, hold this,” Liseho greeted me as she handed me a box of condoms for distribution and we walked over to the combi rink. Weaving our way around the parked vans, we approached a group of ten men sitting around a wooden table under the shade waiting for breakfast before beginning their driving shifts. “*Dumela Mma* (hello ma'am),” said one of the main combi organizers. After introducing ourselves and receiving permission from the driving coordinator to speak with all the drivers, Liseho began to describe CEYOHO and started a discussion on healthy sexual practices. She encouraged the men to consistently get HIV tested and to know their status in order to share with their partners. She further shared the resources that CEYOHO offers and invited them to the center.

Liseho proceeded to pull out a penis and vagina plastic model to perform a female condom demonstration. Met with chuckles and curiosity, Liseho invited the men to touch the models and ask questions about female condoms. “They don’t fit,” many of the men complained. Liseho continued to explain and demonstrate how they could help their female partners insert them to practice safe sex. After the demonstration, Liseho concluded by opening the floor up to questions and comments. As Liseho and I walked back along the dust road towards the CEYOHO center I asked her about the final comments at the presentation. Finally out of the shade, my chilled toes warmed with each step. “They asked for condoms in more sizes,” Liseho laughed.

While the participation among men and women regarding discussions of sexual health and HIV prevention still remain imbalanced, Liseho’s outreach efforts ultimately

reveal how peer educators work to counteract these structural issues. Even though it is difficult to say how much of a connection Liseho was able to establish with her male participants considering the ongoing gender barriers, her work again challenges traditional frameworks in order to initiate conversations that can engage men. By seeking to strengthen intimate connections through the dissemination of knowledge and group discussion, Liseho aims to motivate these men into striving for a future that is educated and aware of HIV.

Conclusion

Out of the connections of trust achieved through testimony, a relationship of intimacy is formed between peer educators and their clients. While testimony enables the trust that clients can have in their peer educators' message of educated hope, intimacy serves as the ethical demand that motivates individuals to aim for this future through the moral reconstruction of their new lives as individuals with HIV. In light of the societal frameworks that shape concepts of intimacy within Botswana, this chapter has explored the ways in which peer educators challenge the stereotyped connections between sex and economic exchange to instead promote an intimacy through friendship and community participation.

Furthermore, this chapter has explored how the exposure of vulnerabilities through intimacy has played a central role in women's empowerment and moral reconstruction. While the involvement of men is still limited, this intimacy is equally important in their transformation as aware individuals who are part of a community striving for educated hope. The previous chapters have addressed the sources of

connection that contribute to moral reconstruction, but it is important to delve deeper into how educated hope is to be sustained throughout time. Intimate relationships offer motivation for moral reconstruction, but how are individuals held accountable for their actions in this process? The next chapter will analyze how individual accountability remains essential in continuing the legacy of morally transforming individuals for an educated future.

Chapter 6

Fulfilling Hope: Responsibility and Discipline

Intimacy offers the motivation to pull individuals out of their moral breakdown, but also fosters a reciprocal relationship of responsibility between peer educators and their clients. Just as peer educators are expected to provide the knowledge and skills needed to transcend an HIV diagnosis, clients are responsible for modeling behaviors that ensure healthy practices of adherence and self-acceptance. Clients must reflect on their role of practicing prevention and are held accountable for following through with these behavior changes that are important in actualizing the social transformation necessary for an educated hope.

The intimate connections between peer educators and clients create a mutual relationship of responsibility that is not without discipline. In framing these different roles of responsibility that peer educators and clients maintain, this chapter will examine how peer educators incorporate a disciplinary approach in order to ensure that their clients are working on themselves and are aware of the consequences if not properly adhering to treatment. Like in Zigon's (2011, 212) research on "The Mill," a heroin addict rehabilitation center affiliated with the Russian Orthodox church, discipline "works to cultivate self-responsibility because it forces rehabilitants consciously and ethically to alter their own behavior so as to remain on the new life trajectory of a self-disciplined, normal, and responsibilized moral person."

By shaping clients into new self-disciplined and responsible individuals, peer educators contribute to a growing awareness of the future possibilities that are not constrained by an HIV diagnosis. Disciplined self-reflection grants clients with what

Zigon (2011, 228) describes as a “responsibilized liberty or freedom.” Within this responsibilized freedom, clients are aware of the various paths on which they can proceed beyond an HIV diagnosis and negotiate the ways of living out an educated hope.

While the hope for peer educators and for CEYOHO is to build a community rooted in prevention efforts and against stigma, they remain realistic of the shortcomings and tragedies. Denial and poor adherence persists in the communities across Gaborone. These losses however should not be viewed as individuals resisting normal lives, but rather as the inability to move beyond their moral breakdown (Zigon 2011). Although the tragedies are part of reality, this chapter explores how the ultimate mission that peer educators have for an educated hope cannot be achieved without individual responsibility and accountability. In bringing together elements of hope, trust, and intimacy, this chapter explores how individual liberation through peer educator counseling contributes to the establishment of self-disciplined moral subjects. These morally reconstructed individuals ultimately form part of the larger community response in heightening prevention and reducing stigma.

Responsibility to the Community

As described earlier, the intimacy born out of trusting relationships not only contributes to an ethical demand motivating clients out of a moral breakdown, but also establishes a relationship of responsibility between peer educators and their clients. This responsibility, however, expands beyond individual relationships towards a larger community obligation. Zigon’s (2011, 103) ethnography in Russia illustrates that an individual moral reconstruction is accompanied by the responsibility “to fulfill this

obligation towards society and to contribute to the eventual realization of a communist nation." When considering the experience of most peer educators in CEYOHO, their moral breakdown connects back to their HIV diagnosis which has caused them to rethink and reflect on their new realities. However, this moral breakdown is also paired with a responsibility to educate others and prevent further HIV infection.

During one of our morning discussions, Kennedy shared the nature of this community responsibility. As he reflected on his years of activism:

> I got the passion from the fact that I got the infection and I have been doing HIV/AIDS work for over 20 years now…we (peer educators at CEYOHO) believe in talking about what we went through and we do not want others to walk our path…We have a duty to protect those who do not have HIV, so that is where the concept and the motivation comes from. We say, 'look we have HIV, we can educate other people living with HIV on how you can live healthy and prevent the transmission of HIV to others.'[42]

Kennedy's narrative highlights that community responsibility serves as part of the ethical demand peer educators maintain in following through with their own mission of contributing to an educated hope and future. Through this duty of self-disclosure, which allows them to educate clients on HIV prevention, peer educators not only contribute to the reconstruction of their own new moralities, but also begin to transform their clients into new moral subjects that are aware of healthy and preventive practices.

Kennedy's example highlights how an HIV diagnosis for peer educators represents an ethical duty to educate and raise awareness. However, this is a responsibility they also pass on to their clients. Zigon (2011, 209) contends that "to be responsible for and care about something or someone is to embed oneself in a relationship of mutuality, a relationship that is constituted by the very expression of

[42] Audio-recorded interview in English with Kennedy on July 1, 2017. All quotations from Kennedy in this chapter draw from this interview.

responsibility." The responsibility that peer educators instill in their clients was clear in my conversations with Jack. When I visited him at the clinic to talk about the nature of his counseling sessions, he made sure to point out:

> As a man, you have your own role to play. You have a purpose to fulfill at the end of the day. Do not waste time on things that will not benefit you at the end of the day. Also as a man, me as a man, I grew up without a father, but there was a time I needed a father. I look at them (client) and say 'your son is going to need someone when he grows, but the question lies on you on where you are going to be. You have to start today. It is your part as a man to help raise that kid.'[43]

Although Jack emphasizes his interactions with male clients, he heightens the importance that all individuals have in fulfilling their duty to society. In this context, the purpose that clients maintain is to properly adhere to their medication in order to live responsible and healthy lives that also impact their family members and communities. This responsibility is binding in the sense that others are dependent on a client's successful follow through with their treatment. Jack summarized, while not everyone can be a peer educator, "everyone should play their own role, so that this fight ends at the end of the day. We try to pass the word, to spread this message through sharing with them."

Enforcing Responsibility with Discipline

Even though peer educators work to motivate clients out of their moral breakdown to lead responsible and educated lives, some clients still face denial regarding their HIV status. Kesego highlighted, "It is not easy to come out and say, I am HIV positive. It is not easy."[44] While peer educators claimed that the number of defaulters or individuals that are poorly adhering to their medication has decreased throughout the

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[43] Audio-recorded interview in English with Jack on June 30, 2017. All quotations from Jack in this chapter draw from this interview.
[44] Audio-recorded interview in English with Kesego on April 26, 2017. All quotations from Kesego in this chapter draw from this interview.

years, defaulting and poor adherence still reflect lifestyle habits characterized by underlying self-stigma. In these situations, peer educators appear to take on a "tough love" stance towards counteracting these behaviors of poor adherence and denial. Peer educators incorporate disciplinary actions that work to morally reconstruct and shape clients towards becoming responsible and educated individuals.

This practice of morality through discipline was evident as I spoke with Chokchok in regards to how she addresses clients that she considers "defaulters":

> If you are a defaulter, we will tell you what will happen if you are not adhering to your medication properly. The virus will increase in your body. Nowadays, if you are a defaulter, you write a letter. Because we do not want to accept someone that is always defaulting. After writing a letter, you should not repeat the mistake. It is an apology letter. Because maybe they were supposed to come in for refill. "I Chokchok am writing this letter to apologize. I made a mistake, I was supposed to come for refill on the 23rd, but I did not come because of work, because I was admitted in Marina, because I did not see the dates." After writing the letter to the doctor, I will advise them that you do not need to default more than three times because the doctors will end up telling you that 'you know what, you are not serious about your medication. You should go back and think.' We do not force anyone to take ARVs, but if you want to continue, you have to apologize.[45]

Peer educators aspire to enforce a moral character within their clients that is founded in the responsibility and awareness of the consequences for not adhering properly to the medication. Zigon (2011, 226) identifies that disciplinary techniques (in the context of "The Mill") contribute to an "authoritative and disciplinary structure within which ethical work must be done in order for there to be any hope that such a life will be possible back in the city." The intent of these letters is not to shame clients for their mistakes, instead the purpose of such moral reminders serves to make individuals accountable and accepting of their new realities of living with HIV. On a similar note, considering that the apology letters brings direct attention to a client's condition, they serve to counteract self-

[45] Audio-recorded interview in English with Chokchok on June 19, 2017. All quotations from Chokchok in this chapter draw from this interview.

stigma and allow individuals to normalize their situation. In providing individuals a disciplinary space to ethically work on themselves, such counseling sessions and disciplines "do more than attempt to make healthy the individual and social body…[but] to make healthy the individual and social soul" (Zigon 2011, 146).

Although the ultimate goal for CEYOHO is to educate and enforce prevention practices that also reduce stigma, this is not always achieved at the individual level. Even with clients that have just started treatment, falling back into denial is a slippery slope. Peer educators also explained that those who have been on treatment but have a suppressed viral load may then also poorly adhere to treatment. Kennedy explained how these issues have led to greater challenges in providing moral guidance for their clients. Even though Kennedy takes his medication daily and encourages the all others living with HIV to do the same:

> There are some few guys that would say, 'I am on drug holiday.' 'Why are you on drug holiday?' 'I am undetectable.' But the thing is, scientists actually discovered that it is dangerous because if you take treatment, you stop, you take it again there are more chances that the treatment will not work for you, you will have developed resistance. There was also an issue that came up when voluntary male circumcision was launched because it was now like, 'oh, now I am circumcised and I can engage in unprotected sex.' But people who are educated say, 'look, even if you are circumcised, please still try to use protection each time you engage in sexual activity.'

These examples of denial and poor adherence reflect what happens when individuals remain in a state of moral breakdown. In these cases, the intimate connections between peer educators and clients are unable to morally shape individuals into responsible and aware members of the community.

While peer educators can offer guidance, it ultimately comes down to individual responsibility in deciding whether or not to participate in a moral reconstruction that will

benefit an educated future. As is the case for Zigon (2011, 203) in his fieldwork, "each person has his own will and can choose the level of his participation in the church." CEYOHO clients who cannot appropriately follow-up with their treatment are no longer re-initiated on to ARVs until they can decide if they are ready to re-continue medication and check-ups. Although it should not be assumed that people who are in denial about their HIV status do not want to lead healthy lives, they continue with practices that are considered poor for their own health and high in the risk of spreading infection. Zigon (2011, 229) also found that for his informants who relapse, it does not mean that they "resist a normal life; [they are] simply unable to break the hold that heroin had placed on [them]." Individuals may move away from high risk behaviors with the mutual sharing of their testimonies and the establishment of trust and intimacy, but they must also assume responsibility in this process of social change and transformation.

Responsibilized Freedom

Individuals who are able to move beyond their HIV diagnosis to embrace CEYOHO teachings of treatment and prevention gain a foundation of self-empowerment. Clients who choose to participate in CEYOHO's mission of educated hope earn what Zigon (2011, 228) calls "responsibilized liberty." Viewed as a "formula of rule," responsibilized freedom enables people to "negotiate the range of possible discursive traditions, and thus the range of possible ways of living normally in the world" (Zigon 2011, 228). By educating clients on their various medication strategies and health practices, peer educators demonstrate the different skills and paths that clients can follow

in order to adhere to their medication with accuracy and consistency while engaging in safe behaviors.

Kennedy elaborated on the client empowerment that results through the education of these tools and strategies. As a leading proponent of treatment literacy in Botswana, Kennedy claims:

> Information usually empowers people living with HIV, because we take this pill once or twice a day and we do not know what that pill is. We want our patients to know what the drugs do, we want them to know that this drug is a protease inhibitor or that this an RNA transcription inhibitor. It empowers us to know that this drug that I am taking is an integrase inhibitor, it blocks HIV at this stage. It empowers you and motivates you actually to adhere to treatment because you know what you are taking.

Treatment literacy becomes a motivating tool in retraining behavioral practices regarding HIV treatment and care. Through this education, peer educators contribute to the empowerment of their clients and their greater awareness of HIV preventive practices. Clients understand how treatment works and why it is important for their health and the health of others. This specifically emphasizes the teaching of treatment as prevention where, when taken correctly, ARVs work to suppress an individual's viral load and thus reduce the likelihood of transmitting HIV onto others. Educating their clients on treatment literacy also helps peer educators undo stigma and misconceptions associated with HIV and individuals living with HIV. Chokchok echoed that people no longer consider HIV a death sentence because of their growing knowledge on ARV treatment and can reconsider how to proceed with their diagnosis. "You can live a long life with HIV if you are on treatment," Chokchok said.

While these paths of education have demonstrated the responsibilized freedom given to clients striving for an educated hope, CEYOHO also applies this approach to

individuals who are not HIV positive, but at risk for infection. Considering that in 2015 the WHO recommended pre-exposure prophylaxis (PrEP)[46] as an additional and effective prevention option for HIV negative individuals at substantial risk, CEYOHO has also begun to advocate for awareness around this approach (AVAC 2016). As a 2017 AIDS Vaccine Advocacy Coalition (AVAC) Fellow, Kennedy has dedicated the past year to integrating PrEP into different Botswana health curriculums. "PrEP should be taught as an option available to those at risk for infection, especially women, sex workers, and men who have sex with men," Kennedy emphasized. For the upcoming year, Kennedy has planned "PrEP think tanks" to be hosted at various venues across Botswana for individuals to learn more about PrEP and the impact it has for prevention efforts.

While not a scientist himself, Kennedy has done extensive research on biomedical treatment programs that make him a knowledgeable treatment literacy trainer not only for peer educators, but also clinicians. Even though PrEP is currently only provided in private facilities across Botswana, there are efforts to roll-out PrEP in government facilities as of 2017 (PEPFAR 2017). With these initiatives, the efforts to educate the community at risk remains essential. Just like informing clients about their ARV treatment, the incorporation of PrEP literacy will allow peer educators to provide individuals at risk with the different opportunities available to lead normal lives that enforce prevention. Liberating individuals through education has "become the dominant ethical strategy in much of the world today for living sanely" (Zigon 2011, 232).

[46] PrEP is when HIV negative persons take ARVs to prevent against HIV. When this treatment is taken correctly, it can reduce the risk of infection (CDC 2018).

Conclusion

Mutual responsibility is created from the intimacy that peer educators establish with their clients. Unlike the Russian Orthodox church described by Zigon that already has a solidified morality, peer educators and clients have a continual responsibility to work on themselves and their moralities. Specifically, peer educators respond to their calling by educating others and clients are responsible in learning from these counseling sessions so that both can contribute to an educated hope. Although peer educators and their clients have different responsibilities to maintain, they come together to work towards accountability in the realm of HIV education and prevention. Peer educators aim to make things better for the community at large, however, their approach should not be seen as authoritative. Rather, it comes down to an individual's decision to follow healthy HIV practices. Even with the disciplinary strategies incorporated by CEYOHO to morally mold their clients to lives beyond an HIV diagnosis, an individual maintains the agency to decide how they will proceed. If individuals fail to learn from their counseling sessions, they remain in a state of moral breakdown and denial about their status. However, when a client actively accepts their HIV status and embraces prevention practices, they are liberated from their moral breakdown and are aware of the avenues they can take to proceed in life; a future of hope.

Chapter 7

Conclusion

On one of the last days in Gaborone, I waved down a combi en route to Tlokweng. Squeezing my way into the last half of a seat, I sat pressed up against the window watching families in their Sunday wear returning from church. Getting off at the usual stop, I spotted the crowd I was looking for gathered under a tree. Approaching the group, I was welcomed into a circle of peer educators dressed in their lime green t-shirts embroidered with the CEYOHO logo along with a number of local church members in their traditional white and blue garb. *"Dumela Go Po Lang.* Thank you for bringing your camera, you will be our photographer for today." Keitumetse smiled and continued to organize the group for the candle-lighting ceremony's opening procession. As an annual and international event, the candle-lighting ceremony serves as an opportunity to commemorate those in the community lost to AIDS-related illnesses.

With the start of drums beating and tubas playing, the march began along the main Tlokweng road. Standing at the front, Keitumetse and Jack carried the CEYOHO banner as other peer educators, church followers, and community members proceeded behind them in song. Arriving at the CEYOHO center, the gathering continued with a series of speeches and community prayers. Walking to the front of the room, Kesego began to address the crowd in the final speech. "We have come a long way. I was diagnosed with HIV, but now I have a son who was born HIV-negative and will be eight years-old this month." With those gathered around breaking out into applause and dance, Kesego lit the first candle of the night.

Even though the candle-lighting ceremony represents a time to commemorate loss and mourning, CEYOHO brings this gathering back to their ultimate message of hope. Abstract conceptualizations of hope are often based purely on desire. In contrast, peer educators root their mission in a concrete hope that considers shared pain and the importance of moving forward from these experiences to promote social change (Levitas 1990). In applying this more concrete conceptualization of hope that Bloch considers as educated hope, peer educators seek to transform an HIV diagnosis into a learning experience that heightens awareness and de-stigmatization.

This ethnography has shown that through interweaving trust and knowledge, CEYOHO peer educators can establish credibility with their clients and the greater community in this mission of educated hope. Although this hope is embodied in representations of youth that symbolize a new generation of knowledge, peer educators embrace a collective approach that allows for the contribution of shared experiences and struggles. This collectivity not only enables the dissemination of HIV knowledge, but also establishes a pedagogy of hope to empower the community of infected and affected through HIV education.

Personal testimony is used to strengthen connections of trust between peer educators and their clients. Even behind narratives that evoke individuality, Gugelberger (1996, 27) highlights that those who share testimony speak "for, or in the name of, a community group." This shared experience strengthens the ties of trust necessary in the peer educator pursuit of educating a future generation of HIV-people living healthy lives.

In fostering a web of hope, knowledge, and trust, peer educators express intimacy through friendship and community participation as opposed to sexualized and

transactional intimacy. These relationships of intimacy provide the necessary ethical demand or motivation to move beyond an HIV diagnosis into a new morality shaped by education and awareness. Intimacy through expressions of vulnerability are also central to the foundation for women empowerment in the process of education and moral reconstruction. Although men are still lacking in this participation, this intimacy also influences their transformation as self-aware individuals that are part of a community striving for an educated hope.

While intimacy serves as the necessary support to move beyond an HIV diagnosis and embrace a new morality of educated hope, each individual remains responsible for their own participation and follow through in this self-transformation. Just as peer educators must effectively share their experiences and knowledge to educate the greater community, clients must also reciprocate by actively learning and incorporating this new HIV information into their lives. In holding each other accountable, both peer educators and clients move beyond an HIV diagnosis to embrace a future of healthy living.

This ethnography has tried to highlight the personalized nature of peer education based in intimacy and knowledge. The individualized characteristics of peer education work at CEYOHO are not in opposition with the need to tackle a larger political message. As a group "for and by those living with HIV," peer educators resist the policies and programs implemented by those "that cannot see through their eyes." While policy makers and health officials may lack understanding, peer educators act as empathetic translators in an environment often overrun by medical jargon and a hierarchical structure. In advocating for the voices of those who have been infected and affected by

HIV, CEYOHO strives to make practices of prevention and de-stigmatization a reality within Botswana.

Peer education programs have often been criticized for the lack of analysis on how relationships between peers are formed and maintained (Knibbs and Prices 2009). My project has attempted to address this gap in the literature by showing how connections of intimacy between CEYOHO peer educators and clients are essential in transmitting knowledge and advocating for behavior change. Although the intimacy between peer educators and clients is important in motivating this moral reconstruction, more research is still needed on how intimacy as an ethical demand manifests itself in relationships outside of peer education. What role do other relationships that individuals have with their families and communities play in restructuring life after an HIV diagnosis? Expanding analysis on the networks of intimacy can further shed light on the ways these expressions have been used across cultural contexts as a tool for social transformation and change.

Key Acronyms

ACHAP	African Comprehensive HIV/AIDS Partnerships
AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral (drug or treatment)
BDP	(Botswana) Bechuanaland Democratic Party
BONASO	Botswana Network of AIDS Service Organizations
BONEPWA	Botswana Network of People Living with HIV/AIDS
CDC	Centers for Disease Control & Prevention
CEYOHO	Center for Youth of Hope
HIV	Human Immunodeficiency Virus
IDCC	Infectious Disease Care Clinic
NACA	National AIDS Coordinating Agency
PEPFAR	President's Emergency Plan for AIDS Relief
PEHAPP	Peer education HIV/AIDS Prevention Program
PrEP	Pre-Exposure Prophylaxis
STEPS	Steps for the Future Documentary Series
UB	University of Botswana
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
WHO	World Health Organization

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