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Traditional Healers in Zimbabwe

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David Sean Simmons

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**MANAGING MISFORTUNE: HIV/AIDS, Health Development, and
Traditional Healers in Zimbabwe**

VOLUME I

By

David Sean Simmons

A DISSERTATION

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ABSTRACT

MANAGING MISFORTUNE: HIV/AIDS, Health Development, and Traditional Healers in Zimbabwe

By

David Sean Simmons

The proliferation of the HIV/AIDS in Zimbabwe has been met with an equal proliferation of research and literature--and internet traffic--on its epidemiology and impacts, social and economic. From an economic and policy perspective, HIV/AIDS spreads faster under conditions of poverty, gender discrimination and economic insecurity--and this is the lot of many Zimbabweans. AIDS is more rapidly fatal where health systems do not adequately meet health needs, causes more serious effects where household resources are sparse, and depletes skills and savings at a time when economic demand for these inputs is high. The overall impact on those with skills and experience is substantial with long term consequences. From an anthropological and historical perspective, AIDS can be seen following the fault lines of long established indigenous practices, the colonial legacy, and present-day political economy.

However, HIV's trajectory is not reducible solely to these practices, processes, and structures. Our ability to comprehend and respond effectively to AIDS will depend on careful analyses and strategies which take these very forces--history, cultural practices, and political economy--into full consideration. This account focuses on a significant, though mostly overlooked, piece of this complex picture: traditional healers,

or *n'anga* in chiShona. In particular, it focuses on how broader socioeconomic forces become embodied as risk for HIV and how it is that *n'anga* interpret and manage these processes of embodiment in the capital city, Harare. *N'anga* interpretations demand that we be aware of a long-standing history of structural violence perpetrated on the average Zimbabwean (and how such forces and processes structure risk of infection), first under colonialism and, currently, under the contemporary Zimbabwean state where virulent strains of economic, political, and social inequity abound. Like AIDS itself, 'modernity'--and especially 'development'--can be metaphorically read as a form of misfortune that must be carefully managed. For while colonial and postcolonial institutions and experiences were seen as routes to an improved material existence, these same institutions and experiences have also come to be associated with people "forgetting their culture and taking on Western ways" and, most importantly, for making them susceptible to AIDS.

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DEDICATION

To Kimberly, my wife and colleague,
 Asha and Aria, our daughters,
 my parents, James and Joan and Judi Simmons
 my brother, Rick, and my extended family
 for your fortifying love, support, and encouragement.

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Misfortunes Without End: An Introduction to AIDS in Zimbabwe

This dissertation chronicles an epidemic as well as the cultural and historical circumstances surrounding its emergence. In 1997, the Joint United Nations Programme on HIV/AIDS (UNAIDS) estimated that, world-wide, the number of adults and children living with HIV/AIDS was 30.6 million. And of this number, 20.8 million, or about 68 percent of the world's total, were living in sub-Saharan Africa. Currently, Zimbabwe is one of the hardest-hit African countries. Along with Botswana, Zimbabwe has been identified by UNAIDS as the country with the highest prevalence of adults living with HIV, the virus that leads to AIDS. For every five adults, it is estimated that one is infected with HIV. While this is a staggering number, more staggering is the fact that most of these people do not even know they are infected. Many, however, are sick and dying. As of December 1997, it was estimated that some 320,000 people had already developed AIDS since the beginning of the epidemic.¹

The social impact of the epidemic is of course considerable. More than 70 percent of AIDS cases are found among adults between the ages of 20 and 49, the most economically and socially (re)productive part of the population. Current peak ages for disease are 20-29 for women and 30-39 for men, reflecting the trend throughout much of Africa where women become infected with HIV at a younger age than their male counterparts. In fact, young women in the 15-19 age groups are more than five times as likely to be infected as males in the same age group.² Geographic distribution is also

uneven. The impact of the disease has been particularly great on the capital city, Harare, which reports significantly higher rates than many parts of the country.

The proliferation of the disease has been met with an equal proliferation of research and literature--and internet traffic--on its epidemiology and impacts, social and economic. From an economic and policy perspective, HIV/AIDS spreads faster under conditions of poverty, gender discrimination and economic insecurity--and this is the lot of many Zimbabweans. AIDS is more rapidly fatal where health systems do not adequately meet health needs, causes more serious effects where household resources are sparse, and depletes skills and savings at a time when economic demand for these inputs is high. The overall impact on those with skills and experience is substantial with longterm consequences. From an anthropological and historical perspective, AIDS can be seen following the fault lines of long established indigenous practices, the colonial legacy, and present-day political economy.

However, HIV's trajectory is not reducible solely to these practices, processes, and structures. Our ability to comprehend and respond effectively to AIDS will depend on careful analyses and strategies which take these very forces--history, cultural practices, and political economy--into full consideration. This account focuses on a significant, though mostly overlooked, piece of this complex picture: traditional healers, or *n'anga* in chiShona. In particular, it focuses on "how confluent socioeconomic forces become embodied as risk for HIV" (Farmer 1999) and how it is that *n'anga* interpret and manage these processes of embodiment in the capital city, Harare. *N'anga* interpretations demand that we be aware of a long-standing history of structural violence perpetrated on the average Zimbabwean (and how such forces and processes structure

risk of infection), first under colonialism and, currently, under the contemporary Zimbabwean state where virulent strains of economic, political, and social inequity abound. Like AIDS itself, 'modernity'--and especially 'development'--can be metaphorically read as a form of misfortune that must be carefully managed. For while colonial and postcolonial institutions and experiences were seen as routes to an improved material existence, these same institutions and experiences have also come to be associated with people "forgetting their culture and taking on Western ways" and, most importantly, for making them susceptible to AIDS. Or, to borrow from Setel (1999:2), for many n'anga, AIDS has been a "plague of paradoxes," emblematic of the Janus-faced nature of modernity.

Moral ideologies amongst n'anga reflect this ambivalent tension. As a socially experienced and lived phenomenon, HIV/AIDS is a signifier of things gone wrong at many different levels of being--individual and collective, empirical and symbolical, the "modern" and the "traditional." It is a signifier of borders--national, cultural, individual--flagrantly transgressed. In this symbolic capacity, HIV/AIDS serves as punishment for breaching social custom and, in this sense, n'anga interpretations of HIV/AIDS and its root causes may be seen as a conservative force, upholding historically buttressed readings of morality and personal conduct in the face of translocal forms of incursion. In this way, n'anga understandings *seem* to fit within a framework of malcontented modernity (Comaroff and Comaroff 1993), HIV/AIDS being the end result of cultural erosion at the hands of modernizing social forces and material forms. This is, of course, only a partial picture, and one which will be expanded in subsequent chapters.

Intersecting the moral tensions of n'anga are the material tensions which structure people's risk in the first place. AIDS in Zimbabwe is primarily a heterosexually transmitted disease (accounting for 92 percent of cases) and, as a result, many (usually externally-funded and orchestrated) intervention programs have focused narrowly on such preventive measures as condom use without concomitant attention to the socioeconomic context in which the epidemic has taken hold and is spreading (Basset and Mhloyi 1991). What role, for example, do migrant labor systems, rapid urbanization, constant wars with high levels of military mobilization, landlessness, structural adjustment policies, the privatization of health care, and poverty play in structuring people's risk for HIV? Careful attention to these forces helps reveals the extent to which this "*new* disease is enmeshed in *historically shaped* social environments" (Setel 1999:4). Therefore, critical analysis of these forces helps inform strategies for effectively combating AIDS in Zimbabwe.

Against this complex and changing backdrop, my goal is to unravel the encounter between n'anga and AIDS in Harare (particularly as AIDS has become a signifier of 'modernity' itself), and this is most readily done through an examination of HIV/AIDS and STD educational messages and interventions targeting n'anga. Such interventions, usually in the form of workshops, provide the most concentrated exposure n'anga have to messages and information regarding the disease. The content of these messages, and their mode of deployment, reveals a great deal about how health development knowledge and practice positions itself vis-à-vis the therapeutic knowledge and practice of n'anga. In fact, health development interventions provide an arena, or site, where ideas about health and healing, illness and disease, are debated and contested. It is at this juncture

that ideas about therapeutic ideology and practice--in this case regarding HIV/AIDS and its treatment--figure prominently in constructions of “modernity” and “tradition” and as a moralizing discourse. A view from this vantage point helps answer questions regarding who is best capable of dealing with the pandemic in Zimbabwe.

In Harare, epidemiologic and demographic accounts--both professional and popular--help describe the context in which the epidemic has emerged and grown; and it is within such a context that I situate my analysis. My conceptual framework is undergirded by a number of postulates, namely: that n’anga play an integral, and mostly ignored, part in combatting HIV/AIDS and ameliorating the symptoms (physical, psychological, and spiritual) of the disease; that a thorough understanding of AIDS is to be found at the intersection of historic (and contemporary) indigenous practices, the legacy of colonialism, and present-day political economy; and that due to its highly symbolic nature, AIDS has come to signify different things to different people and, as such, it constitutes essential and often competing social realities about the nature of its origins and about who is best capable of combating the disease itself.

From the standpoint of n’anga and contemporary social theory, AIDS may be understood as the end product of “...a social process of disorder structured in terms of person, place, and time” (Setel 1999:5). Like its epidemiological ancestor, the devastating 1918 Influenza epidemic--and also referred to in chiShona as *mukondombera* “something once it gets hold of you will not let go”--AIDS emerges from and constitutes a particular discursive field which finds changing meanings in changing contexts. In order to chart these changing meanings over time, this dissertation utilizes a broadly historical framework, moving from a political economy of structural violence under

colonialism to its contemporary manifestations in post-colonial Zimbabwe. Throughout the historical experience of structural violence, n'anga have acted as key intermediaries, soothsayers, and master interpreters (and occasionally charlatans) in managing the misfortunes of their individual clients and, indeed, the collective Zimbabwean body itself in often rapidly changing contexts.

Managing Misfortune: N'anga and HIV/AIDS in Zimbabwe

The tensions and uncertainties of life in contemporary Zimbabwe, and the feeling that malevolent invisible forces are at work undermining individual and collective efforts for self-determination, provides the backdrop for looking at n'anga responses to HIV/AIDS. Historically, in such times of apparent chaos, Shona peoples would consult n'anga in order to gain insight into the cause of their misfortunes. Once the cause had been identified (e.g. offended ancestral spirits, jealous relatives or acquaintances, witches, etc.), the proper ritual behavior and practice could be undertaken to propitiate the offended agent and equilibrium would thus be restored. In addition, n'anga also provided preventive medicines, or *muti* in chiShona, in the form of prophylactics and charms to ensure good fortune (Bourdillon 1998:167; Gelfand 1985). Contemporary demographic changes in the distribution of peoples and 'Westernization' have done little to change peoples' reliance on n'anga to make sense of the changing and often unpredictable circumstances they find themselves in (cf. Janzen 1982; Wafawanaka and Celine 1990).

Zimbabwe's current economic and political upheaval is very keenly felt in the health sector. With the propagation of HIV/AIDS and AIDS-related medical

complications (e.g. a significant rise in incidence of tuberculosis, pneumonia, and the like), the already over-taxed hospitals and clinics within the country are on the verge of collapse. As a result of the government not reimbursing its hospitals for patient care and treatment--through its Social Dimension Fund, designed to make healthcare available to all Zimbabweans who earn less than Z400 per month--many hospitals are owed twice what they owe their creditors. Many government hospitals (such as Harare and Parienyatwa) are now demanding payment upfront from patients, saying this is a state policy of cost-recovery aimed at making hospitals self-sufficient. During the final stages of my field work, in July of 1999, local newspapers were rife with stories of people not receiving medical attention because they could not meet the upfront payments. Patients, frustrated by government health institutions, helped spur the growth of private (and illegal) "surgeries," or doctors' offices, sprouting up in the city's many residential areas. Doctors, likewise frustrated by low and infrequent salaries, found lucrative side jobs in such surgeries (or migrated to other countries). A ban by the Harare city council on residential surgeries had been in effect since September of 1998, but it was not well received by the public and therefore ignored for the most part. Aware of widespread frustration with hospitals and clinics, health officials also began to warn people against 'wasting' their money on n'anga.

The far-reaching economic, political, and social impacts of HIV/AIDS certainly make consultation with n'anga more likely for the average person for a number of reasons. The ratio of bio-medically trained doctors to patients is approximately 1:7,000 (with mostly urban representation) and during the final stage of my 1999 fieldwork, the government reported a deficit of some 400 doctors and over 1,500 nurses. On the other

hand, the ratio of n'anga to patients is approximately 1:300. N'anga are the numerically dominant healthcare provider in Zimbabwe (and in most African countries) and therefore more readily available to prospective patients (cf. de Zaluondo, Msamanga, and Chen 1989). As one Shona friend explained, "They've got time for you. They listen."

Some people shun bio-medical clinics and hospitals because of a perceived impersonality. I remember accompanying a friend's gardener, Alex, to a local clinic in the low-density area where he worked after he described to me what sounded like a case of a sexually transmitted disease. He was reluctant to go, and though he said he had never been to a clinic or hospital before--he was 23 years old at the time--he had heard stories about how people were treated there. We arrived at the clinic and found a receptionist enclosed in a steel cage who promptly asked in a very loud voice why we were there. The whole room turned around to look at us. Poor Alex could not even look the receptionist in the face as he whispered through the metal cage. Later, we were called into an examining room with three 'sisters' (female nurses) who asked him why he was there. He explained why he was there, his voice a crackling murmur. The sisters looked from him to me trying to figure out our relationship. One eventually asked me to leave the room. Several minutes later, Alex emerged with a small plastic bag of pills.

"What are those?" I asked eyeing the medicine.

"I think they're an antibiotic," he replied, shrugging his shoulders.

"Did they examine you?" I asked, feeling that he hadn't been adequately examined.

"Yes, they made me take my pants down," he said looking down at the ground.

I realized by that point that it had been a very shameful experience for him-- publicly admitting to possibly having a sexually-transmitted disease and having women examine his 'manhood.' I was fairly sure Alex wouldn't be visiting another clinic anytime soon. "By the way, why did they ask me to leave?" I asked.

"They thought you were my employer and that I wasn't really answering their questions because you were sitting there," he answered.

Apart from the apparent impersonality of hospitals and clinics, there is also the understanding that doctors can only treat the physical manifestations of illness and disease (and sometimes not even this), leaving untreated the underlying cultural and social causes of the malady. For example, the aunt of another friend, Geoff, had gotten 'sick,' and as her illness progressed she had gone to stay with her sister, Geoff's mother. In the highly visible, and respected, position as Head Mistress of a local school, Geoff's aunt initially worked to conceal the disease. Part of this strategy involved receiving care from n'anga who would visit the house discreetly. She had chronic thrush and was rapidly losing weight. She also suffered bouts of violent behavior. N'anga who had visited her said she was suffering from bewitchment (*kuroyiwa*), sent by her boyfriend's wife (the boyfriend had died months before from AIDS-related complications). Geoff said when she exhibited violent behavior, she seemed to be possessed by spirits. "With our African illnesses," he explained to me later, "it's very difficult to tell what's wrong with someone." During her violent fits, n'anga would come and cast away the evil spirits (*mamhepo*) and she would get better, he said. While Geoff's aunt may have been suffering from AIDS-related dementia, the underlying cause of her suffering was, according to Geoff, retaliatory magic sent by an angry boyfriend's wife. Tempting a

married man away from his family, however common, was clearly a breach in social custom and, in some cases, subject to retaliatory measures.

Another young man, Precious, spoke of his ailing cousin. "You should see him," he began with downcast eyes while shaking his head. "I haven't seen him for five years...and now, he's skinny skinny...and black black...and his hair has changed texture. He asked me if I could get some medicines from work to help him"--Precious worked for the Zimbabwe National Traditional Healers Association as an office administrator-- "But, I'm afraid. You know in our traditional customs if I give him those medicines to take and he worsens or dies, they will say I caused it."

"And what if a doctor prescribed something and it had the same effect?" I asked. "Would they be thought of the same way?"

"Hah!" he chuckled. "Of course not. But, you see, that is how things are with our traditional customs."

The above accounts illustrate the symbolically-charged terrain of health-care delivery for many people in Zimbabwe. Alex's humiliating experience at the clinic is, unfortunately, all too common. Increasingly, such exchanges have become a central concern for many scholars studying health-care systems in Africa (cf. Bassett, Bijlmakers, and Sanders 1997; Chirara 1993; Mandimika 1990). Under economic structural adjustment--with retrenchment of nurses, the increasing flight of doctors to other countries, currency devaluation, labor disputes between nurses and junior doctors, and the slashing of drug budgets--such experiences are already the norm for poverty-stricken people like Alex. Such policies and forces may indeed push people in the direction of receiving care from n'anga. For people like Geoff's aunt, visiting n'anga is,

in part, a way of shielding themselves from the stigmatizing effects of visiting clinics and hospitals--made all the more stigmatizing because of the economic pressures placed on health care providers through structural-adjustment policies. The ambivalence Precious feels over various treatment strategies for his ailing cousin reflect a more general ambivalence people feel suspended between often competing therapeutic traditions and treatment options.

In this way, a focus on n'anga responses to HIV/AIDS provides a view of the diverse and complex linkages--material and symbolic--between macrostructural forces and the health of the individual. Such a focus indeed reveals that a seemingly out-of-the-way Chitungwiza-based n'anga's treatment strategies for HIV/AIDS are linked to a network that includes Harare and Geneva, Switzerland, witchcraft and protease inhibitors, spirits of ancestors and structural adjustment. As Farmer argues, in the context of Haiti (1992:8-9), these "links are the manifestations of the large-scale forces of history and political economy not readily visible to the ethnographer and yet crucial to an understanding of AIDS and social responses to it. It is the task of anthropology to understand these connections..." By exploring HIV/AIDS-education interventions which target n'anga as a site of confluence between the global and the local, the biomedical and the "traditional," the powerful and the powerless, this study will contribute to an understanding that these are not necessarily socioculturally discrete systems violently brought into relationship, but rather they are systems already constituted relationally, entering new relations through historical processes (cf. Clifford 1997). In short, I hope this dissertation will contribute to the ongoing effort to develop an ethic for more equitable strategies in planning and implementing locally-appropriate interventions.

More generally, the story of AIDS in Zimbabwe (and by extension, AIDS in the Third World) evokes familiar problems in the human sciences as pointed out by Treichler (1999:125): “How do we know what we know? What cultural work will we ask that knowledge to perform? What are our own stakes in the success or failure of that performance? How do we document history as it unfolds?” These questions wend their way uneasily throughout this dissertation, the tension of attempting to make the often unknowable knowable. In the wake of a devastating disease, such questions frequently evoke more questions than answers. Despite these provocative, and often answerable questions, it is my wish that this dissertation be useful to world health officials, African health policymakers, and academicians interested in teaching the politics of health and healthcare delivery, international health, infectious diseases, development studies, and general medical history in Africa.

Situating Myself: My Role in the Constitution of Social and Ethnographic Texts

Long seen as compromising objectivity and proper scientific standards, inserting one’s self into ethnographic accounts has become something of a cottage industry of late (and is often judged as so much post-modern self-absorption). I do not agree with this dismissive characterization. During fieldwork I understood myself to be an active agent influencing specific events (sometimes unbeknownst to me at the time) and co-constructing both social and ethnographic texts (cf. Long and Long 1991). It is quite disingenuous of anthropologists to prop up the idea that our presence is unnoticed amongst those with whom we work and that it does not come to shape events and outcomes in ways that are different than if we had never been present in the first place.

On more than one occasion, for example, n'anga expressed apprehension in speaking to me because they felt I might 'steal' their knowledge of medicinal plants and use it for my own financial gain. The theme of outsiders (whether translocal or local) coming in and stealing knowledge was very common throughout my field experience and not without basis. A local research institution had earlier enlisted the aid of n'anga in testing the efficacy of local plants in treating the symptoms of AIDS and had promised to remunerate the n'anga for the plants themselves and the labor involved in collecting them. The n'anga were never paid for their service, and ZINATHA eventually suspended the research project. As a result, ZINATHA began warning its members about thieves posing as "researchers" and "scientists" and to be wary of anyone wanting the names of herbs n'anga use in their treatment strategies.³ The full complexity of these accusations will be handled in a later chapter; but, let me add here that such accusations form part of a greater mosaic of suspicion of outsiders, particularly as they relate to the incursion of misfortune (broadly defined) and diseases such as AIDS.

At the other end of the suspicion spectrum, I was occasionally consulted by patients waiting to see n'anga at the ZINATHA headquarters. A man might roll up his sleeve to show me some lesions and ask my opinion of them. Along with ZINATHA administrators, we would all commiserate as to what the problem might be and what possible curative measures might be taken. Then, the patient would resume his place in the sitting room, awaiting whichever n'anga he had come to consult. Let me hasten to add here that neither I (nor the ZINATHA administrators) offered anything resembling medical advice.⁴ Our comments were general and speculative, often simply reflecting the comments of the patient him/herself. But I was sometimes a more active agent. I have

recounted the story of Alex, who I accompanied to the clinic. Sometimes I paid for prescriptions. Also, it was not unusual to have a patient (or his or her family) ask if I could procure Mocrea (a popular herbal palliative thought to help ameliorate some of the symptoms of HIV/AIDS), which was sold at ZINATHA headquarters. Deciding to honor such requests was difficult for me and not just because of the desperation and human suffering I was witness to, but because I still held doubts about the efficacy of Mocrea in alleviating some of the symptoms of HIV/AIDS. There had been no clinical trials of the herbal palliative, and much of the evidence for its effectiveness was anecdotal. Like other 'miracle cures,' however, Mocrea enjoyed great word-of-mouth marketing.

I also have many friends whom I suspected were engaging in unprotected sexual intercourse--though they would often tell me otherwise when asked. And while a study of their behavior certainly made for good ethnography, I also made it a point to understand their need for unprotected sex in an effort to intervene (even if such interventions often proved futile on my part). One evening, for example, I remember driving around Cranbourne, a medium-density suburb known for its prostitution--particularly along its main drag, the ironically-named Chiremba Avenue, "chiremba" meaning "healer" or "doctor" in chiShona--with a friend who was looking for a particular 'girl.' She was a woman with whom he had spent a lot of time, and I assumed she was his girlfriend. We spent the better part of the evening driving down darkened avenues, inquiring of people walking the streets as to where she might be. Finally, we found her outside a home, sitting in a pickup truck with another guy. I asked my friend what she was doing out so late with another guy. "That's her boyfriend," he answered matter-of-factly.

“And does he know she’s been with you?” I asked, feeling very naive.

“Of course,” my friend responded, “he knows *what* she is.”

“Well, uh, do you protect yourself when you’re with her?”

“Diva” [David in Shona slang], “ah! Of course, I do. I sometimes wear two condoms!”

And yet when I relayed this story to his brother, with whom he shared a flat, his brother responded: “Diva, that’s not true. You’ve stayed with us. Have you ever seen a condom here? I live here and have never seen him with a condom; even when he has his girlfriends here [e.g. when they spend the night].”

As the above bricolage suggests, there is no simple overarching theoretical narrative that arises from a study of n’anga responses to AIDS in Zimbabwe. Any attempt to study these responses is admittedly partial, given the cultural paradoxes of the disease and the social contexts from which it emerged. Following Reynolds’ (1996) study of traditional healers and childhood in Zimbabwe, I consciously resist the pressures to be neat and all-knowing in presenting my work here. Likewise, as Setel cautions in his study of AIDS in Kilimanjaro, “There is no single, paradigmatic analysis offered here, but an acknowledgment that, like the syndrome itself, the cultural experience of AIDS...is perpetually ambiguous and irreducibly plural. An account of this disease is thus best left open-ended, reflecting a recognition that all disciplinary perspectives are inherently partial” (1999:26).

So, what I offer here is a series of fragments, admittedly partial and particular ways of seeing n’anga responses to HIV/AIDS in Zimbabwe. But I hope to ground these

in broad socioeconomic and cultural contexts. Zimbabwe, as a scene of intense human suffering, can be difficult and oppressive enough to the not-quite-complete outsider who finds himself caught up in a society where the tensions appear evident, though they may often seem beyond being located or understood. And though I consider myself a keen observer and recorder, I am deeply aware of how much I could not fully get hold of, understand, assimilate, and express. Zimbabwe in recent years has often been too much for Zimbabweans themselves--there has been just too much suffering, too much poverty, too much chaos, too much bloated bureaucracy, meanness, greed. It can certainly be too much for the intrepid anthropologist, no matter how sympathetic. So, here I attempt, however modestly, to build an interpretive anthropology accountable to history and political economy (Marcus and Fischer 1986:86); or, to quote Farmer (1992:13), it is an "attempt to constitute an interpretive anthropology of affliction based on complementary ethnographic, historical, epidemiologic, and political economic analysis."

Following the "Introduction" are my theory chapter entitled, "Some Theoretical Points of Departure," and a chapter on methods. Beyond that, this dissertation is divided into three parts. Part I, "The State of Health and the Health of the State" examines the emergence of HIV/AIDS through the lenses of political economy, epidemiology, public policy, and an interpretive anthropology which grapples with the diverse symbolic meanings of the disease. Part II, "Genealogy of a Problem: The Historical Constitution of N'anga as Objects of Knowledge," chronicles the longstanding relationship between n'anga and the emissaries of health development--early medical missionaries, colonial officials and public health workers, contemporary doctors and health workers, and international and national health development organizations and individuals. This

chapter offers more a sociology of knowledge than a straightforward chronology per se. Part III, “Managing Misfortune: N’anga Responses to HIV/AIDS,” illustrates the diverse responses of n’anga to the disease. Building on the discussion from previous chapters, I show how n’anga contemporary responses to the epidemic have been deeply shaped by their encounter with ‘modernity’ in general and health development in particular. Additionally, I share indigenous theories of disease contagion (Green 1999) amongst n’anga, focusing on sexually transmitted diseases and HIV/AIDS. I will argue that n’anga interpretations of HIV/AIDS draw attention to a long-standing history of structural violence perpetrated on the average Zimbabwean, first under colonialism, and now under the postcolonial state.

¹ NACP 1998

² *ibid.*

³ Ironically, this hasn’t stopped ZINATHA from pursuing relationships with international pharmaceutical companies. For example, a *Standard* article entitled, “Traditional Medicines to be Exported, “ (June 13-June 19, 1999) reports on ZINATHA’s ongoing discussions with unnamed British “partners” who were particularly interested in traditional medicines that treated barrenness.

⁴ Our commiseration more reflected the communal aspect of health-seeking behavior in much of Mashonaland, or what Feierman and Janzen (1992:18) refer to as “therapy managers” who are usually drawn from a patient’s familial ties and/or close acquaintances.

CHAPTER TWO

Some Theoretical Points of Departure

As far as the origins of the disease is [sic] concerned, I am strongly convinced that this is God's punishment for the adulterous lives being led by so many people. The problem is not only an African problem, but *everyone poor is suffering*.

-a female bone caster, Warren Park

You ask me why I do this when I know that AIDS is raging in the streets? Because I have to feed my children today; AIDS will take years to claim me.

-a Harare-based commercial sex worker

The above quotations, in different but related ways, capture the theoretical essence of this dissertation. The n'anga from Warren Park draws our attention to the immoral behavior of individuals and how such behavior puts them at risk for contracting HIV/AIDS. Her viewpoint (and others like it further elaborated throughout this dissertation) could best be summarized as conservative, an attempt to uphold and maintain notions of morality and proper conduct in line, illness and disease being the end result of non-compliance with sacred precept. Importantly, however, she also draws our attention to the role of poverty in the suffering wrought in the wake of AIDS. She insists that everyone poor is suffering and that such suffering is not unique to the African continent. The full impact of HIV/AIDS, she seems to suggest, is hardly random in its distribution or effect but rather disproportionately affects poor people. A number of corollary questions arise from her insight: Are poor people more susceptible to HIV/AIDS? If so, why? What is the nature of the constitution of poverty in Zimbabwe, and can such poverty be said to 'structure' peoples' risk of infection with HIV? Could we characterize poverty, in this n'anga's assessment, as a form of 'structural violence'?

Like the Warren Park n'anga, the Harare-based commercial sex worker draws our attention to the material context of risk for HIV/AIDS. She is aware, surely, that her choice (is it really a choice?) of income-generating activity would be frowned upon by most people, viewed as immoral and promiscuous. She is also deeply aware that such activity puts her at great risk of contracting HIV, if she isn't already infected. However, her concerns about risk and death are mediated by the material needs of the moment: feeding her children today. How can we argue with such logic?

The material, somatic expressions of poverty, and its articulation with HIV/AIDS, leads the analytical gaze back to the relationship between macrostructural forces and the health of the individual. From the perspective of the commercial sex worker, such an analysis would seek to uncover the social processes and individual decisions which resulted in her current mode of income-generation--and her being placed at risk for HIV. Viewed through such an analytical lense, this young woman's life--far from exemplifying uncontrolled sexuality and blatant promiscuity--reveals the extent to which her method of making money is linked to her impoverishment and to her subordinate status as a woman. Thus is making a living linked to death.

From the perspective of n'anga--the central focus of this dissertation--such an analysis would be interested in uncovering similar sorts of relationships. N'anga readings are regnant with the more sociological regard favored throughout the following analysis. It is apparent from the above quotation that, at least some, n'anga seek to locate illness and disease in a broader social field, recognizing the interconnections of both. But there are also other equally central analytical issues that come to the fore, particularly with regard to health care delivery in the face of a devastating epidemic. How, for

example, do n'anga understand HIV/AIDS? Where do they think the new malady came from, and why do they think it has become entrenched in Zimbabwe? These questions become centrally important when we consider that a majority of the Zimbabwean population, whether rural or urban, still consult n'anga to ameliorate their various afflictions--physical, psychological, or spiritual (Chavunduka 1999). Previous works on neighboring countries (for example, South Africa and Mozambique) suggest that 'traditional healers' are those most commonly called to treat sexually transmitted diseases and that there is a strong correlation between the types of STDs found in southern Africa and transmission of HIV/AIDS (cf. Green 1994 and 1999; Sajiwandani and Baboo 1987). The efficacy of such treatments has yet to be systematically studied, but preliminary research seems to point to their inefficacy. Through ineffective treatments and perhaps other risky procedures (e.g. utilizing unsterilized razors, biting for the administering of medicinal plants, etc.), healers might even be facilitating the transmission of the virus.

Apart from the very serious medical concerns such issues raise, there is also the problematic of health development and n'anga. Are n'anga really 'obstacles' to health development strategies designed to combat HIV/AIDS? What, if any, steps are being taken to include n'anga in efforts to combat HIV/AIDS? What are (and have been) the relationships between n'anga and the biomedical community and the state with regard to health service delivery? How would we characterize the encounters between health development (in its historic and contemporary manifestations) and n'anga, and what lessons might drawn from these encounters?

Health Development and Traditional Healers

In her work in Nepal, Pigg (1995, 1997) describes the confluence of western health development discourse and traditional healers in Nepal. Her work is about *objectification*, and her framework is a Foucauldian one. International development, she argues, relies on a globalized (and generic) vision of 'traditional medicine' when constructing country-specific programs that utilize local health practitioners to further a standard set of health objectives. Generalized categories such as traditional birth attendant (TBA) and traditional medical practitioner (TMP) derive from a process of 'translation' that links local realities to development in particular ways. Such acronyms are the culmination of various acts of translation through which multiple local practices are subsumed into an overarching development framework. Unveiling the processual nature of this transaction, she outlines three key areas: how traditional healers are understood in international health policy; how, in national planning, these conceptions are made to fit with existing Nepalese realities; and how research on local ideas and practices becomes authoritative knowledge about traditions, which then, in turn, forms a basis for the planning and implementation of training programs.

Through this process of translation, the generic conceptual categories of TMP and TBA congeal into the design and implementation of training programs. In this way, even as it seeks to create programs tailored to local conditions, development generates frameworks that efface or exclude much of what local people think, believe, and do. So, while training programs are touted as a way to 'bridge the gap' between the local realities of peoples' lives, she points out, it is also important to remember that, at another level, development discourse produces the very problems it ostensibly seeks to solve.

My intention in this dissertation is, I think, rather different than that of Pigg, though our concerns clearly intersect at many points. Pigg's general interests are the hidden processes of cross-cultural translations embedded in development discourses and how such discourses contribute to shaping a particular kind of world order. She explores how general descriptive glosses such as 'traditional' and 'indigenous' serve to reify artificially static notions of cultural authenticity while, at the same time, positioning such concepts in contradistinction to the 'modern.' To underscore this notion of the hidden and power-laden nature of words, she quotes from Volosinov's (1973 [1929]) book, *Marxism and the Philosophy of Language*: '...we never say or hear words, we say and hear what is true or false, good or bad, important or unimportant, pleasant or unpleasant and so on. Words are always filled with content and meaning drawn from behavior or ideology. That is the way we understand words, and we can respond only to words that engage us behaviorally or ideologically.'

Certainly the hidden meanings and power of words come to suffuse and shape encounters, as pointed out by a number of scholars concerned with development (cf. Sachs, et al. 1992; Escobar 1995). But by focusing narrowly on a broadly-defined health development discourse, and leaving out what local peoples make of this development, she leaves us with an exaggerated sense both of the coherence of this discourse, its hegemonic nature, and of the inevitability of its form. There are few ruptures or hiccups in the portrait she paints. Generalized terms such as 'tradition' and 'modern' and TMP and TBA mutually engage each other in a dialectical (solipsistic?) dance which forms a whole and neatly succinct ensemble.

As convincing and analytically astute as Pigg's account is, it neglects in many ways a central corollary implicit in Volosinov's quote, namely: 'That is the way we understand words, and we respond only to words that engage us behaviorally or ideologically.' Pigg's work is primarily concerned with the processes of objectification. As such, it does deal with the constitution of Nepalese ritual healers--*dhami-jhankri*--as objects of knowledge, but it does so only in terms of the function performed by objectification in the development of the generic (and generalized) monikers TBA and TMP. Pigg does not discuss the question of the effects of this process on those who are so objectified (and she admits as much). Neither can the process of objectification, within the chosen frame of analysis (the generalized acronym), raise the possibility that some discourses might operate less through a unilinear process of objectification than through a more fragmented process by which subjectivities are created.¹

In the chapters which follow, I attempt to analyze, within the specific historical and contemporary context of British colonialism in Zimbabwe, the processes both of objectification and of the creation of subjectivities, through a careful scrutiny of health development discourses on n'anga--from those of early medical missionaries to contemporary development organizations and agents. One of my central concerns here is the operation of these discourses in a specific social context over a period of time. By narrowing the analytical gaze, I attempt a critical epistemology of health development, locating development in a particular social and political context. In doing this, I hope to assemble a portrait, not so much of the hegemonic nature of health development, but a more nuanced and fuzzy one, which incorporates resistances and ruptures with received knowledge and practice. And this has important implications for the contemporary role

of n'anga in combating HIV/AIDS in Zimbabwe--in terms of their response to this new disease and in terms of the conditions of their involvement in educational interventions. More specifically, I will argue that their historical and contemporary encounter with health development (and, more generally, with 'modernity') has shaped their understanding of, and responses to, the epidemic in particular and diverse ways.

Social Constructionism and Medical Pluralism in Africa

Multiple literatures suffuse my approach in this dissertation. Most centrally, I have been informed by a social-constructionist approach to the confluence of African therapeutic systems and biomedicine. One of my primary foci is the ways in which health-development knowledge has wrestled with African therapeutic systems over time in Zimbabwe. A central postulate of this approach is that all forms of therapeutic knowledge and practice, African and non-African alike, are to some extent socially constructed. In Part II of this dissertation, "Genealogy of a Problem: The Historical Constitution of N'anga as Objects of Knowledge," I view both African therapeutic systems and biomedical theories and practices as narratives which draw on a multiplicity of cultural signs and symbols for their own intended purposes. Recent literature on medical pluralism in Africa and its encounter with both biomedicine and, more broadly, health development (comprehensively conceived) informs my social-constructionist approach.

With regard to medical pluralism in Africa, anthropological studies of disease, illness, and medicine have a long history. Much of this early work--dominated by such figures as Victor Turner (1964), E. Evans Pritchard (1937), and Robin Horton (1967)--

sought to understand the beliefs surrounding medicine and illness and the social significance of ritual. Relying on a structural functionalism--which attempted to understand the totality of cultural practices and their interrelationships by embedding them in coherent (and often ahistorical) explanatory frameworks--these scholars located health and disease in the broader matrix of social, ritual, and moral relations. Importantly, however, their focus was not specifically health and medicine per se, but the beliefs surrounding them. Much of the focus centered on studies of witchcraft, sorcery, and magic. The cumulative effect of this focus has been the conception that Africans regard most illnesses as caused by supernatural forces. A corollary to this principle, pointed out by Yoder (1981), is that illness always has social and moral dimensions. Evans-Pritchard, for example, argues that: "Azande attribute sickness, whatever its nature, to witchcraft and sorcery." Turner posits that "The Ndembu, like the Azande, consider that calamities of all kinds are caused by mystical forces generated or evoked or directed by conscious agents."² Yoder (1982:12) points out: "What is problematic about such [work] is not the linking of illness to moral and social issues, but rather that this link has been assumed instead of made the subject of systematic investigation."

Correctives to these approaches have been many and varied. A more narrow focus on disease classification and etiology, for example, has led some researchers to an 'indigenous knowledge' approach which seeks to elicit local taxonomies of disease as a way of understanding the underlying logic of disease entities and their classification into distinct categories (Warren 1974, 1975, 1989; Brokensha, Warren, and Werner 1980). For others (Foster 1976; Lieban 1977) etiologic and classificatory schema are seen as central to an integrative understanding of medical phenomena and cultural settings and as

key to developing cross-cultural comparisons of non-Western systems. Others scholars (Bibeau 1979; Janzen 1978; Young 1975) follow a similar line, focusing specifically on medical knowledge and practices and the ascription of disease causation as part of the process of diagnosis and the search for treatment.³ The challenge for many of these approaches is developing the most appropriate terms for classifying etiological theories of African disease. Most theories of African disease, or “indigenous contagion theories” (Green 1999), seem to rely heavily on an implied dichotomy between ‘natural’ and ‘supernatural’ causation. While there have been attempts to recast these terms--Foster’s (1976) use of ‘personalistic’ versus ‘naturalistic’; Fabrega and Silver’s ‘impersonal’ versus ‘personal’; and Young’s (1976) ‘internalizing’ versus ‘externalizing’--the dichotomy still remains.

More recent work on African medical pluralism (Janzen and Feierman 1979; Janzen and Prins 1981; Packard, Wisner, and Bossert 1989; Feierman and Janzen 1992) has attempted to move beyond the narrow focus on ideas of ‘natural’ and ‘supernatural’ causation. Viewing African curative practices as ‘therapeutic traditions,’ much of this literature focuses on the historically and continuous streams of interrelated theory and practice within these traditions. From this perspective, each therapeutic tradition contains “sets of concepts concerning illness causation, anatomy, society, or self, as they relate to bodies of therapeutic practice, and also to the occupational roles within which healers work” (Feierman and Janzen 1992:xvi). Equally important, this body of literature has drawn attention to the intersections of changing cultural definitions of the individual’s place in society, the human body and its parts, and healing practices. Seen in this way, healing traditions not only emerge from (and respond to) systemic practices and

processes of political and economic control, they provide interpretations of a rapidly changing reality.

Political Economy of Health, Embodiment, and the Structure of Risk for HIV/AIDS

It is surely a truism in social science circles now that health and disease cannot be adequately or fully understood without careful attention to the socioeconomic milieu in which they occur. This view, which has various materialist and non-materialist strands, can best be summarized as a political economy of health and illness approach (Setel 1999; Farmer 1992, 1999; Schoepf 1991, 1993; Turshen 1984, 1999; Packard, Wisner, and Bossert 1989; Packard 1989). Such approaches seek to remedy some of the more narrowly biologicistic frameworks that rely on processes of objectification of the individual body, displacing it from the social context in which illness and health occur. Not only does such displacement make the afflicted feel alienated and powerless, opponents of the biologicistic approach argue, it is also an insufficient way of accounting for the production of disease. By focusing narrowly on the corporeal expressions of disease, the broader socioeconomic forces which come to shape illness and disease (and responses to it) are often left obscured. These are the very forces which comprise systems of production and of social reproduction, exploitation, poverty, and the exercise of political power (Vaughan 1991). Inattention to these impersonal forces, which nevertheless have biological effects, will continue to stymie any efforts to account for patterns of disease and their changes over time.

The mechanisms by which these broader social forces become embodied as biological events is also a central theme throughout this dissertation. As others have

noted (Lock 1993; Bell 1992; Combs-Schilling 1989; Comaroff 1985), the body (and processes of embodiment) as an analytical unit has enjoyed a renaissance in anthropological investigation and theory. Classical anthropological studies usually included analysis of ritual adornment, scarification, and the like; however, they did not usually theorize the body as the medium for the internalization and reproduction of social values and for the simultaneous constitution of both self and the world of social relations. Viewed in this more socialized way, the body becomes the locus of different levels of experience (Bourdieu 1977) and bodily practice is seen as a logic embodied in the physical movements of the individual (part of a constellation of bodily acts referred to as “body hexis”) that both reflects and structures individual and group experience. It was at this level, for example, that the non-Conformist missionaries to South Africa sought to reform their would-be African charges, for the missionaries recognized the structuring effects of bodily practice on the mind, behavior, and spirit of individuals (Comaroff and Comaroff 1991). Likewise, Combs-Schilling (1989) illustrates the role bodily practice and symbology played in the restoration and reinscription of the monarchy in Morocco. He argues that culture reproduces itself most forcefully through (and in) our bodies.

Taking a more agentic approach to conceptualizing bodies, Setel argues:

Seen in cultural context, bodies and illness are connected in a dynamic flow of the generation of meaning, or signification, that entails a cultural and corporeal hermeneutic of disordered persons, of disruptions to the proper performance of agency and meaningful action. Rather than employing a discursive idiom of the Body as an externally inscribed and structured object, I shall emphasize an idiom of process, of living and dying bodies as dynamically unfolding and directed processes that are organized and changed in time and space and culture (1999:11).

It is this idiom of process that I want to emphasize throughout this dissertation. Processes of signification of the African body are mediated by time, space, and culture. In other words, what the African body has come to mean to both Africans and non-Africans alike is the product of historically contingent forces, of place (both geographic and conceptual), and of changing cultural practices. Illness and its representation with(in) African bodies is deeply implicated in these sorts of processes. As a result, what illness means and how it is treated is implicated in the very discursive construction of the body itself and the signs and symbols attached to it over time by differently positioned actors.

N'anga, in particular, play a crucial role in conceptualizing and interpreting the body (in both its biological and symbolic capacities) within Zimbabwean society. As we shall see in the chapters which follow, from life's nascent beginnings to its final transition into the state of ancestorhood, n'anga and their *muti*, or medicine, figure prominently in how the Shona person understands her own body and, indeed, its connection to the wider social world. For n'anga, the human body is the site where various struggles--emotional, spiritual, and psychological--are carried out and won or lost. Illness is never *just* illness.

The idiom of "living and dying bodies as dynamically unfolding and directed processes" takes on added significance in the age of AIDS and begs Treichler's (1988) question posed at the beginning of the epidemic: "What is the nature of the bodies most at risk for AIDS? What is their discursive history?" From its earliest impacts in Africa, AIDS and its relation to black bodies figured prominently in the international media and in the social and biological sciences. Early translocal discourses on AIDS in Africa shared mutually reinforcing logics, namely that "any infectious disease is a knowable

biological phenomenon whose strange and seemingly contradictory aspects are ultimately illusory” (Treichler 1999:100) when subjected to the expert, scientific gaze. Second, such discourses usually equated Africa with “the savage, the alien, or the incomprehensible, then asserted the achievability of reason and control. Although these two features may seem to conflict, they exist in fact in a relation of discursive symbiosis: the metaphors of mystery and otherness produce the desire for control, which is in turn fulfilled and justified by the metaphors of otherness and mystery” (ibid:101).

Images of the dark continent, harboring dangerous diseases, inhabited by people with monstrous and exotic sexual appetites, have long been inscribed in the Western imaginary of Africa (cf. Comaroff and Comaroff 1991). Early media coverage of the unfolding epidemic in Africa framed the disease in these very tropes. A 1990 *Washington Times* editorial, for example, entitled “Free Love in Central African Nation Lets AIDS Take Toll of Middle Class,” warned of the eminent end of the Central Africa Republic’s “sexually promiscuous” upper-middle class. Both the *New York Times* and the *Amsterdam News*, also from 1990, reported that experts were attributing the spread of the disease in central Africa to the high incidence of people having multiple sexual partners.⁴ Even that arbiter of mainstream fashion, *Cosmopolitan* magazine, weighed in, arguing that HIV transmission via heterosexual contact in Africa could be explained through cultural differences in sexual practices--that is, that Africans engaged in unadmitted homosexual or quasi-homosexual activities, the practice of anal intercourse as a method of birth control, and violent, excessive, or erotic sexual practices.⁵ News reports such as this reinforced a public health focus on controlling sexual behavior through, for example, the use of condoms and limiting sexual partners. As we will see in

later chapters, such a focus not only placed the spread of HIV/AIDS on its very victims, it concealed other important mechanisms contributing to the dispersion of the disease.

Around the same time, US- and European-based public intellectuals and activists announced the source of the epidemic to be Africa before data to substantiate their hypotheses were definitive. Dennis Altman, for example, early in the epidemic's history in 1986, announced:

The most striking indication that AIDS was in no intrinsic sense a disease of homosexuals came in the mounting evidence of widespread existence in central Africa, where it seemed to have very little correlation with male homosexuality. The connection with Africa was known to researchers as a real possibility from 1982 on, but it took some time to be reported in the mass media, at least in the United States.⁶

Likewise, Peter Tatchell, a British gay activist and left-wing socialist, held forth arguing that

Most...AIDS cases are in central Africa, where the incidence of AIDS far surpasses New York or Los Angeles. According to World Health Organization figures released in June, between five and ten million people have been infected with the virus worldwide. In Africa it is estimated that 6% of the total population is now infected but in some countries it is much higher--25% of the Malawi population, 23% of the Ugandan population and 18% of the populations of Rwanda and Zambia.⁷

As Chirimuuta and Chirimuuta (1987) point out in Tatchell's sweeping claims (and evocation of WHO figures), no such data existed to support such assertions.⁸ Still, work on genetic markers for susceptibility rapidly found its way into print, reminiscent of colonial views of Africans as particularly susceptible to disease (cf. Vaughan 1991). Even data on cranial capacities, a relic of eugenic science, were trotted out to explain

African susceptibility (Bassett and Mhloyi 1991). African women, in particular, have suffered the brunt of this assault, their bodies often conceptualized by local men and the wider world as polluted vessels bearing equally polluted and condemned babies.

This way of thinking about AIDS in Africa, though to some extent self-correcting in the past few years,⁹ has had a lasting impact on the many African nations' self-images and the continent's image abroad. Sensationalistic titles of newspaper articles such as "Out of Africa, Origins of AIDS Emerge -- A Virus Turns Deadly Jumping From Chimps to Man"¹⁰ have helped to shape a public perception of Africa and Africans as being responsible for the genesis of the disease, its spread, and the apparent failures of various interventions. Such titles also help cast Africa and Africans as a place and peoples who engage in strange and barbarous behaviors--how did the virus "jump" from chimps to humans? From humans eating chimp meat, or perhaps engaging in sexual intercourse with chimps? This title very succinctly links Africa+Origin of AIDS+Chimps.

In the case of Zimbabwe, as the full impact of the disease was borne out, and fear of losing needed foreign currency in tourist revenues and investment, the government initially delayed and even suppressed a systemic public health response to the pandemic.¹¹ To admit to the existence of the AIDS epidemic became tantamount to admitting to the inferiority of African ways of life (Bassett and Mhloyi 1991).¹² As Treichler notes (1999), for example, while the HIV/AIDS epidemic in industrial and post-industrial societies is believed to be complex, intellectually and politically contested, and theoretically interesting, much of the epidemic in Africa is seen to be simply a material disaster. Western representations of the disease in Africa reinforce familiar stereotypes: skeletally thin, passive "natives" lie in rudimentary, crowded hospital rooms, staring

pitifully and longingly outward. Sadly, this linking of Africa and Africans with AIDS has resulted in further discrimination and violence, not sympathy, perpetrated on Africans living abroad. In one case, this bias sparked riots against African students in China.¹³ In these ways, Africa, Africans, and AIDS have become symbolically intertwined in the popular imagination.

The view from Africa was and is, of course, quite different. While the above biased Western AIDS coverage depicts Africa and Africans as being responsible for the origins of disease, its continued spread, and as passive recipients of internal and external help, such depictions are based on an almost complete ignorance of the African press. Even a cursory overview of African publications reveals tremendous engagement by government, NGOs, church groups, youth groups, women's organizations, and the like.¹⁴ In such publications, Western AIDS coverage is often criticized and lampooned. In some cases, the United States and Europe are blamed for the genesis and spread of the disease (see, e.g., Chapter Six). Importantly, too, indigenous medical practitioners and their curative practices are usually dealt with respectfully and, though sometimes criticized, they are usually not, as in the West, fetishized or treated with disrespect.

The distorted image of Africa and Africans also becomes important from the standpoint of structural violence and risk for HIV. What, in fact, constitutes "structural violence"? What are the particular processes through which structural violence is embodied in Zimbabwe? What are the effects of embodied structural violence, particularly with regard to health and risk for HIV? Following Farmer (1999:79), I take structural violence to mean those "historically given (and often economically driven) processes and forces which conspire to constrain individual agency. Structural violence

is visited upon all those whose social status denies them access to the fruits of scientific and social progress.” In colonial times, this was the lot of many Black Zimbabweans: forced migration for large-scale agricultural and industrial production, the forced separation of husbands and wives (and the subsequent reconfiguration of sexual practices and social reproduction), transformations in legal structures and land administration, and unequal integration into a cash economy. The contemporary trajectory of HIV/AIDS in Zimbabwe has been deeply shaped by these processes and practices.

Similar sets of processes and practices are discernible in post-colonial Zimbabwe. In 1999, the country seemed inescapably swept up in a downward spiraling socio-economic and political vortex which extended itself into all facets of life. The government was involved in costly (allegedly \$1,000,000-2,000,000 a day) and increasingly unpopular support of Laurent Kabila’s forces in the Democratic Republic of Congo in the name of preserving ‘democracy’ while, at the same time, facing with charges of rampant domestic governmental corruption, skyrocketing inflation and interest rates, astronomical increases in the price of basic goods, a collapsing health care system, a controversial land reform and resettlement program, and stalled talks with the International Monetary Fund (IMF) regarding the release of some \$53 million in desperately needed aid. The dismal economic and political climate, in conjunction with the country’s plans to celebrate 19 years of independence in April of 1999, prompted Harare-based economist Edmore Tobaiwa to lament:

At the end of the day, independence must, for example, mean being able to walk into a shop and buy whatever you want. This is not happening because people cannot afford very basic requirements and this can only

come with sound economic policies, something that is lacking right now in this country.

These virulent strains of economic instability, briefly glossed above, will be further elaborated in subsequent chapters. Let me mention here, however, that these macro-recessionary trends have very real material consequences for the average Zimbabwean: unable to buy adequate amounts of food, people tend to eat less (thus weakening their bodies and immune systems); unable to pay for increased user-fees for medical services under draconian structural adjustment policies, many people no longer attend hospitals and clinics (sometimes leaving such ailments as STDs untreated or undertreated); unable to pay school fees for all their children, some parents may pull their daughters from school (and daughters, to pay for school fees, may take on “sugar daddies”); women, unable to find “legitimate” work, may engage in prostitution (loosely defined) to support their families; and so on. Seen in this way, the processes through which social forces come to be embodied as biological events appear in sharp relief.

This focus on the “political economy of risk” (Farmer 1999) suggests how certain people are placed at risk while others are shielded from risk. What, for example, explains the relatively low levels of HIV infection in Zimbabwe’s predominantly affluent White community [ask Lynde about numbers]? And once diagnosed with HIV, what accounts for the longer survival among Whites and affluent Blacks vis-a-vis the rest of the majority population? As these questions intimate, risk usually follows sharp gradients of race, class, and gender. In subsequent chapters, I hope to explore more systematically the ways in which these social variables shape risk for HIV/AIDS. Part I of this dissertation,

“The State of Health and the Health of the State: A Social Demography of AIDS,” explores many of these issues.

(Bio)Medical Hegemony on a Shoestring

Much of the above-mentioned viewpoint has shaped my analysis throughout this dissertation. There is little doubt now that narrowly biologicistic approaches fail to embed ill-health in the broader social, economic, and political contexts in which it occurs. And certainly part of the failure of HIV/AIDS-education interventions in Zimbabwe can be attributed to the fact that no serious account was taken of the broader sociopolitical and historical context (cf. Mhloyi and Bassett 1991). Paradoxically, however, as Vaughan (1991) points out, much of the medical knowledge produced in and about colonial Africa *was* explicitly concerned with locating the social and cultural origins of disease and illness, drawing on both science and social science--and often pseudo-science--for its authority. In this sense, biomedical knowledge on Africa was simultaneously socially constructed (from the perspective that its concerns and ways of viewing its object of study were the result of a particular place, time, and worldview) and social constructionist in the sense that it often sought social explanations for biological phenomena (ibid).

The fragmented nature of biomedical knowledge and practice in the African context has been increasingly addressed by a number of social scientists. Vaughan (1991), for example argues that the biomedical account of colonialism was not

monolithic, that biomedicine 'argued with itself.' Differently positioned social actors in Africa--medical missionaries, doctors, nurses were--, at various times, critical of certain aspects of colonial rule and of colonial ideology. The power of colonial medicine, she argues, was located not so much in the direct impacts on the bodies of its subjects, but rather in its ability to construct a biological and pathologized account of those subjects. In this way, "Biomedicine helped produce a concept of 'the African' and an account of the effects of social and economic change which was plausible and socially relevant to colonial asministrators and, at various points, to individual Africans themselves" (25).

Likewise, Comaroff (1982) discusses the central paradox of biomedical knowledge, namely that even while its base is an apparent empirical objectivity, biomedicine's underlying epistemology remains a cultural construct, constitutive of the wider social context within which it finds expression. For Comaroff, the core of biomedicine's 'cultural construction' is the idea of a 'rational individualism' which views people as 'self-determining, biologically contrived individuals' existing in a context of 'palpable facts and material things.' This focus on the self-determining subject is, in Comaroff's view, part and parcel of the capitalist mode of production and of modernity which paradoxically, bestow on subjects a sense of self-determination while denying them direct control of the means of production. Thus, when illness and/or misfortune strike, the contradiction between self-determination and lack of control over our own bodies leads us to feel conflicted and alienated (see also Comaroff 1985). Within the context of Rhodesia/Zimbabwe, such feelings of conflict and alienation, especially during major traumatic events, might take the form of new religious movements (the Vapostori

movement which emerged, at least in part, to the 1918 Spanish Influenza epidemic comes to mind) or sweeping accusations as to the nature and 'true' cause of affliction.

Social-constructionist approaches to biomedicine are diverse. Most share a healthy skepticism of 'biological facts' viewed in isolation, instead centering their analyses on the mutual interplay of the 'social' and the 'natural.' Such an approach lends itself well to a study of therapeutic systems in Africa. Throughout this dissertation I will analyze a number of biomedical and African therapeutic narratives from colonial times up until the present. Following Vaughan (ibid:7), I treat 'these narratives as constructions of reality, and try to understand why they take the form they do. At the same time, however, I have stopped short of a full-scale constructionist approach, and have assumed that there may be a more accurate way of accounting for and describing a disease pattern, an epidemic or a rise in mortality.' As she rightly points out, there must be a *material reality to which medical constructs, at some level, refer*. While AIDS, for example, has been labeled a *disease of signification* (Treichler 1988), it nonetheless has a material, biological, reality. CD4 cells can be counted. Viral load can be empirically measured. AIDS-related symptoms--weight loss, tuberculosis, kaposi's sarcoma, etc.,--can all be scientifically diagnosed and treated.

For these reasons, medical discourses must be seen to reflect and shape the material and political circumstances in which they find expression. Phimister's (1973), and to a lesser degree Ranger's (1988), work on the 1918 Spanish Influenza epidemic in Rhodesia and its impact on mining illustrates the relationship between the political economy of (black) mining labor and the medical/social construction of influenza. Likewise, Packard's (1989) work on similar processes with regard to tuberculosis in

South Africa points to the need to 'ground' any constructionist narratives in the very material concerns of political economy and the fact that disease entities do exist in an empirically biological sense. People get sick.

Thus far, I have elaborated an approach that draws on strains of constructionist and political-economy-of-health frameworks. Some of these approaches, especially those of Vaughan, Comaroff, and Pigg, draw heavily on Foucault and his work on the medicalization of power in the nineteenth and twentieth centuries. So here, very briefly, I want to discuss some of the major tenets of Foucault's approach and its relevance to the conceptual framework of this dissertation. I leave to one side critical analysis and assessment of Foucault's work, as this has already been handled by a number of scholars (see Dreyfus and Rabinow 1982; Parry 1987; and Vaughan 1991). The two most central aspects of Foucault's knowledge/power regimes throughout this dissertation are: processes of objectification and the creation of subjectivities.

Foucault's notion of objectification draws attention to the role of discourse in explaining and naming reality. Inherent in this classificatory process is a sense of cohesive patterning, or what Pigg (1995) refers to as 'translation,' which produces a sense of truth and fact which, in turn, gives rise to particular techniques for managing, organizing and disciplining people. For Foucault, penal interventions (through the institutional apparatus of the prison) offer one example of how specific modes of subjection constitute individuals as objects of knowledge. This process relies heavily in the creation of discourse accorded a scientific status (1979:24). The desired end result of penal interventions is ostensibly 'rehabilitation.' This rehabilitatory process is supposed to instill in inmates the qualities of good citizenship: to refashion felons into law-abiding,

hard working citizens who could resume a normal place in society. As Foucault shows, however, the constitution of objects of knowledge is an inherently unstable process. Far from reforming criminals, penal institutions appear to create and intensify forms of criminality. From the perspective of planners' intentions, such results would have to be seen as a failure. However, Foucault argues, such an outcome must be viewed within the systemic nature of the social reality which resulted in these outcomes in the first place. Viewed from this perspective, the construction of a delinquent group within the prison system serves the useful purpose of domesticating 'popular illegalities' and, to quote Ferguson (1991:19), "transforming the political fact of illegality into the quasi-medical one of pathological 'delinquency.'" As a result, the prison does end up serving as a form of social control, but not in the way that planners envision. For Ferguson (who is writing about "development") such outcomes can be viewed as 'side effects,' the end result of "unintended outcomes that end up, all the same, incorporated into anonymous constellations of --authorless 'strategies,' in Foucault's sense (1979, 1980)--that turn out in the end to have a kind of political intelligibility" (Ferguson 1991:20).

The 'intelligibility' of these outcomes is comprehensible only through an understanding of the nature of power as alluded to above. That is, power is 'subjectless' and 'decentered,' not embodied in the person of a powerful subject (ibid:18). It is not exercised in any deliberate manner, but capillary in its mode of deployment, constitutive of every speech act, movement, and practice of day-to-day life (Vaughan 1991). For these reasons, differential positionality on the parts of individuals or groups with regard to power is impossible, since such a viewpoint sees power as external to the individual. So, while Foucault conceptualizes power as moving through the minute determination

and specification of difference between individuals through classificatory schema, there can be no acknowledgment of the difference that differences make in relation to power (ibid). In other words, "...when you want to know how strong the power is, and how strong the resistance is, and what is the changing balance of forces, it's impossible to assess because such a field of force is not conceptualizable in his model" (Hall 1996:135).

Like Hall, I wrestle with this conceptualization of power particularly as it relates to processes of objectification and the creation of subjectivities. A cursory analysis of health development in Rhodesia and contemporary Zimbabwe seems to indicate that missionaries, colonial administrators, and current-day development institutions and agents wield a great deal of power in setting the terms of n'anga engagement in education interventions. They wield power in the very conceptualization of n'anga roles in public and private arenas. This can be seen clearly as a process of objectification. However, this same process--this different constellation of social, cultural, and economic forces--also creates an environment for the emergence of subjectivities, through the ascription of differences (again, usually articulated through a classificatory schema). In the case of Rhodesia, such ascription found expression in terms such as 'witch doctor,' 'fetish priest,' 'heathen,' etc., the terms used by medical missionaries and colonial administrators to describe n'anga. Moreover, such differences were eventually codified into law under such legislation as the 1899 Witchcraft Suppression Act and the Medical Practitioner Regulations. The end result of this ascriptive process was the creation of an often dangerous subject, the n'anga, who in many ways embodied all the qualities and

characteristics missionaries and colonial administrators sought to transform in Africa and in Africans.

At first blush, this process seems like a pretty straightforward exercise in power, missionaries and colonial administrators and settlers utilizing their resources (both material and ideological) to curtail the activities of n'anga. Colonial agents set up structures and institutions--legislative, judicial, religious, educational, military--which served to concentrate and intensify their ability to shape the material and ideological environments in ways that benefited them directly at the expense of African peoples. In this view, power did seem to be invested in an identifiable social group. Such an interpretation is, however, incomplete. First, it assumes that missionaries and colonial administrators, et al., comprised a homogenous group with identical goals and objectives; as Vaughan (1991) reminds us, biomedicine argued with itself. Second, missionaries and colonial administrators hardly had, at least early in Rhodesia's history, the resources and material base to make African peoples conform to European rules and regulations. Third, despite efforts to coerce African peoples into new ways of doing things, European settlers were often met with a great deal of resistance, actively and/or passively. Seen from the perspective, the idea of an all-powerful colonial state apparatus is more problematic.

So, what on earth does the above discussion have to do with n'anga responses to HIV/AIDS in contemporary Zimbabwe? First, it is important to develop an analytical framework which locates illness and disease in a broader socioeconomic context. By expanding the analytical field of inquiry--through attention to history, cultural practices, and political economy--the spread of HIV/AIDS throughout Zimbabwe can be seen to be following fault lines long in the making. In saying this, I do not want to sound overly

deterministic in accounting for the spread of the disease. Rather, I draw attention to the structuring effects of these historical, cultural, and political economic forces and processes in shaping the trajectory of the virus. It is only within such a context that n'anga responses to the disease become decipherable. Second, the discussion above points to the need to take the long view, the *longue duree*, in terms of looking at the historical constitution of n'anga as objects of knowledge by various actors--missionaries, colonial administrators, doctors, social scientists, development institutions and agencies, etc. Taking the long view allows us to see that n'anga have historically acted as key intermediaries, soothsayers, and master interpreters (and occasionally charlatans) in managing the misfortunes of their individual clients and, indeed, the collective Zimbabwean body itself--in often rapidly changing contexts. This historic relationship, and in particular the confluence of African therapeutic systems and health development ideologies, continues to structure (without necessarily determining) the role that n'anga publicly play in efforts at combating HIV/AIDS.

This dissertation is an attempt, however modest, at an interpretive anthropology that is accountable to the history and political economy of Zimbabwe and its most vulnerable population (Marcus and Fischer 1986:86); or, to quote Farmer (1992:13), it is an "attempt to constitute an interpretive anthropology of affliction based on complementary ethnographic, historical, epidemiologic, and political economic analysis."

¹ cf Vaughan 1991.

² Quoted in Yoder, 1981.

³ See Yoder.

⁴ "AIDS in Africa: Experts Study Role of Promiscuous Sex in the Epidemic." *New York Times* Oct 19, 1990. "Multiple Partners Blamed for Rise of AIDS in C. Africa." *Amsterdam News* Aug 18, 1990.

⁵ "Reassuring News about AIDS: A Doctor Tells Why You May Not Be at Risk." *Cosmopolitan*, January, 1988.

⁶ D. Altman, *AIDS and the New Puritanism*. Pluto Press: London and Sidney, 1986, p. 25, quoted in Chirumuuta and Chirumuuta, *AIDS, Africa and Racism*. Chirumuuta: Derbyshire, 1987, pp.5-6.

⁷ P. Tatchell, *7 Days*, October 18, 1986, quoted in Chirumuuta and Chirumuuta, *AIDS, Africa and Racism*. Chirumuuta: Derbyshire, 1987, p. 8.

⁸ Chirumuuta and Chirumuuta argue that the European and American gay communities sought to deflect growing anti-homosexual sentiment (in the face of AIDS) to central Africans.

⁹ Erik Eckholm and John Tierney's 1990 New York Times series on the epidemic in Africa marked a clear departure from earlier reporting on the disease. Focusing on a diverse swath of African actors, the articles focused on the depth and scope of the epidemic on familial relations, political and economic dimensions of the disease and how Africans are pragmatically responding to it. Also, as early as 1989 other journalists and public intellectuals called attention to the reckless, unsubstantiated assertions about the origin of AIDS being Africa, citing this misinformation as a cause of racial discrimination. See, for example, "Facts, Fallacies of AIDS Origin." *Houston Post* Dec 17, 1989

¹⁰ *Wall Street Journal* Feb 1, 1999.

¹¹ This fear was only confirmed by some US news reports which portrayed travel in Africa as dangerous and risky. A 1989 *Washington Post* article, for example, reported that a young American tourist visiting Africa became infected with the AIDS virus after the minibus he was riding wrecked. The wreck left several bleeding bodies piled on top of him, one or more of whom were allegedly carrying the AIDS virus.

¹² Such apparent underreporting did go unnoticed. In 1989, Dr. Thomas C. Quinn, a senior investigator with the National Institute of Allergy and Infectious Diseases, told a House Committee on Foreign Affairs subcommittee that AIDS infections rates were as high as 20 percent in much of Africa, although Africa had reported only 24,000 cases. "Officials Disbelieve Africa's Report of 24,000 AIDS Cases." *Washington Times* Jul 20, 1989.

¹³ "AIDS bias hits Africans in China." *San Francisco Chronicle* Jan 1, 1989.

¹⁴ For an overview of AIDS coverage in Africa, see Nancy Schimdt (1990) "African Press Reports on the Social Impact of AIDS on Women and Children in Africa." Paper presented at the conference "Impact of AIDS on Maternal-Child Health Care Delivery in Africa," 4-6 May, University of Illinois at Urbana-Champaign.

CHAPTER THREE

Methods and Procedures

My evidence-gathering approach is primarily ethnographic, and secondarily ethnohistorical, and recognizes that specific questions require specific data collection techniques. Toward this end, I utilize the ethnographic technique of participant observation, coupled with case studies and structured surveys to acquire information that answers questions about the cultural rules that underly n'angas' theories of contagious diseases, the dynamics and effectivity of n'angas' organizations, and the presence of contradictions between n'angas' social reality and their explanation of it. The standard anthropological methods aimed at eliciting qualitative data, such as unstructured interviews and life histories, were used to record n'angas' subjective responses to HIV/AIDS in a broader socioeconomic and political context. Ethnohistorical research complemented the primary ethnographic methods enabling me to utilize "objective" data to trace the historical relationships between n'anga and the emissaries of health development--medical missionaries, colonial administrators, doctors, nurses, and other health workers as well as social scientists and international aid organizations.

The study of ZINATHA (and non-ZINATHA organizations) was comprised of interviews with current staff, board members, and membership about their views of the organization, its purpose and effectiveness. Specifically, I focused on the structure of the organization, how policies are generated and ratified, and the mechanisms used to ensure that services offered meet the needs of the community to be served. I also examined funding sources and the programs generated through such funding. The goal of this component of my study was to ascertain those features of the organizational structure that

contribute to its membership feeling empowered, which features mitigate against empowerment, and how the organization directly impacts the day-to-day reality of n'angas' lives.

The second major component of this project was the collection of life histories derived from a selected set of ZINATHA- and non-ZINATHA-affiliated n'anga. By talking to a small number of n'anga in-depth, I wanted to explicitly address those issues that relate to the effect of participation (in ZINATHA, in HIV/AIDS and STD workshops, etc.) on individual lives. N'anga were questioned about their understandings of HIV/AIDS and how to treat it as well as their personal aspirations and their needs -- both perceived and real -- in order to obtain specific data about the impact and effect of power and status on their particular lives. Interviews were both informal and semi-structured; the latter to ensure some consistency in types of questions asked for comparative analysis. Through this interview process, I achieved a constellation of interpretations and constructed narratives that might be said to compromise what n'anga think about their roles with regard to HIV/AIDS prevention, diagnosis, and treatment. Furthermore, this process might be said to comprise what n'anga think about their role and status in Zimbabwean society and culture.

Archival and ethnohistorical research were confined to local sources. The expansive literature on Zimbabwe already in existence covers the pre-colonial, colonial, and post-colonial eras. There was no need to duplicate that primary research. However, primary local sources (organizational documents, government position papers on the role of n'anga in HIV/AIDS education and prevention and general health service delivery, ZINATHA's organizational history, and the like) were an on-going part of the data

collection process to see how the simultaneous elevation and devaluation of n'anga knowledge and practice operates as part of structural inequality in Zimbabwe. The goal was to identify the particular cultural expression n'angas' inequality assumes over time in Zimbabwe and to tease out its origins and the symbols attached to it.

Interviews were conducted with healers in ten designated districts in Harare which included: Chitungwiza, Dzvarasekwa, Glen Norah, Glen View, Highfield, Kuwadzana, Mabvuku, Mbare, Mufakose, and St. Mary's. A snowball-sampling method was utilized with researchers first interviewing district chairs of ZINATHA, then individual healers according to gender and area of specialization (e.g. spirit mediums, faith healers, traditional birth attendants, and herbalists). A questionnaire designed to provide a demographic profile (e.g., age, level of education, etc.) as well as a general picture of healers' knowledge and practices with regard to HIV/AIDS, was utilized.

A team of four researchers, comprising two American researchers and two Shona researchers, undertook the survey.¹ Both Shona researchers were affiliated with the Zimbabwe National Traditional Healers Association (ZINATHA) and underwent training in research techniques before beginning the survey. The questionnaire was tested and revised at ZINATHA headquarters in Harare by traditional healers before being administered in the field.

The research team conducted 100 interviews from June 17, 1996 to July 24, 1999. Most of the interviews were conducted in Shona, though healers who were fluent in English were interviewed in English. Questionnaires were written in English, translated into Shona, then translated back into English by a third party to insure their accuracy. Most often, interviews were conducted in healers' homes (e.g. in their matare -- the place

where they practice their curing/treatment), occasionally at ZINATHA headquarters, and occasionally at district meetings.

In addition to this explicit focus on n'anga, I also gathered narratives of people living with HIV/AIDS. This particular facet of the research was particularly sensitive, especially from the perspective of building up enough rapport and trust with those individuals living with HIV/AIDS so that they would feel comfortable talking with me about their experiences. There is still a great stigma to even admitting to having the disease, and the fear of disclosure is warranted particularly because of the very real possibilities of violence, losing a job, etc. All of the individuals I interviewed either worked at, or were clients of, an HIV/AIDS support organization known as the The Centre. Located in Milton Park, The Centre teaches long-term holistic survival techniques to people infected with HIV. It also provides counseling and home-based care to clients. As of July 1999, there were 150 seropositive people receiving counseling. Interviews were facilitated by the director, Lynde Francis, an openly HIV-positive White Zimbabwean who has been living with the virus for the past 14 years. Informal and semi-structured interviews focused primarily on coping mechanisms and the general experience of living with the virus.

Some Notes on Writing and Conceptual Strategies

Clifford (1986) reminds us that an ethnography is something “made” or “fashioned” and that ethnographic ‘truths’ are necessarily incomplete and partial, as they are, paradoxically, the ‘objective’ representation of a very subjective experience. Inherent in this representation of ethnography is the idea that the totality of observed

cultural forms and practices can never be fully rendered in textual form. As a result, the ethnographer makes calculated choices about observation and recording strategies as well as choices about how to represent observed phenomena through what Emerson, Fretz and Shaw (1995) refer to as a *textualization of experience*.

The demands of 'sound' anthropological methods -- participant-observation, writing up of field jottings and notes and the subsequent open and/or focused coding of fieldnotes, selection of analytic themes, and the transposition of fieldnotes into ethnographic texts -- involve an often unilinear process of abstraction from on-the-ground experience to extrapolations of broader social theory. Such abstraction is necessary in the development of new knowledge as well as the creation of general conceptual models which may have cross-cultural and cross-problem applicability. I suspect, however, that this process of abstraction has, at times, a certain subtext, namely the nullification of the implicit sloppiness of the fieldwork experience. As fieldworkers, we stumble upon answers (and perhaps more questions); we struggle to understand local people's languages, explanations, theories, and cultural frameworks; we have to be told things time and again before they finally sink in and make something akin to sense. There are, of course, personal and professional issues at stake in choosing to include, or not include, the messiness of our experiences. In not accounting for this messiness, however, we have to ask ourselves what is lost and what is gained by such omissions.

Emerson, Fretz, and Shaw (1995:8) suggest that "...it is important to recognize that fieldnotes involve inscriptions of social life and social discourse. Such inscriptions inevitably reduce the welter and confusion of the social world to written words that can be reviewed, studied, and thought about time and time again." What Emerson, et al.,

emphasize, apart from practical instruction on the *how* of fieldnote taking, is the *why* of this process and its implications in terms of representation and relations of positionality and power. Detailed fieldnotes with lush descriptions are important for establishing ethnographic authority (that 'I was there and am qualified to speak of such matters'). The inclusion of large blocks of fieldnotes within ethnographic texts, however, also serves another very important purpose, namely it allows various readers and interlocutors to judge for themselves the truth claims and theoretical assertions expressed in the text (as well as to appreciate, in some cases, the sloppiness of the fieldwork experience). This results in an inherent semiotic instability to ethnographic compositions as subsequent readers impute sometimes new and different meanings to the given corpus. As Tyler remarks (1986:135): "Even less can the text, by means of its form, dictate its interpretation for it cannot control the power of its readers."

I think ethnographic transparency is a good thing, in as much as such a stance is possible. In keeping with this idea, I employ a number of textual and rhetorical strategies throughout this work. First, this is a fieldnote-centered work, relying on large blocks of descriptive passages. The approach here is strictly interactionist in that I attempt to illustrate, through close detailed reports of people's interactions, how "social life is a process where emergent meanings are established in and through interaction" (Emerson, et al., 1995:14). Additionally, I try not to "foreshadow" the outcomes of events or offer general conclusions prior to actually describing the events, behaviors, or interactions. It is my attempt to place the reader in the sometimes overwhelming context of everyday life and fieldwork in contemporary Zimbabwe.

Secondly, in saying that this is a fieldnote-centered work, I want to clearly define what I mean by the term 'fieldnote.' Fieldnotes are usually the written end result of participant observation, whereby the ethnographer textualizes her/his experiences within a given cultural context. Within this work, fieldnotes refer to detailed written descriptions that I made during participant observation. Usually, my fieldnotes began as jottings in a small 3" x 5" memo book which, I hoped, was unobtrusive. Later in the evening, when I was alone, I would sit down and write a full account of the previously recorded jottings of conversations and interactions.

In addition to these self-generated fieldnotes, I also treat historical primary documents gathered at the Zimbabwe National Archives as fieldnotes in the sense that they represent written texts which may be subjected to processes of coding and thematic development similar to self-generated fieldnotes. Primary documents are subject to the same sorts of biases and issues of power and positionality (and perhaps more so) as self-generated fieldnotes; and unlike self-recorded fieldnotes, it is often more difficult to ascertain the motivations and/or hidden agendas underlying the production of historical documents. Bourdillon (1998:4-5), citing historiographical challenges in utilizing Shona oral tradition, for example, cautions that oral traditions are often recounted for specific and usually self-interested reasons (e.g. claims on ownership of land). For these reasons, I attempted to find corroborating documents (and in some cases conducted interviews with the necessary individuals) for cross-referential purposes.

I also treat newspaper and magazine accounts as fieldnotes. As with primary historical documents, the same precautions apply in terms of positionality of the writers (and the particular news agency they work for) and hidden agendas. At issue, too, is the

competency of the reporters and the reliability of their sources/informants; and in the case of an independent and government-controlled press, there are the added issues of ideological and state-propagandistic functions of the media. Fortunately, both government-controlled and independent media perform a mutual self-checking function with regard to the factuality of reported news and are very quick to point out sloppy reporting.

¹ This was the case in 1996 where I worked with an undergraduate from Michigan State University. In 1995 and 1999, research was undertaken by myself and two ZINATHA-affiliated colleagues.

PART I

The State of Health and the Health of the State: A Social Demography of AIDS in Zimbabwe

Romans 13:14: But put on the Lord Jesus Christ and make no provision for the flesh to fulfill its lusts.

Jonathon wrote to me during his last days to oblivion. Did I understand the letter, brother? No, I did not. In those days life was good. So good that I failed to grasp the essence of his message. Lying on this bed, waiting to meet my maker with nothing to do but memories to keep me company, I find time to think about that letter Jonathon wrote. With regret I can even peruse the message he was trying to put across to me. I ask myself, to what good. For already I am beyond saving. I recall the letter now because a dying man's memory becomes sharp.

"In life," he wrote, "It's not what you have that counts, but how you get it. It's like the means justify the end and not the other way around. There comes a time when the villain becomes the victim. My strength is failing me...I will try to finish this letter to you, my dear. Tell you what...it's not death I'm worried about, because I know sooner or later I am going to die. What worries me is how I am dying. It's a death my kids will be too grateful to forget. I am truly wasted, my friend.

"I had many lovers, you know it. We even shared memories...remember Rumbi? I said I would die to have her if only for a night. How about Tsitsi? I could write all of them in the sequence I met them. I have nothing but memories to indulge in. Eddy, sex is an illusion. Not reality. Nothing.

What I see in the eyes of those who come to see me is what has prompted me to write this letter to you. In them I see fear. I see horror-stricken people and I see pity."

Postscript: Dear reader, for me my friend's advice is too late. Like I said, I am in the same hospital, probably the same bed. Maybe you who are still free might take heed.

--Vainani
Mujaragwanda¹

My return to Zimbabwe in March of 1999 for the last leg of ongoing fieldwork amongst urban n'anga and their understandings of HIV/AIDS was filled with heartbreak. I had entered my field site initially in 1995, intellectually equipped with the latest anthropological theories and what I thought was a thorough grounding in the HIV/AIDS literature for sub-Saharan Africa. For all my intellectual preparation, however, I lacked the emotional preparation for the social and economic devastation I was to witness over the span of four years. Upon landing in Harare for my latest trip, I quickly dialed the number to the George Hotel, a short walk from the University of Zimbabwe and my second home, and asked to speak to my good friend, Margaret, the manager. "May I ask who's calling?," the receptionist asked. That's strange, I thought to myself.

"This is David Simmons. I'm a friend of Margaret's," I said tempering the annoyance I felt at being asked in the first place.

After a short pause, the receptionist continued, a plaintive note to his voice, "I'm sorry, Mr. Simmons. Margaret passed away."

I stifled a cough after inhaling while swallowing at the same time at the shock of his news. "Excuse me?" I asked incredulously, patting my chest to suppress the cough and calm myself.

"Margaret passed away sometime last year...August or September if I remember correctly," he continued.

"But how?" I asked more to myself than to the receptionist. There was a pregnant pause on the phone. I knew instinctively what the pause signified. "She had a 'short illness'?" I asked rhetorically, finishing what the receptionist was probably thinking.

“Exactly,” the receptionist answered, sounding relieved at not having to utter the terrible words.

AIDS.

In the interim months since my last stay in Harare, AIDS had certainly become more prevalent, reflected in no uncertain detail in the National AIDS Co-ordination Programme’s latest statistics as well as local media’s weekly tally of AIDS-related deaths (allegedly a shocking 1,000-2,000 deaths per week) and those newly infected with the virus (allegedly 2,000 per week as well). In March 1999, the first thing a visitor to Harare would have seen on their way into town from the airport was an AIDS education billboard. The ride along Airport Drive would eventually bring the visitor through the crowded residential area of Mbare, best known for its sprawling marketplace and crime, and to a large cemetery on the side of the road. The name of the cemetery isn’t important or remarkable, but what is remarkable--and it’s difficult to miss--are the huge heaps of excavated red-brown earth littering the area, evidence of recent or impending burials.

Indeed, the large numbers of deaths from AIDS-related complications is causing some to seriously reconsider traditional methods of burial. Burial space is fast becoming scarce. In a country where so much blood has been shed over the politics of land, its control and ownership for the benefit of the living, it’s a strange irony now that so much energy is being put into the acquisition of land, or burial space, for the dead. Some local people are making pleas for alternative forms of burial, including cremation--which many see as a violation of one’s spirit--and vertical burials. For other, mainly coffin makers, death has brought good fortune.² In economically hard-hit residential areas like

Chitungwiza, coffin production appears to be the only growing industry. And burial societies are thriving now as one of the rare cooperatives that actually works.

Watching television, listening to the radio, reading magazines or newspapers, it was difficult to escape the omnipresent reality of AIDS. Paradoxically, however, AIDS as a socially lived experience had retreated to the dark corners and private spaces of public discourse, in one case prompting the Southern Africa AIDS Information Dissemination Service (SAfAIDS) to organize a three-day regional editors' workshop on problems journalists face in reporting on HIV/AIDS. In particular, the workshop focused on ways to report peoples' personal experiences with HIV/AIDS as a way of giving the epidemic a human and public face. Many people, for example, might speak of dead relatives and friends as having suffered from a 'short illness' (and newspaper obituaries were, and are, replete with this phraseology); terminally ill relatives and friends were often described as just being 'sick.' No one it seemed, unless pressed, wanted to admit that relatives or friends were suffering from, or had died from, AIDS.

The stigma of AIDS, particularly for women, is very profound in Zimbabwe--and perhaps much of sub-Saharan Africa where women's sexuality is closely policed and controlled by men (see, e.g., Chapter Seven). To admit to having HIV/AIDS is to admit to being sexually promiscuous, still unthinkable for many women, and to having breached social custom. The very real social price of disclosing your HIV status still haunts the memories of many people in the person of Gugu Dlamini from Kwamushu, on the outskirts of Durban, South Africa, who died on December 22, 1998 as a result of the vicious beating she received at the hands of her own neighbors. They accused her of bringing shame to their community after she openly revealed that she was HIV-positive.

Her unfortunate and brutal death was well covered in the Zimbabwean press and her name still finds its way into other stories dealing with AIDS or violence towards women. One of Gugu Dlamini's greatest legacies is, perhaps, that of the importance of strategic silence in an environment where ignorance and violence are close bedfellows.

The narratives of people living with HIV/AIDS in the following pages speak to the complex sets of issues facing such individuals on a daily basis. Stigmatization. Depression. Feelings of intense loneliness, shame, and, even suicide. Cruel treatment at the hands of strangers as well as loved ones. Ambivalence about treatment strategies, whether "modern" or "traditional." It is striking that the horrible individual suffering of those Zimbabweans living with HIV/AIDS serves as a metaphor, a microcosm, of the tremendous suffering of the collective Zimbabwean body, a body being consumed by virulent strains of economic, political, and social insecurity. The metaphorical and material linkages between the health of the State and the state of health in Zimbabwe constitute a central focus of analysis throughout the dissertation.

The overall aim of this section, Part I, is quite simple: namely to illustrate how the socio-economic and political "health" of the nation correlates with the health of the individual and how the health of the individual, in turn, correlates with the "health" of the nation. HIV/AIDS offers a multi-faceted prism through which the health of the state and the individual may be seen at the intersection of historic local cultural practices, the legacy of colonialism, and present-day political economy (cf. Bassett and Mhloyi 1997). Efforts to understand the spread of HIV/AIDS in Zimbabwe, and attempts to combat and halt the epidemic, must take into account the peculiar historical, economic, and political context of the country. In this vein, Chapter Four offers an early epidemiology of

HIV/AIDS, locating the proliferation of the disease in the historic socio-economic context of Harare. Chapter Five analyzes the impacts of structural adjustment policies on the health of the average Hararian. Chapter Six chronicles local theories surrounding HIV/AIDS, theories that also figure prominently in the narratives of many n'anga. Chapter Seven analyzes the gendered dimensions of the disease. Finally Chapter Eight offers narratives of people living with HIV/AIDS, illustrating their coping mechanisms and the multiple ways they understand and make sense of their illness.

¹ Excerpted from Letters to the Editor, *Moto*, March 1999.

² The Harare branch of Doves-Morgan, one of the most prestigious and well-established funeral homes and which caters to some 85 percent of the country's funeral services, only had about 40 workers five years ago. But now, because of the skyrocketing death rate, the funeral home now employs more than 450 workers, has 16 branches, five regional managers and is planning to expand business throughout southern Africa. "Where death brings fortune." *Horizons*, May 1996.

CHAPTER FOUR

AIDS Comes to Harare: An Epidemiology of the Disease

“It’s very worrying. They’ve been educated, and they have something they can give back to the country. But just when they reach that point, they depart this life.”

-Dr. Timothy Stamps, Zimbabwean Minister of Health and Child Welfare

Harare, also known as Sunshine City, is the capital of Zimbabwe and located on the highveld or watershed plateau between the Limpopo and Zambezi Rivers. A city of profound contradictions, it is a place where glittering glass and steel high-rises stand side by side shelters made of discarded wood and sheets of plastic, where cybercafes and the latest model Nokia and Eriksen cellphones proliferate and the majority of the population of 1.5 million cannot even afford an in-house phone. The Jacaranda-shaded streets of the mainly northern (formerly majority White) low density suburbs stand in stark contrast to the crowded usually treeless former (mainly Black) “townships” or high density suburbs of the city’s southern borders. It is in these latter areas where the majority of research for this dissertation was carried out and where one gets the sense of the pulsating life--raucous backstreet beerhalls, bustling streets, markets, backyard shacks, crowded buses and taxis (or ETs “emergency taxis”)--of older African cities (cf. Rakodi 1995). The buffer zone for both of these areas--located along the railway line east and west of the city center--are the industrial areas. It is tempting to see this buffer zone as the dividing line between African and European, poor and rich, disease and health. While this would be an oversimplification of the social geography of the city, such a depiction would have

some basis in truth, particularly during colonial times when, to quote one observer, “black slums sprang up all over, constructed of the simplest and cheapest materials: poles and dagga, grass and tins, tied and nailed together to form some sort of shelter.”¹

In this thoroughly “modern” city, it is also common to hear accusations of witchcraft and many people live in fear of being bewitched, of being subject to the persecution of *tokoloshis* (invisible creatures said to possess magical powers) and other supernatural agents and/or phenomena.² Living in and traveling around Harare, one is aware of moving through a heterogeneous modernity, to use Clifford’s (1997) term, where the staccato rhythms of *mbira* mix with the bold sounds of African American R&B and Hip-Hop, where affluent teenagers, most often “nose brigade,”³ wear the latest urban gear of Fubu and Cross-Colors and debate whether or not 2-Pac is really alive or dead while sipping cappuccino at the trendy Book Cafe, while their less affluent age mates beg for “a dollar please, Boss” on the streets outside. In Harare, one gets the sense that linear history is broken, “the present constantly shadowed by a past that is also a desired, but obstructed future: a renewed, painful yearning” (Clifford 1997: 264).

Harare’s ‘shadowed past’ includes the fact that it was established by European settlers initially drawn by rumors of the legendary ‘riches of Ophir’ (Phimister 1988), a chimerical gold reef reportedly similar to that of Witwaterstrand. Through the machinations of the British South Africa Company, De Beers, and Gold Fields of South Africa, plans were quickly developed to facilitate the accumulation of capital, much of the control of which was in foreign hands, and domination of the surrounding territory. Infrastructure provision, land use planning, and the implementation of measures necessary to ensure a low cost pliable workforce ensured the maintenance of lifestyles for

European residents (Rakodi 1995:256; see also Phimister 1988) at the expense of local Black Africans. Such infrastructure provided the internal scaffolding, the template, upon which post-colonial Harare, the seat of government, has fashioned itself and its relations with the rest of the country.

Many travelers to other African countries are struck by the level of “development” as witnessed in Harare’s apparently sound infrastructure, 24-hour electricity, decent roads, “modern” architecture and urban planning, and the general cleanliness of the city. Some people say Harare is not really Africa, a good place to visit as an “introduction” to the continent. “Africa-lite,” as it were.⁴ Ask most Hararians about their city (and by extension their country), however, and they will tell you things are worse for them today, that the city is falling apart. “It’s bad, man, I tell you!” were the first words uttered by a friend of mine, Isiah, when I returned in March of 1999. Both the *Herald* and the *Daily News*’ Letters to the Editor in 1999 were replete with angry citizens complaining about the deteriorating standards of the city. The most mentioned topics were the lack of timely and systematic refuse collection, the rapidly deteriorating standards of the city’s roads (where potholes were now commonplace⁵), intermittent water shortages, and faulty street lights in many suburbs which many people felt contributed to increased muggings and robberies at night. The unhindered feeling of safety many people used to enjoy was now being replaced by a feeling of suspicion of strangers and neighbors alike, particularly as the economy worsened.

Everyone, it seemed, was more susceptible to misfortune.

Diseases once thought to be safely under control in Harare (and Zimbabwe in general) -- malaria, cholera, tuberculosis -- have resurfaced with a vengeance. In March

of 1999, Harare was in the midst of a cholera epidemic (with an allegedly lethal strain said to kill within a few hours⁶), ostensibly facilitated by a breakdown in City Council facilities and heavy rains which made septic tanks overflow with raw effluent.⁷ The outbreak of cholera, at least in part, had its roots in the city's decaying infrastructure, incapable of absorbing the tremendous growth of its population in recent years and poor city management (see next chapter). In the high-density suburbs in particular, shanty structures mushroom amid officially built houses, resulting in overcrowding and the increase of backyard shanties and settlements such as Porta Farm, Dzveresekwa Extension, the Public Works Department compound in Highfield and Hatcliffe Extension. Such settlements pose serious public health threats because of a lack of adequate sanitary facilities and are often singled out by the media and government as scapegoats for the city's chronic malaise.

Related to the cholera outbreak--and the social and economic roots of its spread--was a surge in tuberculosis, accounting for some 14.7 percent of total deaths in the city in 1998 (in 1997, TB accounted for 13.1 percent of total deaths in the city). From 1996 to 1997, the number of reported new cases almost doubled from 4, 774 to 7, 013, with poor housing conditions, malnutrition and concurrent HIV infection largely contributing to the increase. Pneumonia, however, continues to be the leading killer disease in Harare, accounting for 23 percent of the 14, 421 deaths recorded at the Harare district office in 1998.⁸ As Scheper-Hughes (1992:31) points out in a different context, however, though we tend to think of these maladies as endemic to the tropics and as arising from a confluence of "natural" climatological, geographical, and human ecological interactions, "we might do better to think of them as poverty diseases or as diseases of 'disorderly

development' (to use Doyal's 1981 term) in which the social relations that produce rural to urban migrations (and vice versa), unemployment....and malnutrition are the primary culprits behind the epidemics."

Under colonialism, rural to urban migration--and the demand for cheap labor pools that created it--had particular consequences for the health of Africans in the city (and, by extension, their rural counterparts). Forced to live in highly unsanitary locations and compounds, Africans suffered heavily from hookworm and other intestinal diseases. As Phimister (1988:261) points out, the 1944 Howman *Committee to Investigate the Economic, Social and Health Conditions of Africans Employed in Urban Areas* reported that about 70 percent of all black workers suffered from bilharzia. Other afflictions--malnutrition, tuberculosis and pneumonia--all became increasingly common during the 1940s and, by the middle of the decade, medical examinations conducted in Salisbury (now Harare) discovered that about 3 'natives' in every 4 admitted to hospital with pneumonia, tuberculosis and other complaints were also suffering from either malnutrition or a disease such as bilharzia or hookworm. These 'diseases of poverty' so rampant in the wretched conditions created in the wake of a burgeoning monopoly capitalism and the creation of production zones and trading territories foreshadow, and help bring into clearer focus, the devastating trajectory of HIV/AIDS and how socioeconomic forces come to be embodied as biological events.⁹

These diseases also reflect the health practices imposed by a British colonial power initially intent on insuring the health of European settlers ostensibly at the expense of the health of black Africans. For example, as Phimister's (1988) important work illustrates, during the reconstruction of the mining industry from 1903 to 1910, poor diet

and squalid living conditions led directly to a high mortality and morbidity rate (see also Ranger 1992:261). At a conservative estimate, pneumonia and scurvy and, to a lesser degree, tuberculosis, miners phthisis, dysentery, influenza and syphilis, altogether claimed an astonishing 34, 000 black miners between 1900 and 1950.¹⁰ At the same time, little provision was made for African housing, diet, and medical attention. Black workers often built their own housing. "As a rule," noted one compound inspector, "four or five natives agree to live together and start to build themselves a hut which may consist of anything from a substantial pole and grass hut to a few bundles of grass tied roughly on to a flimsy structure of twigs, usually the latter, according to the length of time the natives intend to remain on the mine."¹¹ During the reconstruction period, such structures were often no more than corrugated iron sheds, hastily erected on sites which soon proved unsuitable and were generally left without windows and floors. Built to either accommodate a day or night shift, but not both together, they were usually overcrowded.

Food, too, succumbed to the cost-cutting demands of the ruthless extraction of absolute surplus value. Phimister (1988:52) points out that fresh vegetables and meat,

because of the uneven development of commercial farming, were considerably more expensive, and efforts to include them as a regular part of miners' diets were loudly opposed and widely evaded. Compromised by considerations which had much more to do with the industry's profitability than with workers' needs, and by the fact that the state and its compound inspectors ignored all but the most blatant contraventions of the regulations, the diet scale was never nutritious enough on its own to maintain workers' health. Instead, black miners supplemented their rations where they could with purchases from the local store [where prices were usually inflated], from neighboring villages, and by hunting and fishing expeditions.

Outside of the mine areas, urban blacks' diets were being squeezed by similar sorts of economic pressures. Nutritious fresh fruits and vegetables, peddled by women in either marketplaces or on various corners, were construed by many blacks on limited food budgets to be too expensive (Packard 1992). And while some blacks had garden plots around their living quarters for growing fresh vegetables, even these began to disappear as more and more people were squeezed into the same area (ibid.: Bonner 1982). Other dietary changes included the substitution of relatively nonnutritious white bread in place of maize and other grains. Relatively cheap coffee sometimes replaced milk as a staple beverage. The resulting loss of essential vitamins and animal protein may have made people more susceptible to infections such as tuberculosis (Packard 1992).

As elsewhere in Anglophone Africa, from the late 1800s to the 1920s, health provision focused narrowly on the well-being of Europeans, health being viewed as a requisite condition to further the development of the colony (Gilmurray et al., 1979). Outbreaks of scurvy in 1908 among laborers in the mines and on farms, for example, were viewed as industrial relations problems by the colonial government. Employers, in turn, blamed the employees for their ill health (Loewensen 1992). The cruel economic calculus of colonial capitalism on the mines depended on a flow of migrant labor created within a regional economic system, and not on the capacity of a fully developed proletariat to reproduce itself. So long as there was little stimulus to pay compensation, and as long as there was no compensation, there was little incentive for any coordinated attempt to reduce disease in the compounds. Even where huts and buildings were set aside as hospitals, in the great majority of cases they were singularly uncomfortable and

totally unsuited for their purpose. There is little doubt that the growing profitability of mining in Southern Rhodesia was a road littered with the broken and diseased bodies of black workers.¹² In 1899, for example, a troubled Native Commissioner confessed:

I should like to point out the utter want of foresight, or more properly speaking callousness on the part of the Director of Mines. There are no medical appliances or comforts of any description, neither splints, bandages, or the many articles that might relieve pain in the event of an accident. The Mine Managers cast the blame on the Directors. Whoever the delinquent, it is a scandalous state of affairs, and if no law exists, one should be devised, to compel those who neglect, what in any other country, ordinary instincts of humanity prompt.¹³

Packard (1997:94) reminds us that the ability of Europeans to tap into the wealth of tropical areas was contingent on their ability to survive in tropical climates. Efforts at overcoming Europeans' health challenges in the exploitation of African resources facilitated research into the etiology of diseases associated with the tropics, and led to the development of schools of tropical medicine in Europe and the United States at the turn of the last century. Early successes of these schools in treating malaria and yellow fever helped further the tendrils of European control into the tropics. As Europe consolidated its holdings in Africa, the health of Europeans continued to generate interest in tropical health (ibid.).

The focus of European health initiatives shifted after World War I to be more inclusive of African populations. This focus was by no means altruistic in most cases, but rather shaped by narrowly economic concerns: colonial economic production depended on healthy (African) workers and not just healthy (usually European) managers. As such, some monies were directed toward combating illness among

workers, at least while they were in the employ of Europeans. During much of the early 1900s, this material concern dominated much of European health efforts in the tropics. Viewed through such an economic lens, the success or failure of health interventions was assessed by their ability to maintain or increase levels of production rather than actual levels of health. Losses in production, defined in terms of days or shifts lost, served as a surrogate measure for the health of the “native” work force (ibid.).

This emphasis on production intimately shaped the distributive patterns of health services. For example, health services were usually concentrated near sites of production (mines, large-scale commercial farms, etc.) with little attention given to populations outside of these productive areas. Missionary doctors and nurses usually provided services to the rural areas (Gelfand 1953, 1988). In fact, much of the rural medical infrastructure was intimately tied to missionaries, hospitals being linked to the main mission of a particular area, clinics being tied to minor mission stations. Missions provided one or two completely equipped medical centers at the main mission stations with qualified (European) doctors and African personnel; male medical assistants (usually African) and/or nuns (also referred to as “sisters”) staffed rural outposts. Such medical facilities proved to be a powerful socializing tool, both in preparation for Christian doctrine as well as incorporation into the cash and moral economy of the growing colony. In many hospitals, for example, regular morning prayers and special services were held for disseminating the Gospel. Mission hospitals (and perhaps more specifically, mission doctors), like local n’anga, were the embodiment of the sacred and the secular worlds. The missionary efforts of a Dr. M.H. Steyn, circa 1924, at the Dutch

Reformed Church mission hospital at Morgenster eventually resulted in the local appellation “*nganga huru yenyika*” (the great ‘diviner’ of the country).¹⁴

Another characteristic of health services at this time was their narrowly technical focus in design and implementation. The disease load, and the focus on parasitic models in colonial medical thinking, combined with the medical research interests of colonial medical practitioners, led to a heavy reliance on technology to deal with health problems (Packard 1997:95). At the same time, efforts to remediate health issues through the reformation of social and economic conditions were viewed as simultaneously impractical and unnecessary (ibid.). Related to this point, was the colonial view that African populations were inherently unhealthy and incapable of caring for their own health needs when, in reality, the “unhealthiest period in all African history was undoubtedly between 1890 and 1930.”¹⁵ Such epidemiological “creation myths” usually equated risk for illness with race.¹⁶ And if missionary and colonial officials still clung to the idea that their presence and medicines resulted in healthier populations, Africans had already come to connect the dominance of whites not with an improvement in health but rather a grave deterioration (Ranger 1992:260). These inconsistencies and fissures in therapeutic practices and discourses continue today and have particular implications for the contemporary proliferation of HIV/AIDS.

By the time that AIDS first appeared in Harare, African lifeways had been undergoing more than a century of change, changes which simultaneously structured the cultural and epidemiological manifestations of the disease. Even before the pandemic began, however, cultural concepts of personhood--moral character, sexuality, desire--were filtered through a misplaced nostalgia for pre-colonial times. Not surprisingly, of

course, pre-colonial cultural practices also contained many elements that contributed to the emergence of demographic and economic conditions of risky sex and disordered domesticity.¹⁷ Though sexual and social reproduction in the nineteenth century among Africans could probably never be considered stable, such instability probably accelerated under the profound changes taking place under colonialism. Forced migration, the separation of men from their wives, incorporation into a cash economy, and social mobility as well as constraint made many question the newly developing social order under colonialism. The enculturation of persons through chiefs, elders, and in many cases the duma (or indigenous court), was for the most part a thing of the past. In their place, a sense of loosened morality, social drift, control over sexuality, over the nature of sex and when it took place, and the very constitution of relationships.

Tied to these tectonic shifts in political economy and cultural practices were equally significant shifts in the epidemiology and the overall burden of diseases, and new afflictions were introduced. Whooping cough and measles--the great child-killers of nineteenth century industrial Europe--found their way into African populations (Ranger 1992:260). The forced separation of men and women for extended periods of time placed them in different disease ecologies, introducing or exaggerating differentials of risk among them (Setel 1999; Turshen 1984). Newly created, highly mobile jobs created under colonialism--porters, labor migrants, troops, etc.--helped to carry the new diseases to new environments and populations. Under colonialism, continent-wide, mortality and morbidity levels rose from such afflictions as tuberculosis, malnutrition, and what some now call "diseases of poverty." Ironically, during disease episodes, colonial authorities took great pains to control the movement of subject African populations on the grounds

that the Africans themselves, rather than the pitiful conditions in which they were forced to live, were responsible for the rises in morbidity and mortality (Setel 1999; Packard 1989; Curtin 1985; Schoepf 1991).

These shifting practices and processes set the context for the emergence and sustainability of a deadly disease. The first case of AIDS in Zimbabwe was identified in 1985. During the same year, mandatory national screening of blood supplies for HIV was initiated--one of the first nations, and certainly one of the first African nations, to do so. In the following year, an AIDS advisory committee of health experts was established and, in 1987, it was reorganized into the multidisciplinary Zimbabwe AIDS Health Expert Committee (ZAHEC) with technical subcommittees. A one-year emergency Short Term Plan (STP) for AIDS prevention and control was implemented from 1987 to 1988 and followed by the development of the Medium Term Plan (MTP) from 1988 to 1993. As a means of identifying the magnitude of the disease, a routine reporting system for AIDS was developed in 1991 using sentinel surveillance sites in each of the provinces plus Harare, Bulawayo, Gweru, Mutare, Kwekwe and Chitungwiza. This strategy is based on monitoring the rate of HIV infection among pregnant women at the designated sites. The blood is routinely drawn and tested for HIV on an unlinked and anonymous basis. Given the paucity of available data in HIV infection, HIV prevalence rates among pregnant women are used to make estimates of the current and future extent of HIV infection among the adult population.¹⁸ In 1991, cumulative reported AIDS cases totaled 4,557 with almost double the representation for men (2,663) as compared to women (1,860).¹⁹ As of June 1998, cumulative reported AIDS cases were 40,655 for men and 33,250 for women respectively.²⁰

The trajectory of AIDS in Zimbabwe has been paralleled by other opportunistic diseases. The number of tuberculosis cases has been rising rapidly. Since 1985, the Ministry of Health and Child Welfare has reported a 550 percent increase in reported TB cases, and two-thirds of these patients are thought to be HIV-positive. Perhaps half of all adults in southern Africa carry latent TB infection that, ideally, is suppressed by a healthy immune system. The specter of HIV greatly increases the likelihood of TB's proliferation as people with weakened immune systems are no longer able to suppress and control latent TB infection. Four-hundred and eighty-eight smear-positive pulmonary tuberculosis patients were tested for HIV prevalence in Harare between May and October of 1997 (Easterbrook, et al 1998). The majority (65%) of the patients were male, with a median age of 31 years at presentation; 41% of the patients gave a history of recent contact with tuberculosis, and 8.2% had a past history of TB. The overall HIV sero-prevalence was 72.8%. Significantly, the prevalence of HIV infection in this cohort of TB patients was higher than previously reported in Zimbabwe or other sub-Saharan countries, especially in the 30- to 39-year age group. Such findings suggest that the impact of HIV infection on TB is an especially serious problem because tuberculosis is infectious through casual contact and poses a major public health threat.

Additionally, drug-resistant strains of TB are also appearing, making it more difficult and expensive to treat the disease.²¹ A recent study (Makombe, et al 1999), for example, sought to characterize the prevalence, clinical and radiological features of drug-resistant tuberculosis in selected patients with pulmonary tuberculosis in Harare between 1996 and 1999. Resistance to one or more drugs was detected in 16 isolates (n=165), or 9.7%, single drug resistance in five (3%), and resistance to two or more drugs in 11

(6.7%). The low drug-resistance rates are striking given the resurgence of tuberculosis in Harare (and Zimbabwe generally) and the high prevalence of HIV infection. Importantly, the study found that a large number of DRTB cases appeared to be due to new transmission of drug-resistant strains. The findings reinforce the importance of maintaining a surveillance system for monitoring drug susceptibility.

When we restrict our field of vision to Harare Province, the numbers illustrate a grim picture. 1990 HIV sentinel survey results for pregnant women (n=282) revealed that 24 percent were seropositive. In 1997, this number had risen to 28 percent (n=601). From 1987 to June 1998, Harare reported the highest cumulative AIDS cases by province and gender, 5,460 for women and 7,374 for men (see table 1 below for national comparison). Likewise, Harare led the country in reported TB cases from 1993 to June 1998 (see table 2).

Table 1. Reported Cumulative AIDS Cases by Province and Gender: 1987 to June 1998

Province	Women	Men	Unspecified	Total
Manicaland	3331	4128	38	7497
Mash Central	2896	3686	55	6637
Mash East	2875	3793	31	6699
Mash West	4261	4565	191	9017
Masvingo	3455	4141	57	7653
Mat North	1847	2376	18	4241
Mat South	1701	1726	13	3440
Midlands	3222	3762	42	7026
Bulawayo	4076	4778	79	8933
Harare	5460	7374	65	12899
Unspecified	126	326	288	740
National	33250	40655	877	74782

Source: NACP 1998

Table 2. TB Cases by Province

Province	1993	1994	1995	1996	1997	Until June 1998
Manicaland	2177	3113	3472	5075	5349	2482
Mash Central	1225	1702	1730	2172	2989	1721
Mash East	3726	1073	2024	2254	3034	1813
Mash West	2285	2599	3687	4629	4965	2438
Masvingo	2495	3061	4953	4071	4800	2549
Mat North	3191	1329	1596	1798	2388	1176
Mat South	1925	2286	2293	2097	2160	1243
Midlands	3101	3283	4510	4961	4840	2238
Bulawayo		2314	3462	2873	3653	1932
Chitungwiza		325	2390	1081	2116	1308
Harare		2874	714	4818	6993	3037
National	20125	23959	30831	35829	43287	21937

Source: NACP 1998

Perhaps unsurprisingly, sentinel surveillance data show that urban centers, cities and growth points have higher HIV infection rates. Industrial sectors that recruit workers of predominantly one sex and provide housing in isolated communities--mining, army and police camps, agricultural estates--commonly demonstrate higher infection rates. Evidence also seems to indicate that seasonal or migrant employment patterns are also associated with higher risk sexual behavior (Lowenson and Kerkhoven 1995). Increased HIV incidence is also witnessed in sectors characterized by work-related mobility, such as the transport industry (Forthal et al, 1986; Nguma, Leshabari, and Mpangile 1991;

O'Connor, Leshabari, and Lwihula 1992; Orubuloye, Caldwell, and Caldwell 1993).

Detailed monitoring of HIV infection amongst formal sector employees in specific sectors has not been undertaken; however, surveys indicate HIV rates in the workforce ranging from 8.6 percent in 1990 to 33 percent in 1994 (Blair Research Institute, 1994).

With the early proliferation of AIDS throughout the country, Zimbabweans developed their own theories as to its epidemiology and meaning, often embedding the root causes of the disease in larger social forces. At one time, for example, AIDS retained the local appellation “American Invented Disease to Stop Sex.”²² It was a popular belief that the American government (in collusion with other ‘Western’ nations) had conspired to find a way to get Black Africans to stop engaging in sexual reproduction as a form of population control (see, e.g., Chapter Six).²³ The popularity of this acronym happened to overlap in time with another acronym, namely that for ESAP (Economic Structural Adjustment Program), quickly labeled, “Extreme Suffering for African Peoples.” That the two acronyms overlapped in time and space is no coincidence, and I hope to clearly illustrate how structural adjustment programs/policies (see next chapter) have helped further the proliferation of the deadly virus by eroding the ability of the average Zimbabwean to cope materially in an unrelentingly harsh economic environment. Less jocular interpretations of HIV/AIDS also emerged at this time. As HIV/AIDS initially affected truck drivers, prostitutes, and a highly mobile elite, the disease came to be very quickly associated with urban environs and subsequently thought of as a “disease of the cities” (and often created a false sense of security for rural dwellers and others during the early days of the epidemic).²⁴ Importantly, AIDS was conceived of as something alien, from “out there”--whether the “out there” was the bush in which soldiers

fought, the United States, or Europe, for example--which, for whatever reasons, had infiltrated the country and the bodies of its citizens. These local narratives became coupled with medical and epidemiological accounts of the nature and meaning of the disease and contributed significantly to the changing meaning of adulthood expressed through sexuality, mobility, and notions of morality (cf. Setel 1999).

A 20 year-old Shona man, Lionel, commented on the generational differences in notions of sex and sexuality in the age of AIDS. Lionel was currently in-between jobs, like so many young men his age. He had completed his O-levels and had a certificate in international tourism, the industry in which he was looking for a job. He shared a "garden boy" cottage with his brother in one of the medium-density suburbs, Cranbourne. Lionel explained that his generation was more promiscuous than previous generations, summing up the difference as the result of eroding cultural practices. "We have lost our culture, Diva," he said. "In the past, there were measures in place to curb promiscuity. You had the chief and the court of elders...now, no one respects the chief." He added that with the current economic instability, it was not uncommon to find young men with older, wealthier women. "You'll see these guys driving Beemers (BMW's), living in nice flats in the Avenues or the low-density suburbs. They have cellphones and nice stereos...and you never see them working." The subject of "sugar mummies" as they are known locally had even captured the attention of the media, with the *Sunday Mail* running an article on their "abuse" of male street children. One such child, a Jack Kambezo age 16, accused his sugar mummy of infecting him with an STD, then summarily dropping him. She, in turn, accused him of giving it to her. Jack said he failed to get medical treatment for the STD (which he'd already had for four months)

since the clinics were demanding cash up-front and he did not have the money to pay for it.²⁵

The perceived trend in older women pursuing younger men was/is a departure from the usual trend of older men (“sugar daddies”) dating younger women (and girls) and speaks to shifting ideas surrounding sex, sexuality, and gender. Social services and schools throughout the country had already developed educational programs targeting young girls in the case of sugar daddies. Recognizing the proliferation of young girls taking on sugar daddies, for example, UNICEF in conjunction with local health authorities, conducted puppet shows as an HIV/AIDS awareness campaign. One such campaign, popularly known as the Gypsy Joe Puppet Show, disseminates information about HIV/AIDS in a format designed to hook the attention of children. The puppet show seeks to make young girls know that there is a very real risk in participating in such sexual activities. The shows, meant to interrupt the behavior, are less concerned (and rightly so) with the socio-economic conditions that make such behavior possible. The socio-economic reality of education in Zimbabwe, with steadily rising school fees, however, has left some girls little choice with regard to taking on sugar daddies if they want to continue with their education. Girls are often pulled from school before their brothers when a family feels financial constraints.

Diagnosing AIDS based on perceived physical cues became a pastime for many Hararians in their daily lives, and a friend, acquaintance, or family member suddenly losing weight was cause for concern and, often, gossip. On my way to finding the Express Motorways bus depot one afternoon [I was going to spend the weekend in Mutare in the Eastern Highlands], I was accompanied by a Shona friend, John, who

wanted to make sure I indeed found the depot. We walked around much of the city center looking for it and finally asked a guard in front of a block of flats for directions. The man sat huddled on a steel barrel. He was skeletally thin, his blue uniform ballooning into great creases around him. Dried mucous caked his nostrils. It was mid-day with the sun blazing in the sky and yet he still looked cold, his arms folded over his chest protectively. I found myself 'studying' him, casting a penetrating eye on his physical condition. He glanced at me, a flash of recognition in his eyes that perhaps I was looking too hard at him. I felt a twinge of guilt for invading what I perceived to be his private suffering, and quickly looked down. He gave us directions, we thanked him, and then left. When we were out of ear-shot, John asked me, "Did you notice something?"

"That he was really skinny?" I asked, knowing where he was headed.

"He has AIDS," he said matter-of-factly. "He's too skinny. His bones are sticking through his face. Also, his hair..."

"What about his hair?"

"The texture has changed. Mine," he said reaching up to touch it, "is considered normal."

"You mean he doesn't have BDBs [a reference to 'nappy hair' from the Martin Lawrence television show of the 1990s]?"

"Yeah," John laughed. "You may see some BDBs. But when someone's hair gets slipperier-looking, more curly like yours, you know it's AIDS. And his skin is smoother," he said rubbing his cheeks with the palms of his hands.

I wondered about the tremendous lengths some people must go to hide the effects of their illness. What does it mean to watch the daily and gradual dissolution of your body? How long can you continue to conceal such a thing? At what point do you stop caring? Lost in my thoughts, I followed John along the city center's crowded streets: people queuing up for ETs, produce vendors hawking their fruits and vegetables, business men rushing back to the office after a too long lunch, mothers with sleeping babies fastened to their backs. I had since abandoned the mental game of counting one out of five people as a measure of the number of HIV-infected individuals; but looking around at the vitality on the streets, it was hard to imagine a disease was slowly and progressively eroding that vitality. Almost in response to the questions floating through my mind, John mentioned that a girl he knew casually had AIDS. He said she used to have very long hair, of which she was very proud. But, as the illness progressed, her hair texture and color began to change, becoming straighter and more red. Fearing that others would notice these changes, she cut her hair very short in a style that downplayed its newly-developing straightness.

Baring a blood test, it is of course impossible to deduce someone's HIV status. However, with the weighty stigma attached to the disease, other afflictions that may mirror some of the symptoms of AIDS are viewed with a mixture of dread and suspicion: a tubercular-sounding cough, unhealing sores, drastic weight loss, and chronic diarrhea. Riding around town in ETs, and the most common form of transportation for the average Hararian, provides passengers a real opportunity to closely scrutinize their fellow riders. At the first phlegmy sounds of a deep-chested cough, most passengers will look around

with a mixture of concern and anger, feeling trapped in a confined space with someone who might have a highly contagious (and potentially deadly) disease, TB.

In some cases, the multiple meanings invested in HIV/AIDS carried a clearly occult dimension. For example, in a 1996 UNICEF-organized HIV/AIDS workshop²⁶ for listeners of the Radio 2 program, “Ko munotii neizvi?,” a woman from Karoi posed the question: “If a man with *mubobobo* is sleeping with all the women in our community, is there no danger that he will be spreading HIV? How can we protect ourselves from this menace?” In local folk beliefs, some men have the power to cast a spell on a sleeping couple, forcing the man to get off the bed in a trance, and sleep on the floor. The man with the *mubobobo* charm then rapes the unsuspecting woman and she remains unaware of what has transpired until the following morning. Allegedly, in some cases, the woman knows what is taking place but is totally powerless to do anything about it. Women in a given community might complain about getting such visitations from men usually considered to be indigent. And while they might agree on who he is and what he’s up to, without tangible proof (which there isn’t in the case of *mubobobo*), there is nothing to be done. In part, such narratives speak to the increasing social vulnerability felt by women in a harsh economic climate (see, e.g. Chapter Seven). Ironically, the men accused of such actions are also some of the most socially and economically vulnerable--wealthy men are usually not accused of possessing and using *mubobobo*.

N’anga, or traditional healers, also developed their own initial epidemiologies, or “indigenous contagion theories” (Green 1999) regarding AIDS. Struck by its similarity in symptomology to other locally-recognized STDs and other afflictions, some n’anga conflated AIDS with such conditions as *runyoka* and *rukombe* [footnote definitions] and

treated it accordingly. However, as AIDS began to establish itself, it became clear that it was indeed a *new* disease, demanding new forms of intervention and management. As one n'anga (an herbalist) told me: "...in the past, we used to administer some herbs and [these afflictions] would go away for good. But now, it seems all is in vain...you are not as successful. Where did this stuff come from?" Indeed, *where did this stuff come from?* When asked this very question, many n'anga relate the coming of AIDS in Zimbabwe to the contemporary material suffering of the country. They point back to an imagined past where such forms of material suffering and cultural reticence did not exist.²⁷ Indeed, part of managing AIDS in the present, is imagining an idealized past where socioeconomic and spiritual upheaval were apparently unknown. In this sense, 'modernization' and 'development' have been double-edged swords, creating new opportunities for material advancement while simultaneously constraining this advancement through often internationally-developed, and locally-orchestrated, programs, policies, and procedures. The most recent and resonant of these has been the 1991 Economic Structural Adjustment Program. It is the subject of the next chapter.

¹ Vambe, *From Rhodesia to Zimbabwe*, p.170, quoted in Phimister 1988:260.

² Recent headlines from Zimbabwe's national newspapers, *The Herald* and *The Daily News*, for example, read: "Modern Court Must Address Issues Dealing with Witchcraft" (*The Herald*, June 5, 1999), "Six Teachers Transfer Over Alleged Witchcraft Activity" (*The Herald*, June 6, 1999), "Man Jailed for Killing Father over Witchcraft Allegations" (*The Daily News*, May 14, 1999).

³ "Nose brigade" is the derogatory term used to refer to Black Zimbabweans who are (White) American- or European-identified, e.g. those Black Zimbabweans who want to be "White." It is often assumed that Americans and Europeans have a generally nasalized way of speaking. The term is a product of urban youth culture.

⁴ Karl Maier (2000), in his recent rumination on Nigeria, quotes a Nigerian diplomat's wife as saying, "Zimbabwe is nice, but it's too quiet. It's not Africa, you know. Nigeria is the real Africa" (xxxii).

⁵ A local newspaper recently featured a photo where someone had planted a flower in a particularly large pothole on a well-traveled road.

⁶ A World Health Official attached to the Ministry of Health's Epidemiology and Disease Control (EDC) department identified two strains of the cholera, *vibrio-cholerae inaba* and *vibrio-cholerae ogawa*.

⁷ In 1999, Harare and Mashonaland Central led the nation in cholera cases, Mashonaland Central accounting for 851 cases, 52 of which had been confirmed. The disease very quickly spread to Mount Darwin where 415 cases were reported, Manicaland (78 cases), Makoni (44 cases), Nyanga (27 cases), and Chimanimani (13 cases). See "As the Epidemic Spreads in City: New Cholera Strain Emerges," *Zimbabwe Independent*, March 26, 1999; "Number of Cholera Cases Shoots Up," *Herald*, April 12, 1999; and "Cholera Outbreak Hits Gokwe," *Daily News*, May 24, 1999.

⁸ "Pneumonia the Leading Cause Killer Disease in Harare," *Sunday Mail*, June 27, 1999.

⁹ While the demands of an initial merchant and speculative capitalism helped facilitate poor African health during the last quarter of the nineteenth century, this was quickly replaced by a form of industrial capitalism located in mining and agricultural sectors. The movement toward industrial capitalism further entrenched poor African health, as it does even today. Of course, today African health is further impacted by the effects of economic structural adjustment policies.

¹⁰ Phimister 1988:52.

¹¹ Quoted in Phimister, p.51.

¹² Phimister, p. 55.

¹³ Quoted in Phimister, p. 54.

¹⁴ M. L. Daneel, *Old and New in Southern Shona Independent Churches, Volume I: Background and Rise of the Major Movements*. (The Hague, 1971), p. 230-231.

¹⁵ Patterson and Hartwig 1978:4.

¹⁶ cf. Vaughan 1991; Setel 1999

¹⁷ cf. Setel 1999

¹⁸ Medium Term Plan 2 1994; NACP 1998

¹⁹ NACP 1996

²⁰ NACP 1998

²¹ NACP 1998

²² Schoepf et al. (2000:107-108) note similar appellations in Kinshasa, for example (SIDA in French) "an imaginary syndrome to discourage lovers" (*Syndrome Imaginaire pour Decourager les Amoureux*) and *Salaire Insuffisant Depuis des Annees*.

²³ This viewpoint will be echoed throughout this dissertation.

²⁴ See, for example, contributors to Miller and Rockwell, et al., 1988.

²⁵ "Sugar Mummies Abuse Street kids." *Sunday Mail*, April 18, 1999. The sexual abuse of street boys by sugar mummies was said to be so rampant that it prompted the Zimbabwean Red Cross Society to organize a workshop to seek ways of assisting children.

²⁶ The workshop brought together a large group of listeners from Shona-speaking parts of the country in an effort to create a supportive environment for people living with AIDS. The radio program seeks to give HIV/AIDS a human face and move away from overly technical and medical coverage of the disease.

²⁷ Pamela Reynold's (1996) wonderful work, *Traditional Healers and Childhood in Zimbabwe*, examines this reflexive moral self-critique and healers' ruminations on the past and the character of idealized social categories in the context of childhood. She argues that such reflection gives flexibility to the present. This focus on the past also evokes what Malkki (1995:55) refers to as "mythico-history," that is a process of world-making that constructs categorical schemata and thematic configurations that are relevant and meaningful in confronting both the past and the pragmatics of everyday life. Importantly, this is an oppositional process, creating a sense of the past in distinction to other pasts, thereby heroizing the past of African peoples in distinction to, say, European colonizers.

CHAPTER FIVE

Economic Structural Adjustment and the State of Health

“Government holds the view that health is a necessary and primary condition of development. While it cannot be considered in isolation from other elements in the economic and development progress it is also a human right regardless of the economic status or value of the individual.”

-Growth with Equity, 1981

“The promotion of health for all depends fundamentally on improving socio-economic conditions or the elimination of poverty and under-development.”

-Health for All Action Plan, 1986

When they were written, years ago now, the above words captured in explicit detail the relationship between health and development and government’s role in its promotion. President Robert Mugabe’s vision of ‘health for all,’ of health care as a fundamental right, as a state of being that is inextricably intertwined in the socio-economic fabric of society, was prescient in more ways than he or his government could have known at the time. Both statements predate Zimbabwe’s experience with economic structural adjustment (begun in 1990/91) and, ironically, it is in the era of economic structural adjustment that the relationships between macro-economic and political forces and trends and the health of the individual has come into sharper relief. Paradoxically, if it is the mandate of government to help facilitate health and development for its citizens, it may also happen that government also plays a determinative role in the non-attainment of these goals. In this chapter, I examine the effects of structural adjustment on the health of segments of Harare’s population, drawing in particular on the pioneering work of Bijlmakers, Bassett and Sanders (1995) and others. Specifically, I hope to clearly

illustrate how such policies reinforce underlying power relations and asymmetries, and further facilitate rising social and political violence, the proliferation of HIV/AIDS, and the deteriorating quality of health care available to the poor and middle classes. The analysis here is an attempt to problematize past explanations of the spread of HIV/AIDS in Zimbabwe, and Africa generally, that often conflate cultural difference with structural violence.

The Structure of Health Services in Zimbabwe

The main provider of health care facilities is the Ministry of Health and Child Welfare, providing services directly through four central hospitals and indirectly through grant-aiding local authorities. District and Rural Councils and Municipalities make up the local authorities which manage networks of clinics and hospitals in their areas of jurisdiction. Other providers of health care include church missions, mines and commercial farms, industries, voluntary organizations, private practitioners, and traditional healers.

Upon Independence in 1980, Zimbabwe inherited an urban-centered, fragmented health service which focused mainly on curative services (Bassett, et al. 1997). It was at this time that government began a re-organization of the health sector into a four-tier system of service delivery that is still utilized today. At the lowest tier are the hundreds of rural health centers in addition to 56 rural hospitals. At this level, preventive health services and basic curative care are provided. These facilities are staffed by State Certified Nurses, Nurse-Midwives and Environmental Health Technicians. The second level of the tier includes District Hospitals run by the MOHCW or Church Missions.

These facilities provide more complex curative care and minor surgical operations, have more numerous State Registered Nurses than the primary facilities, and doctors are also found at this level. The third level is made up of eight Provincial Hospitals and four General Hospitals, serving as referral facilities for their respective provinces. The fourth level comprises five central hospitals in Harare and Bulawayo--hospitals at levels three and four make up the overall national referral centers and teaching hospitals.

In addition to this re-organization, and seeking to remedy colonial health policies which did not provide healthcare for the majority of the Black African population, post-Independence policies sought to ensure greater equity in access to health services and to strengthen preventive services. Free medical care was introduced for low income groups earning a monthly income of Z\$150 or less. During this period, there was an immediate and phenomenal increase in outpatient attendance of between 200 and 300 percent (Loewenson 1991). Under the *National Transitional Development Plan* 1982-85, war-damaged health facilities in rural areas were rehabilitated or replaced with new facilities. As a result, health care expenditure, between 1980 and 1984, rose from 4.6 to 8.8 percent. In 1984, however, the economic prosperity which immediately followed Independence came to an end and the governmental health budget declined to 6 percent where it remained throughout the 1980s (ibid: 1845). Spending on health care as a share of the Gross Domestic Product had, by 1990/91, fallen to a paltry 3.1 percent and by 1996 to 2.2 percent.¹ Though health care in government facilities was free for 90 percent of the population at Independence, steadily climbing inflation necessitated the introduction of new user fees, though these were not rigidly enforced. Fees covered complete care: consultation, laboratory tests, and treatment.

The *First Five-Year National Development Plan* 1986-1990 included a period of expansion of static and mobile health care facilities. Since 1980, about 290 rural health centers have been built and staffed; 160 war-damaged clinics were reconstructed and another 160 were upgraded. District and provincial hospitals were also upgraded. Additionally, the 1986 *Health For All Action Plan* aimed at providing a comprehensive national health system that catered to the needs of all Zimbabweans, with emphasis on the rural areas. The plan emphasized preventive and promotive rather than curative care, though budgetary allocations continued to be heavily curative. An important innovation of the 1980s was the introduction of village-level health workers to promote primary health care (PHC). Village Health Workers (VHWs) have played an important role in the promotion of PHC activities. By 1987, there were 7,000 VHWs country-wide, short of the planned target of 15,000 VHWs. This cadre, in turn, evolved into today's VCWs, of whom there are 5,000.

The opportunity costs of emphasizing rural development included the lack of expansion of urban facilities in line with population growth and increasingly obsolete medical equipment at urban facilities, including referral hospitals (see below discussion of Harare Hospital). While MoHCW acknowledges the urgent need to improve referral facilities to match new levels of demand, the costs of maintaining health care facilities are such that preventive care services are unable to expand further at current funding levels.

Economic Structural Adjustment

The emergence of AIDS within Zimbabwe happened to correspond with (and perhaps be further facilitated by) the government's adoption of a structural adjustment program in 1991 (introduced in October 1990) under the auspices of the World Bank. Locally known as the Economic Structural Adjustment Programme (ESAP), and quickly termed "Extreme Suffering for African People," the agreement included such austerity measures as reduction of the budget deficit, through a combination of reduction of public enterprise deficits and rationalization of public sector employment; trade liberalization, including price decontrol, and deregulation of foreign trade, investment and production; phased removal of subsidies; devaluation of the local currency; and enforcement and introduction of cost recovery in the health and education sectors.² It is important to point out here that the Zimbabwean government's initial proposal to the World Bank, *Framework for Economic Reform, 1991-95 (FER)* (Zimbabwe Government 1991), differed markedly from other structural adjustment programs in Africa at the time. On the one hand, originally there was no accompanying agreement with the International Monetary Fund (IMF) which may have given the government more leeway in determining the duration of the program (five years as opposed to the more normal three) and the limitation of parastatal reform to semi-commercialization rather than privatization. On the other hand, the *FER* contained a long annex entitled, "Assessing and Addressing Social Dimensions of Adjustment," a fairly rigorous and detailed effort to assess the impacts of *FER* on various socio-economic groups.³ Possible impacts of retrenchments, higher inflation levels, removal of subsidies and cost recovery measures

were included in the summary, and a gender dimension was incorporated into each of these sections.⁴

Additionally, it was estimated that the phased withdrawal of subsidies to the Grain Marketing Board (GMB) would probably lead to the closure of collection depots where production was low, with “potentially devastating effects on the welfare of poor people in those areas.” In the absence of compensatory measures, cost recovery measures were speculated to reduce the uptake of social services--the main burden of all these measures falling squarely on the shoulders of poor women who already lacked access to resources and suffered from lower social status. Complete candor in the report, notes Gibbons (1995:12), only disappeared in relation to consumer price inflation; the impact of the potentially massive rise in the price of maize-meal, the staple food of the poor, was simply not mentioned.

Upon implementation of the program, it was not long before problems began to surface, initially due to an unanticipated increase in imports. At the same time, the World Bank and other donors failed to punctually disburse the funding which was intended to support the Open General License (OGL) which was to gradually replace the former control/forex allocation system. As a result, the government was forced into borrowing US\$ 155 million on a commercial short-term basis in mid-1991 and attempted to offset import demand by introducing a 20 percent tariff surcharge on all OGL items and new limitations on forex allocations for those items not so far included. These events set in motion a need for negotiations with the International Monetary Fund (IMF), one precondition being the massive devaluation of the Zimbabwean dollar. Further flexing its considerable economic muscle, the IMF mandated substantial public expenditure cuts and

the reduction in numbers of ministers and ministries. A second condition was the introduction of positive real interest rates. With these agreements in place, the World Bank finally released the first disbursement of funding in March of 1992 (originally scheduled to be released in 1990-91). Other donors followed suit in June of 1992.⁵

The machinations of these international financial institutions (IFIs) corresponded with the most serious drought in Zimbabwe's recent history. Poor rains in 1990-91 were followed by even poorer ones in 1991-92, with many parts of the country receiving a scant 40 percent of normal precipitation or less. Maize production, which had already fallen by 25 percent in 1990-91 fell by at least a further third in 1991-92, and the official values of commercial farm and communal lands sector production in 1991-92 fell by 28 percent and 73 percent respectively. These drastic decreases should not have led to a grain shortage on the scale experienced, and the resulting famine can only be explained as the effects of devastatingly careless human intervention. Between March 1990 and December 1991, for example, the GMB exported 0.6 million tons of maize at considerably lower prices than it had paid for it, in order to meet adjustment-related financial targets. To cover the drought deficit, 1.9 million tons of maize were imported on commercial terms over the course of the next year and a half. Retention of the 0.6 tons would have spared the Zimbabwe exchequer some Z\$ 1000 million, minus storage costs! By December of 1992, nearly two thirds of the country (six million of an estimated 10.4 million people) was registered for drought relief.

The net effect of this stage of structural adjustment was growing poverty, particularly for the already economically destitute. The Zimbabwe Central Statistics Office issued a time-series index for both low-income consumer prices and real average

earning up to 1992, using 1980 as its referent. The index clearly illustrated low-income consumer prices rising from 361.9 in 1990 to 453.6 in 1991 and 741.2 in 1992, implying rises of 25.3 and 59.5 percent for the last two years respectively. General inflation for the same period hovered between 25.3 and 47 percent, while most rises in wages were in the region of seven to 15 percent annually. In 1992, real average earnings fell to \$Z 6,700 from their 1990 high of \$Z 8,600. In 1993, real average income figures showed a decrease of 5 percent, with subsequent levels now around the same as in 1970.⁶

Adding insult to injury, in the context of growing economic uncertainty, many politicians and government bureaucrats were in the process of making state and local treasuries their own personal banking accounts. To many, the Zimbabwean state was rapidly devolving into a kleptocracy, a vampire state. The formation of a viable Anti-Corruption Commission was still in process in 1999, but this fact did not prevent Zimbabwe from earning the dubious distinction of being dubbed the second most corrupt country in the region,⁷ after Zambia. An editorial in the *Daily News* summed up the anger and frustration of many Zimbabweans felt at the level of corruption:

The land resettlement exercise has been hijacked by senior government ministers and officials. The VIP housing scheme; the District Development Fund borehole drilling scheme; schemes such as the 1990 African Bank Development facility meant to assist nascent private sector entrepreneurs expand their businesses have gone to politicians. The War Veterans' Fund; manipulation of tender procedures; customs officers being arrested for bribes; police officers who openly solicit for bribes; and influence peddling or the suggestion that senior officials in government are known by the percentage they demand as commission for facilitating any transactions have all become symptoms of massive corruption in Zimbabwe.⁸

In June of 1999, for example, a newspaper article disclosed that disgraced former executive mayor of Harare, Solomon Tawengwa, gave personal instructions to allocate land to top politicians, businesspeople and judges in Harare's upscale low-density suburbs, ahead of more than 100,000 home-seekers on the city's waiting list. Nationally, at least a third of all Zimbabweans were lodgers or did not have the bare minimum of decent housing--some one million households. The idioms of infection and disease, commonly used with local AIDS coverage, were now idioms used to describe local corruption, a *Sunday Mail* article opining, "There seems to be an infectious disease taking its toll on these local authorities. It has now become customary to hear of a number of cases of corruption...[and] mismanagement..."⁹

More and more, Zimbabweans were of the mind that corruption--both private and public--was, and is, a pathogen, definitely man-made, wielded against the average citizen. Chairman of the Zimbabwe chapter of Transparency International, Dr. John Makumbe, stated, "Corruption is a conspiracy against the people. We really need a coalition of all stakeholders in fighting corruption and the creation of an anti-corruption culture. No organization can win the war against corruption on its own."¹⁰ He blamed the rise in corruption on the deteriorating macro-economic environment, saying many people were struggling to make ends meet. In reality, of course, those individuals involved in corruption tend to be those who are more economically and politically powerful--in other words, those who are in less economically precarious situations.

Real and imagined governmental corruption made many people question whether or not the government had its citizens' best interests at heart--especially since much of this corruption directly impacted projects and programs designed to help the standard of

living of citizens [insert examples]. In this way, corruption must be read as a form of structural violence. As Schoepf, et al (2000:102) argue, “Struggles for control of the state as a site of enrichment have led to the ‘implosion’ of states...” The debilitating effects of economic structural adjustments policies and corruption have gone hand in hand in Zimbabwe and, unfortunately, those who suffer the most are the poor. Both forms of structural violence have particularly acute effects, discussed below, on the average Zimbabwean’s health and the ailing health sector.

Economic Structural Adjustment and Health

The introduction of user fees for hospitals and clinics, as stipulated under adjustment, had the most immediate impact on the health sector (Biljmakers et al., 1995), causing a subsequent decline in attendance at hospitals and clinics in the range of 25-30 percent in 1993-94 (Hongoro and Chandiwana 1994). In 1994, this “fee rationalization” exercise amounted to a 10-fold increase in charges (Bassett et al. 1997). This at a time when the average poor Zimbabwean had trouble paying for maize meal. Also, the distribution of condoms from surveyed health units fell by 43% after a nominal charge for them was introduced in January 1993 (inter-Ministerial Committee 1993); in those same sites, the number of sexually transmitted disease cases presented at those same clinics increased. As a result, the Ministry of Health and Child Welfare later reverted to free distribution of condoms.

As suggested above, the initial introduction and enforcement of fees coincided with skyrocketing inflation rates during the early phase of adjustment. The official inflation rate nearly tripled between 1990 and 1992, reaching 46.3 percent. The food

inflation rate surpassed even this at 72.6 percent in 1992. Additionally, the devaluation of the Zimbabwean dollar drastically diminished the drug budget, effectively crippling the government's ability to procure (usually foreign-produced) drugs because of its inability to clear its debts. By 1991, real per capita expenditure on health began to decline and by 1993, it had fallen by 30 percent (Bassett et al. 1997:1846; Biljmakers et al., 1995). In 1998/99, the Ministry of Health received Z3.7 billion, a reduction from the Z3.9 billion allocated in 1997/98. Meanwhile, the Ministry of Defense was allocated Z5.4 billion for the 1998/99 financial year.¹¹

In 1999, the Zimbabwe Programme for Economic and Social Transformation's (referred to as ZIMPREST and the latest incarnation of ESAP) proposed target of eight percent inflation by the year 2000 was drastically far away. According to the Central Statistical Office, year-on-year inflation sat at 50 percent by June of 1999. The higher-than-expected rise in year-on-year inflation, it was speculated, could be explained by an increase in food inflation which rose 10.2 percentage points to 65.7 percent.¹² In 1999, consumers were bracing for: another round of milk price increases, following a 12.8 percent hike in the milk producer price by Dairibord Zimbabwe Limited; a 70 percent hike in the price of petrol (which was still less than a comparable unit of milk!);¹³ a 20 percent increase in sugar prices; a 28 percent hike in bus fares (an average of 60 percent, staggered up to February 2000); a 50 percent increase in chicken; a 30 percent increase in the price of beef; and five percent increases in bread and cooking oil.

The economic squeeze many Zimbabweans were feeling had many re-evaluating the very idea of "African hospitality." In such lean economic times, the *Daily News* offered a number of points for consideration by would-be guests, which included: Do not

fill the bath to swimming pool level; Where possible, contribute to household expenses; Do not eat at will and; Avoid arriving after 10 p.m. People will feel obliged to make you a meal but the day's rations will have been depleted.¹⁴

In Harare, the general cost of living was in the process of spiraling out of control, effecting not only the poor and destitute but the middle-class as well. Finding affordable accommodations became a constant quest, with many middle-income earners casting their eyes on premises in the high-density areas (something unheard of in the days of relative economic stability where the goal was to move to the higher-status low-density suburbs) or "garden boy" cottages next to the main houses in low- and middle-density suburbs. The ability to buy a home--the dream of many, especially the aspiring middle-class--was quickly becoming a dream deferred. Active buyers of property were coming from a narrower cross section of the community which was increasingly confined to companies, diplomatic missions, and a few relatively wealthy buyers who could pay cash.

In 1999, the Consumer Council of Zimbabwe (CCZ) estimated that the prices of basic commodities had gone up by at least 300 percent over the same time the previous year. They also estimated that a family of six needed about Z3, 469.50 in 1998 to survive and that this amount had since escalated to Z6, 067.69 in April of 1999, reflecting a 57 percent increase in the cost of food items.¹⁵ Reflecting on the price increases of basic commodities, CCZ Mashonaland region manager Victor Chisi commented:

Most people have cut down on the number of meals they have a day. They have breakfast which doubles as lunch, later in the morning, and a heavier meal in the evening. So raising prices means consumers are forced to further reduce the number of their meals per day to only one.¹⁶

A vegetable seller in Mbare (a high-density area of Harare), Hedwick Marere, who was taking care of her “sick” husband and their nine children said that beef was a luxury she could rarely afford and that her family relied on dried kapenta [a small minnow-like fish] once a week for its protein. With regard to maize meal, she said:

Price rises have affected us badly, and we’re surviving through the grace of God. We don’t buy mealie-meal at all. We just buy dried maize and go to hammer millers to have it processed. It’s cheaper that way, especially for us who have large families.¹⁷

Having to cut down on its daily meals, she said the family sometimes has no breakfast or lunch. There was only supper, which usually consisted of sadza and vegetables.¹⁸

As the above examples illustrate, such economic degradation very quickly becomes nutritional and somatic degradation--that is to say, in a very literal sense, such forces become *embodied* as biological events. A 1992 survey of the high-density suburb, Chitungwiza, for example, revealed that 39 percent of households surveyed had no savings, could not save, and made no major expenditures (except for school fees) in the previous year. The changing economic fortunes of the working poor directly impacts their consumption patterns. Households surveyed in Mbare in 1992 averaged 3 meals a day. By 1993, this number had dropped to 2. Eighty percent of these households reported significant changes in their diets, 68 percent admitting they ate less meat and 59 percent saying they ate less bread. Households in which there were retrenchees (laid-off workers) were twice as likely not to have been able to purchase bread or meat at the end of the month. Among these, there was even a considerable rise in those saying they could not afford maize meal, the staple food item of the poor.¹⁹

Numerous studies demonstrate that nutrition is a significant determinant of health (see, e.g. the interview with “Lynde” in Chapter Eight). A corollary of this fact is that poor nutrition is correlative with disease, meaning there is an inverse relationship between good nutrition and disease. As other researchers have shown, the strongest predictors of child health are both the broad and equitable distribution of food and primary health services and the education of women. The fulfillment of these services is less dependent on gross national product than on government’s strategic choices in allocating resources to varying segments of the population (Schoepf, et al 2000:112). Under structural adjustment, access to quality food as well as primary health services is gradually deteriorating as witnessed in Harare.

The latest (1997) City of Harare Annual Report of the City of Health Department gives some insight into the nutritional status of Hararians. In general, the report found that there was increasing malnutrition in the city as shown by the increasing number of low birth weight babies, increasing numbers of weights and heights falling below the 10th centile in school children and the number of pellagra cases. Of 47, 537 pupils from 89 high-density schools in the city of Harare, eight percent were shown to be grossly stunted.²⁰ Boys (9.2 percent) were more stunted than girls (6.8 percent). Of 31, 222 grades 1 through 3 pupils assessed on the weight-to-height index, 6 percent were found to be acutely malnourished, or wasted.²¹ Again, males exhibited higher percentages (6.2 percent) as compared to females (5.7 percent). From 1995 to 1996, there was a slight increase in pellagra²² cases, from 99 to 105, most of these cases (88.6 percent) being older children.

From January 1991 to January 1993, the number of child malnutrition cases attending clinics in urban high-density areas increased by almost 150 percent (Inter-Ministerial Committee 1993). And current economic trends continue to threaten urban household food security and nutrition. As discussed above, real urban wages in the formal sector have fallen dramatically in recent years back to the levels of the 1970s (ZIANA 1993). During the current economic recession, unemployment and under-employment continue at high, perhaps even rising, levels.

Food insecurity is not the only factor in malnutrition in Harare. The relatively heavy burden of disease, especially diarrhoeal disease, reduces the body's ability to process food even when the person consumes enough of each of the right types of food. A recent survey of over 5,800 households (in Harare?) showed a strong association between diarrhea and malnutrition in children under five years. "A child with diarrhea is at least twice as likely to be malnourished as a child without diarrhea" (InterMinisterial Committee 1993b).

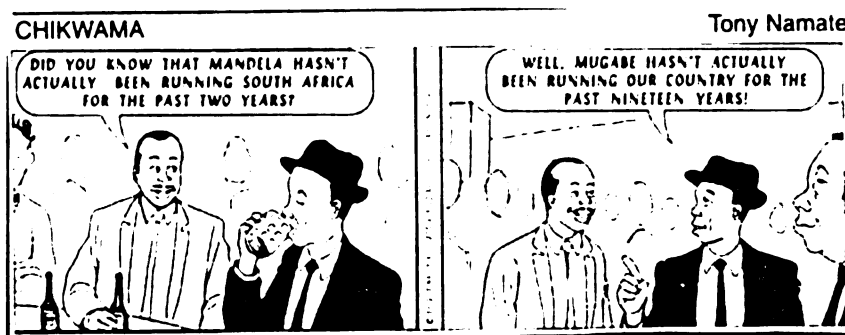
Nutritional insecurity is only compounded by a lack of access to quality health care. The lack of pay increases and benefits under economic structural adjustment has hastened the outward flight of Zimbabwean-trained doctors and nurses both from government service and from Zimbabwe. The number of nurses per capita fell by 17 percent between 1988 and 1993 (Chisvo 1994). This, in turn, has had an adverse effect on health services in the public sector. Enforcement of fee collection (as mentioned above), combined with an apparent deterioration in the manpower situation and quality of service at these facilities (see below), appears to be causing profound and negative changes in health-seeking behavior, especially for mothers and children. The observed

overall decline in 1992 in the outpatient attendance rate among children under five years of age, as compared to the same period in 1988-91, may reflect a developing reluctance on the part of mothers to take their children to health facilities caused by the need to pay, and tends to confirm Hongoro and Chandiwana's (1994) study on the impact of fee collection on health service delivery.

Lack of access to reasonably-priced staple food items, ostensibly the reason for nutritional instability, and lower real wages have helped facilitate social upheaval as well. The popular response to Zimbabwe's adoption of structural adjustment has often been strikes and street demonstrations protesting rising prices and lower real wages [insert examples here]. In July of 1999, city workers struck, effectively crippling essential health, funeral, fire, and ambulance services. Most council clinics in high-density areas were closed, denying services to thousands of Harare residents. At Kuwadzana Polyclinic, for example, there were only two staff members attending to maternity cases. At Warren Park Polyclinic, a Municipal Officer turned away patients because there were no nurses to attend to them. Funeral Services said they were unable to conduct cremations and so had to keep bodies in storage. Striking workers locked up the Rowan Martin building which houses the city treasurer and some district offices, resulting in residents failing to pay their rates and water bills. Cleveland House, head office of the Department of Works, where all senior technical staff are housed, was also locked up. Sewer blockages in some high-density areas were not attended to and rubbish continued to pile up in the central business district because there was no one to sweep the streets.²³

The strike was no doubt also facilitated by city workers' fears surrounding job security and the precariousness of their positions in the changing fortunes of the city.

Earlier in the year, in May of 1999, the Harare City Council announced that it would be retrenching 3,000 of its employees in a move that was expected to save some \$Z 200 million in wages and salaries every year. People being retrenched included 1, 246 workers between the ages of 55 and 65; 687 casual workers; 474 under-utilized workers, 270 excess positions; and 155 workers holding superfluous positions.²⁴ At the same time, the World Bank effectively stopped funding the Council's \$100 million dollar projects because the Council failed to submit audited accounts the previous year.²⁵ Suspended projects included: trunk sewers, major road construction works, several water reservoir projects, five primary schools, and two clinics.



A letter to the editor of the *Daily News* (July 6, 1999) captures the growing sense of frustration and disappointment many Hararians felt with Mugabe and his government:

As long as the majority of people of any country continue to struggle to get a decent meal, the leadership of that country is a total failure. A good government is one that provides food, health care, jobs and security for its people.

Viewing President Mugabe as any better than former South African President Mandela does not advance the economy of this country an inch. Mugabe has a host of failures ranging from driving this country to the brink of bankruptcy to failure to resettle the landless people. The economy of this country is failing to thrive because of his government's

myopia and gross mismanagement. Our once powerful currency continues to fall against all other major currencies.

Mugabe has failed to come up with a working policy to rescue this country from its socio-economic woes. Parastatals continue to lose billions of dollars every year.

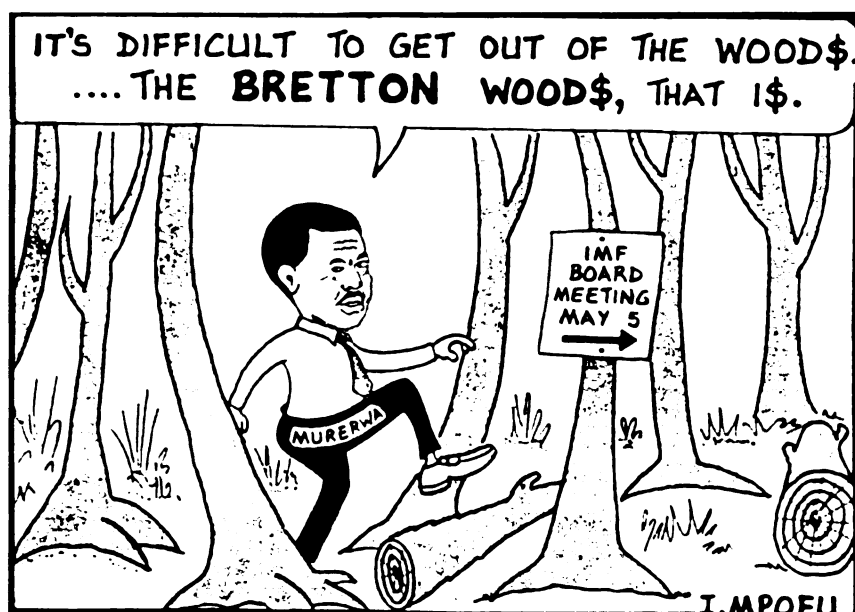
What happens in South Africa should not be really of our concern. Mugabe should not be comforted when people say he is better than Mandela when millions of people in this great nation are struggling to survive.

Civil servants are forever disgruntled while industrialists are frustrated.

We badly need leaders better than Mandela and Mugabe. We need leaders with African solutions to African problems.

Such public criticism would have been unthinkable a few years ago when people lived in fear of governmental repression.

As social unrest grew in Harare with the continuing harsh economic climate in 1999 and 2000, ZANU-PF began a very vocal condemnation of 'international interests' who were thought to be undermining the political and economic life of the country. This interference was usually attributed to international financial institutions (IFIs) such as the International Monetary Fund and the World Bank, in particular over some \$53 million in promised and desperately needed aid. Africa Desk assistant director for the IMF, Michael Nowak, said there was a need to clarify some technical details before the Fund's board could consider disbursement of the remaining funds and any new aid programs. In particular, the IMF cited concerns over Mugabe's land reform policy, military intervention in the Democratic Republic of Congo, and lack of transparency in formulating government policies.²⁶ It also expressed concerns over the reimposition of price controls on a range of basic food items (including bread and mealie-meal). Sorely pressed economically, Mugabe accused the IMF and Western countries of playing politics by shifting targets each time the government met the Fund's required stipulations.



After a 15-day tour of China, Iran, Singapore and the United Arab Emirates (ostensibly to drum up sympathy for Zimbabwe's ailing economic situation) in 1999, Mugabe openly castigated the IMF, stating that Zimbabwe could survive without it.²⁷ He said:

I don't like the IMF. It's a tool being used by imperialists to subject us to their will. The IMF is being political and we will become political in our attitudes towards it. It is a monster we do not deserve.²⁸

In this public venting of frustration, which occurred at Vice President Joshua Nkomo's much-publicized funeral at Heroes' Acre in July 1999, Mugabe told mourners Zimbabwe was tired of being told what to do by the international community that tended to become involved only when it affected a "few of their fellow country men." This, of course, was

a direct reference to the country's minority population of White [mostly British-descended] large-scale commercial farmers whose lands were in the process of being seized and redistributed to Black allegedly landless peasants.

The contentious politics surrounding land reform were another source of violence perpetrated, usually and unfortunately, on poor Black farm workers; this despite the international press which often focused on the isolated violence directed at White commercial farmers and their families. The first phase of land reform, 1980-1997, had redistributed about 3.5 million hectares of land to 71,000 families. In April of 1999, the government had sanctioned the immediate implementation of the first phase of the second land reform program to resettle about 118,000 families on 1 million hectares of land. Scheduled to be implemented over the following two years, the inception phase was to be financed through an integrated approach that would coordinate funds through the government, donor agencies, and other contributors. A team of government officials had been dispatched to the World Bank headquarters to broker the release of US \$10 million for technical development. The deal would finance two types of settlement approaches. The first was community-initiated, market-assisted approach that would have communities identify land, negotiate with owners, and make proposals for development with the government. The second approach involved a variety of other approaches that included the development of available land acquired by the government, private sector organizations, and civil society. In May 1999, the government also signed a technical agreement with the United Nations Development Program worth \$35 million to support the country's inception phase of the land reform and resettlement program.

Increasingly in 1999, race and racial hatred emerged as explicit tropes in the popular discourses that justified violent and illegal police and military actions within the city and in the commercial farm areas [use examples from parade here]. As elections neared in June 2000, Mugabe became very uncomfortable as popular dissatisfaction with ZANU-PF intensified under the current harsh economic climate. Mugabe seized on the emotional issue of racial discrimination, a vestige of colonial days, as a pretext to order a campaign of bloody intimidation of his principal opponents. These included the Movement for Democratic Change (MDC), a viable and increasingly popular opposition party, as well as the White farmers and workers on farmers' land who were thought be financially supporting the opposition.²⁹ Hundreds of white-owned farms were in the process of being occupied, with the express support of Mugabe and ZANU-PF, by so-called veterans of Zimbabwe's liberation. British officials' protest over the illegal seizure of White-owned lands gave Mugabe exactly the ammunition he needed to defy the onetime colonial ruler and paint it as a racist power only interested in its own people and investments in the region. Britain's offer of refuge to the 15,000 White Zimbabweans entitled to British citizenship only added more fuel to the fire and invariably led to the view among many Zimbabweans, and some Britons, that British policy was racially biased.

Zimbabwe's Foreign Minister Mudenge openly accused the United States and Britain of teaming up to destabilize the country before parliamentary elections on June 24-25, 1999 and warned both against supporting opposition parties in Zimbabwe and other countries in southern Africa, saying the region was ready to repulse their "evil attempts." He told a group of 8,000 supporters in the Masvingo area, "Today they have

targeted Comrade (President Robert) Mugabe and the ZANU-PF government. Tomorrow it is going to be Comrade (President Sam) Nujoma and his SWAPO in Namibia, then Comrade (President Thabo) Mbeki and his African National Congress in South Africa, and then the whole region."

Mugabe and ZANU-PF, facing a stiff challenge from the opposition Movement for Democratic Change (MDC), accused Britain of backing the MDC. In the United States, the powerful Senate Foreign Relations Committee approved a bill in June 1999 to suspend bilateral US assistance to Zimbabwe until democracy and the rule of law was restored. The bill was to help opposition groups mount possible legal challenges to the election results or repressive practices. At least 28 people, mainly MDC supporters, had died and hundreds of others had been beaten, raped or forced to flee their homes in the last few months leading up to elections. In one of the latest incidents, a Black MDC activist Finos Zhau, 23, died after he and his brother were abducted and beaten by suspected Zanu-PF supporters, the MDC said in a statement. The MDC met with international observer groups to discuss the pre-election violence, MDC leader Morgan Tsvangirai saying that the withdrawal of the UN team confirmed the MDC's argument that the election process was fundamentally flawed and a free and fair vote is impossible. Peaceful protests attempting to draw attention to the coercive and violent nature of the farm occupations were met, in turn, with violence and coercion.

The physical violence in the country also had symbolic manifestations as well; that is, a systemic structural violence. In particular, the dismal political and economic climate had particularly negative impacts on the country's hospitals and clinics. In Harare, basic health delivery had deteriorated to the point that patients and their relatives

often had to provide drugs, food, and other basic goods as some hospitals could no longer provide them because of severe budget cuts. At Harare Hospital, laundry equipment originally installed in the 1940s was no longer operational and beyond repair, leaving laundry workers to wash sometimes blood- and feces-soiled linen and pajamas with their bare hands (as no protective gloves were available either). Likewise, there were few chemicals available for the cleansing process. Of the three boilers at the hospital, two were irreparably damaged and the remaining one was unreliable, sometimes leaving the hospital without steam to sterilize laboratory instruments, cook food, and warm bath water for patients. Due to the shortage of drugs and specialist personnel, some patients might languish in hospitals wards for days waiting for medical attendance. The hospital's medical superintendent said the hospital had a nursing staff complement of only 839 when it needed at least 1,200 nurses to operate efficiently. Of the 500 doctors the institution needed, it had only 133 most of whom were also shared with other hospitals.³⁰

A male visitor to the hospital who had gone to see a relative commented:

My cousin has been here for four days but he has not been attended to. So the next time we come, we may be forced to ask for his discharge. There appears to be nothing that he is going to get from this place.³¹

Another female visitor, who had brought food for a relative, commented:

It is surprising that this institution remains open when it can no longer afford to serve its purpose and when it cannot meet the minimum standards of hygiene. If it was a private hospital, I don't think it would still be open.³²

Parirenyatwa Hospital, the country's largest referral hospital, was now demanding that patients not covered by one of the medical aid societies³³ or the Social Dimensions Fund (which was bankrupt anyway) buy their own medication (such as drips and drugs) before being treated.³⁴ J.K. Margesson, of Harare, spoke of the appalling state of the hospital after visiting the casualty department with a friend in 1996:

We arrived at 5:30 p.m. to see a huge mass of men, women, and children surrounding a desk. This I eventually ascertained to be the reception area, where everyone is required to "check-in." It was chaotic. I could not help but wonder how an acutely ill person could possibly manage to force himself through the crowds when immediate attention was necessary. needless to say we had to wait over half an hour to receive service. The Z\$64 "consultation fee" was paid and we were then given vague directions as to where to go next.

Naturally we went to the wrong area but a strolling nurse eventually put us on the right track. There we found another queue in a small room of people looking as lost and confused as we were.

Beds were being wheeled about haphazardly, a woman was sitting alone crying. I spoke to her and learned that she had been waiting there for over an hour. I tried to comfort her. Through her lonely tears she told me that she was three months pregnant and bleeding.

She waited for another hour with us before anyone spoke to her. I met a whimpering baby with three fist-sized lumps on his bald head, obviously needing quick attention, her mother waited and waited.

During this time I visited the lavatories. The whole area, floor, walls, toilet seat, etc., were not only covered with blood, urine and vomit, but feces also covered the bowl and seat. I was extremely ill and completely distressed at this stage and made the staff aware of the situation. I'm not sure whether the area was cleared.

A doctor did finally arrive, strolling casually along, examined the man I was accompanying and calmly told me that the patient would have to be operated on. I use the direct quote -- "when someone has the time." I then went through the whole rigmarole of queuing, form-filling, etc., yet again simply to admit this person to the hospital overnight.

I left feeling exhausted, distressed and disgusted. I felt concerned for the hoards of people still inside the "hell-hole" and wondered how many of the critically ill people would live long enough to receive care and whether they'd live through that!

Whoever is at fault here, however impossible it may seem to rectify the case, surely people should be more aware of what is happening? Human beings should not be treated in this manner. Dogs visiting veterinary hospitals have far superior attention, aid and care.³⁵

In an effort rescue the hospital from its serious financial and operational difficulties, Minister of Health and Child Welfare, Dr. Timothy Stamps, began an appeal to diplomatic missions in Zimbabwe.

The desperate situation also found Deputy MoCHW, David Parirenyatwa, appealing to mission hospitals to exploit their connections with the outside world to lure foreign doctors and nurses into the country. This appeal was met with protests by the Zimbabwe Nurses Association, which argued that government's decision to recruit expatriate health professionals would not alleviate the shortage of indigenous medical staff as more professionals continue to leave the country because of poor working conditions. Such recruitment, ZNA argued, was tantamount to putting a Band-Aid on the problem--the problem being that until working conditions improved, the country would continue to experience brain-drain. ZNA also feared that expatriate nurses could end up being paid more than their local counterparts. Despite these concerns, however, Minister Parirenyatwa said government still intended to recruit foreign health professionals, mainly from Tanzania to fill hundreds of vacant posts in the civil service--mainly created by the dismissal of 800 nurses after they staged a 1997 strike and the departure of others for greener pastures. The government had resorted to authoritarian methods to deal with the striking workers. An extreme example of this high-handedness was the suggestion by a member of parliament to use a 'sjambok,' or whips, to get the striking doctors and nurses back to work. It was only after the strike had reached its fifth and final week, with the dismissed health professionals trickling back to work after being ordered to reapply

for their jobs, that President Mugabe, who had earlier said the medical workers had nothing to strike for, finally conceded that they were “not well salaried.”

One effect of nurses and doctors striking was the media’s finger-pointing at n’anga as ‘cashing in’ on the crisis. The March/April 1997 *Catholic News* proclaimed, “ZINATHA cashes in on nurses’ and junior doctors’ strike, mission nurses not involved.” In a sub-title, the article painted the motives of n’anga as less than noble: “Local n’angas cashed in on last year’s critical strike by government medical workers around the country, making huge turnovers from the desperate and ill.” The article went on to say that ZINATHA “seized the opportunity to maximize its earnings by opening its magic doors to the many poor people who could not afford the high fees of private doctors and hospitals.” Then administration manager for ZINATHA, Boniface Makoni, is quoted as saying: “The strike brought about two faces. Firstly, many poor people who could not afford the huge fees of private hospitals turned to us for treatment. So we had a very big turnover at the peak of the strike. Secondly, we were faced with emergency cases we could not deal with, such as fractured bones. We referred such cases to conventional hospitals, but only the lucky few got treatment, and there was nothing we could do to help out the situation.” He, wisely, went on to say that although the strike brought in ‘huge earnings’ for ZINATHA, money was not first priority concern for n’anga. “We value most the life of the patient, not the money that we make out of him.”

The above examples help demonstrate the relationship between the socioeconomic and political health of a nation and the health of the individual. In particular, I have endeavored to show how Zimbabwe’s adoption of economic structural adjustment measures reinforce underlying power relations and asymmetries, and further

facilitate rising social and political violence, the proliferation of HIV/AIDS, and the deteriorating quality of health care available to the poor and middle classes. All of these factors, in turn, directly or indirectly impact the health of poor and middle-class Zimbabweans. While the impact of structural adjustment programs on HIV/AIDS transmission and control is still being assessed, there are a number of themes that stand out. First, there is little doubt that the austerity measures of trade liberalization, removal of government subsidies (on basic foodstuffs and other items), reductions in social spending, and currency devaluation have resulted in sharp declines in standards of living with the resulting rise in inflation, declining real wages, increasing unemployment and accelerated urban drift (Sander and Sambo 1991:160). And with decreased allocations to the health sector, currency devaluation and shortages of foreign exchange, severe drug unavailability is an everyday reality in Zimbabwe.

It is also difficult to see how the cost recovery program is working to achieve one of its goals, namely increasing the amount of government resources available for health and education. First of all, the fees are not retained by the collecting ministry, but go straight to the central treasury. Second, and despite the increased collection of user fees, real government spending on health and education has decreased dramatically since the introduction of ESAP as part of the effort to control public spending. Finally, there is no evidence that user fees in fact make a net contribution to the public treasury or, even if they do, that this is an efficient method of collecting government revenue. While user fees have generated substantial revenues (around Z\$80 million in 1993 from education fees alone), no one has measured the cost of collecting these fees or the cost of administering the rather cumbersome fee exemption system, which involves no less than

three ministries. The Ministry of Health is aware of the problems surrounding cost recovery and is redesigning the systems so that health fees are charged primarily in order to make the health referral system work better (UNICEF 1994).

In these ways, economic recession and SAPs further aggravate the transmission, spread and control of HIV/AIDS in Zimbabwe in two major ways: 1) directly by increasing the population at risk through increased urban migration, poverty, women's powerlessness and prostitution (see, e.g., Chapter Seven), and 2) indirectly through a decrease in health care provision. This latter point entails not only reduced facilities to care for patients with AIDS but also less effective treatment of genital ulcers and other STDs as well as decreased spending on health programs like health education.

At the same time, with an estimated 70 percent of bed occupancy in government hospitals AIDS-related, and more than 500,000 "AIDS orphans," the social costs of the epidemic is significant and the need for public assistance is high at the very time when such assistance is being curtailed. High mortality in workers, especially in skilled and experienced workers, and in management have reduced production in all sectors and may lead to inter-sectoral negative impacts on infrastructure and services. In turn, falling production and incomes in the informal sector are creating further pressure on formal sector incomes and public sector social services (Lowenson and Kerkhoven 1995). It is in these ways that the health of individuals comes to impact the health--particularly the economic health--of the country.

Such a context of structural violence that most Zimbabweans are forced to live under has particular implications for their sense-making of HIV/AIDS. In this chapter I have already hinted at the sense of suspicion many Zimbabweans harbor against their

government, that their democratically-elected officials do not have their best interests at heart. Of course, it is not only the government that people are suspicious of, particularly when it comes to a runaway disease such as AIDS. The material deprivation many people are forced to live under has them asking questions about the linkages between their poverty and the emergence and continued spread of a deadly disease. Such "moral demographics"--that is, folk beliefs that are based upon a perceived link between concrete biological events, cultural experience, and population processes (Setel 1999)--are the topic of the next chapter.

¹ *Daily News*, June 2, 1999.

² Zimbabwe Government 1991.

³ To facilitate its Social Dimensions of Adjustment Programme, the government created a Social Development Fund (SDF), under the Ministry of Public Service, Labour and Social Welfare [then Labour, Manpower Planning and Social Welfare]. SDF administered only two programs: the Employment and Training Programme to assist recent retrenchees from the private and public sectors; and the Social Welfare Programme, designed to protect the poorest from the adverse effects of cost recovery and the removal of subsidies. Despite this addition, it was not until a full year after the start of ESAP that the government announced its Social Dimensions of Adjustment plans in detail. It took another 16 months to appoint a full-time SDA Coordinator (GoZ 1991).

⁴ Gibbon (1995:11-12)

⁵ *ibid.*, p.14

⁶ *ibid.*, p.16

⁷ According to the world anti-corruption coalition, Transparent International, Zimbabwe is ranked number 43 out of 85 countries lumped under the corruption perception index.

⁸ "Prosperity, development victims of corruption." *Daily News*, July 5, 1999.

⁹ May 16, 1999.

¹⁰ "Corruption riles State, business community." *Business Herald*, July 8, 1999.

¹¹ In May of 1999, Zimbabwean Defense Minister Moven Machachi had asked Cabinet to urgently authorize a Z1.2 billion supplementary budget to help finance the country's costly military operations in the Democratic Republic of Congo

¹² *Zimbabwe Mirror*, March 26-31, 1999.

¹³ In June of 1999, fresh milk cost around Z7.25 for 500 milliliters, which equaled Z14.50 per liter; petrol, on the other hand, cost Z12.25 per liter.

¹⁴ “Africans’ hospitality under threat as economic hardships set in.” May 6, 1999.

¹⁵ *Herald* May 19, 1999.

¹⁶ *Daily News*, May 22, 1999, p.5

¹⁷ *Daily News*, May 13, 1999, p.6

¹⁸ *ibid.*

¹⁹ Bijlmakers, et al. 1995.

²⁰ Stunting is an indicator of cumulative deficient growth or a marker of past growth failure. It is associated with a number of long-term factors including chronic insufficient food intake, frequent infections, sustained incorrect feeding practices and low socio-economic status.

²¹ Wasting indicates current or acute malnutrition resulting from failure to gain weight or actual weight loss. Like stunting, causes include inadequate food intake, incorrect feeding practices, disease, infection, or a combination of these factors. Wasting in individual children or in population groups can change rapidly and shows marked seasonal patterns associated with changes in food availability or disease prevalence to which it is very sensitive.

²² Pellagra (niacin deficiency) is a nutritional disorder found occasionally amongst people who eat a poor diet of maize or sorghum or among heavy drinkers of the locally-made alcohol called Kachasu. Pellagra is characterized by a dark peeling rash mainly on the parts of the body that are exposed to the sun, and in severe cases, causes chronic diarrhea and dementia.

²³ ‘City Workers’ Strike Enters its Third Day.” *Herald*, July 13, 1999.

²⁴ “City to Retrench 3, 000.” *Herald*, May 18, 1999.

²⁵ “WB Freezes \$100m fund for Harare.” *Daily News*, May 15, 1999.

²⁶ It is hypocritical, of course, of the IFIs to blame Zimbabwe for corruption and a lack of transparency and to demand that Zimbabweans own up to their foreign debt while at the same time allowing the funds loaned to Zimbabwe--and often siphoned off to line party members’ nests--to be deposited in Western banks.

²⁷ The end result of this tour was allegedly more than \$1.4 billion in soft loans, grants and investment pledges by these countries’ governments and businesses. “Mugabe Turns East as Economy Sinks.” *Financial Gazette*, May 20, 1999.

²⁸ “Zimbabwe, IMF and WB: Rhetoric Vs Reality” *Daily News*, June 14, 1999. Not all Zimbabweans shared Mugabe’s vision of these international financial institutions, the *Zimbabwe Independent* being very outspoken on this issue arguing: “The world, particularly the IMF and the World Bank, do not owe us a living but we desperately need their support. The sooner we all come to this realization, the better. There is a real world out there and whether ZANU-PF likes it or not Zimbabwe is part of it...What the IMF is demanding is not as outrageous as the spurious revolutionaries in our midst suggest. The majority of Zimbabweans share the concerns raised by our international partners about accountability and transparency.” April 16, 1999.

²⁹ On several public occasions, Mugabe expressed outrage that the white community teamed up with the Movement for Democratic Change (MDC), to campaign for the rejection of the government-sponsored draft constitution in February 2000 because of the inclusion of the land clause. Worse still, Mugabe said, white industrialists and farmers

had openly backed the MDC financially and regimented the labor force on the farms to support and vote for the MDC in the parliamentary election.

³⁰ Zimbabwe Independent, May 21, 1999, p.4

³¹ *ibid.*

³² *ibid.*

³³ Medical aid costs continue to escalate. CIMAS, for example, a medical aid society which provides insurance coverage for over 300,000 beneficiaries, has seen claims escalate, with average direct cost of an AIDS case at Z\$4, 900 in 1994 (the amount being higher in higher income schemes), most costs being incurred during the last two months of illness. CIMAS data show a large share of the costs being taken by medical practitioner fees and that a large share of hospital costs derive from the overhead costs, such as accommodation and facilities. While CIMAS had built up a reserve to meet the projected costs, more recently, it has proposed or introduced further measures--including premium increases and capping of reimbursements on treatments of illnesses identified as HIV/AIDS-related (Lowenson and Kerkhoven 1995).

³⁴ Herald, May 6, 1999, p.6

³⁵ Letter to the editor, *Herald* July 23, 1996

CHAPTER SIX

Conspiracy Theories: The So-Called AIDS Virus

As we look over the meanings that AIDS has generated as it moves among subcultures and around the globe, we can ask different kinds of questions. Who are cast as villains in a particular account of AIDS? How does a given account resonate with different constituencies? What's in it for its adherents?

Paula Treichler¹

Given the material effects of structural adjustment policies, governmental corruption, and their articulation with HIV/AIDS, as discussed in the last chapter, it is not surprising that poor, and even middle-class, Zimbabweans would be suspicious as to the origins of the disease. The above questions serve as an entry point for exploring the often fantastic terrain of conspiracy theories surrounding HIV/AIDS in Zimbabwe. Treichler draws our attention to the diverse functions of these theories with regard to blame and causation and how such paradigms serve as 'templates readily adapted to the charged social divisions and power inequalities of the disease's multiple environments.' She suggests that indigenous conspiracy theories create an uneasy tension for anthropologists. On the one hand, we are accustomed to privileging local narratives and worldviews, the emic perspective, no matter how 'implausible, incomprehensible, exasperating, or appalling.' When carefully decoded, such theories--or moral demographies--may indeed shed light on inherent tensions in particular social and historical configurations. On the other hand, anthropologists working in the midst of a serious epidemic may feel a professional and moral obligation to 'correct the misconceptions of their informants and seek to control their dissemination.' The uneasy tension between these viewpoints

certainly confronted me in my work in Zimbabwe. This chapter seeks to identify conspiracy theories surrounding HIV/AIDS in Zimbabwe--theories that figure prominently in the readings of n'anga--and explore the diverse purposes they serve. However, a quick note on usage here: by labeling a particular understanding/interpretation of AIDS, a 'conspiracy,' I don't want to give the impression that it is necessarily 'untrue,' particularly for those who believe (or feign belief) in it for varying reasons and purposes. Whether or not the truth claims of such theories are verifiable or not (and certainly they would not be labeled conspiracy theories if such claims were accepted as conventional thinking), the belief in them has very real consequences.

Throughout the theories which follow, there is a common theme--that is the role of powerful outsiders in either creating or disseminating HIV/AIDS for the express purpose of destroying and/or controlling African peoples. A recently published British work of fiction, Benjamin Geer's *Something More Sinister* (1998), for example, brilliantly captured this theme and enjoyed great popularity in Zimbabwe in 1999. Its provocative jacket summary began: "What lies behind the global disaster AIDS--the sinister plague that threatens the very existence of mankind? RACISM! Ben Geer's powerfully persuasive biological thriller, based on thorough medical and historical research, reveals a deeply disquieting trail of political conspiracy and intrigue ultimately leading to genocide." Though a work of fiction, it was based on historical facts--facts that were conveniently asterisked throughout the text--regarding organ transplant surgery and the technology created as a result which could suppress the immune system as a way of facilitating organ acceptance. The end result of this biotechnology, the book

speculates, may have been HIV. The book also chronicled the use of biological agents--anthrax and marburg to name a few--on black freedom fighters in South Africa and Zimbabwe.

In part, the book's popularity derived from the fact that it portrayed white southern Africans and Americans as the villains, secretly plotting to destroy black people. The image of whites as villains runs counter to prevailing ideas where blacks are often seen, simultaneously, as villains--wantonly spreading HIV/AIDS through unsafe and risky practices and usually attributed to "culture"--and victims, skeletally-thin innocents ravaged by a runaway disease. In this way, the book shifted the blame from the victims of the disease to a more powerful class of people--indeed a group of people with the wherewithal, resources, and motivation to develop and implement such a catastrophe. But, the book's theme also resonated well with black Zimbabweans' sense that they have always been pawns in someone else's game, that they have historically been pathologized and victimized in word and in deed.

History lends credence to such interpretations. In 1990, four South African doctors and a scientist were questioned in Canada regarding their involvement in South Africa's apartheid-era germ warfare program. Some admitted to manufacturing small amounts of poisons, making large amounts of ecstasy, and initiating a program to establish a method of reducing fertility among black South Africans.² During a hearing of South Africa's Truth and Reconciliation Commission into the country's chemical and biological weapons, bio-engineer Jan Lourens discussed devices for killing opponents of the government such as walking sticks and umbrellas which fired lethal pellets, syringes disguised as screwdrivers, and rings with cavities for poison. A version of the

umbrella/walking stick fired a small ball--the ball having had small holes drilled in it and filled with a toxic substance. Fired into the back of the victim's leg, the ball would feel like a bee sting. Polycarbonate was used because it was difficult to pick up on x-rays.

Attribution of blame, as Farmer (1992) reminds us, can be seen as one of the weapons of the disempowered. Such non-violent counterattacks are one of the few tactics available to resource-starved people in defending themselves against powerful interests. Within Zimbabwe, however, it is not only the disempowered who view the ascendance of AIDS as part of a larger plan of social engineering. Pointing back to the country's historical experience with biological warfare--indeed Zimbabwe (then Rhodesia) may be the first modern nation to have used biological warfare against its own citizens--some individuals draw correlations between past and present disease episodes. This very subject was broached recently by Dr. Timothy Stamps, the current Minister of Health and Child Welfare for Zimbabwe, during an interview on the British Broadcasting Corporation (BBC). Stamps' frankness in admitting the likelihood of the Rhodesian government's use of anthrax, cholera, and bubonic plague--to name a few--on its own citizens, especially during the war for liberation, is remarkable. Importantly, he draws connections between the use of biological agents in Rhodesia and South Africa's attempts to maintain its apartheid regime against the overwhelming freedom movement which was threatening the very foundations of white supremacy in southern Africa. He also speculates that South Africa and Rhodesia were being used by "foreign agencies" as a "laboratory for evaluating the effectiveness of biological weapons." Here, I begin with Stamps' interview as a way of foregrounding a discussion of various local "conspiracy theories" regarding AIDS. Indeed, Stamps' ruminations on biological warfare only lend

further credence to local ideas about the role of human agency in the disease, its origins, and its distribution--ideas that are too often dismissed as mere paranoia and irrationalism.

A Laboratory-Created Virus for Killing African Peoples?

Before we turn to Stamps' interview, a few introductory comments. The "Introduction" to *Something More Sinister* asks some provocative questions regarding the genesis of AIDS, questions that reverberate with local peoples' sense of encroaching misfortune at the hands of translocal interests:

Who, if anyone, was responsible for AIDS?

- Who would have had some kind of involvement in associated medical or genetic research, at the time of the sudden emergence of AIDS in the mid-nineteen sixties?
- Who would have had the resources and the biological expertise to create these terrible viruses?
- Who would have had sufficient motive to use biological weapons, and against whom?
- Who would have been so totally devoid of moral conscience to have used such a weapon?
- Where could it have deployed--taking the emergence of the AIDS time-scale into account?

Such questions cannot be written off as mere paranoia, as even a cursory review of Zimbabwean history will reveal. Dr. Timothy Stamps' following discussion actually helps answer some of the above queries. Here, I share a partial transcript of that interview. Interviewer questions are in italics; Stamps' responses are in normal type:

Why have you ordered an investigation into the use of biological warfare against Rhodesia?

Because there are certain infectious conditions that have come to my notice over the period of the hostilities that are, to say the least, very strange. The evidence is very clear that these were not natural events. Whether they were caused by some direct or deliberate inoculation or not, is the question we have to answer.

What particular biological agents are we talking about?

I'm talking about anthrax and cholera in particular, but also a couple of viruses that are not endemic to Zimbabwe [such as] the Ebola type virus and, we think also, the Marburg virus. We wonder whether in fact these are not associated with biological warfare against this country during the hostilities. It's quite coincidental, and a very interesting coincidence, that the height of the infection should occur when the hostilities were at their height.

Now you've studied the epidemiology of all these possible agents. Let's start with anthrax. Anthrax is indigenous to Zimbabwe.

Yes, but when you have an annual incidence of around two dozen or less for a period of about twenty years, and then you suddenly get a spike of 10,000 in 1979-80, there's some extraneous influence at work. And this coincided with the intensification of the struggle right toward the end, just before independence.

You're saying that it is epidemiologically inconceivable that you can have an average of 24 cases a year that then spikes to 10,000 in the next two years

I think it is very unlikely...I haven't heard of it.

What about cholera? Cholera too is endemic in certain parts of Africa.

We've looked at the records right back to the date of occupation and there have never been any outbreaks of cholera until 1975 and that coincided with the introduction of cholera in East Africa. It's very interesting that it occurred so quickly after the introduction, partially during a period of hostility when movement was severely restricted in the eastern districts of this country.

Now what else was it about the pattern of the cholera outbreaks that has made you suspicious?

If the [outbreaks] had been endemic or if they had been natural, we would have expected them to continue and recur, and certainly with the health services in the disarray that they were toward the end of the war, we wouldn't have expected them to come under control [such a] quick period. In fact, one of the people who studied cholera in Southeast Asia remarked to me on the 1993 outbreak, that he was surprised that we had got cholera under control within three months and eliminated it within seven.

That just wouldn't happen if it were an endemic outbreak.

Well, even if it were suppressed it would recur, and it has not until very recently and these are new imported cases.

Now, you were talking about Marburg, Ebola and bubonic plague. What evidence do you have of these agents?

Again, the interesting feature is that they are focal, they are not generalized, and plague tends to spread very rapidly--bubonic plague--because it's carried by a flea, and the rats which carry the fleas are a natural wild animal in Southern Africa and yet it occurred in just one area, and it has recurred in just that one area. That again was an area where there was intense fighting between the forces of liberation and the freedom fighters.

What evidence, in terms of the number of cases, and again epidemiology of it... We looked at seriological tests on strange cases which occurred around 1980, and found nine cases including a fifteen-year-old child, who showed seriological evidence.

Who do you believe could have been responsible for the introduction of these biological agents?

That is really outside my ability to conjecture. But we know that it could not have been the Rhodesia forces acting on their own, they didn't have the logistics...we know that there was a tremendous amount of support from the apartheid regime because they were intensely concerned that if this country became independent and democratized, it wouldn't be long before apartheid fell apart...I think it was introduced by foreign agencies probably through South Africa and probably by the South Africans in order to use Zimbabwe as a mechanism for protecting their apartheid regime against the overwhelming freedom movement which was threatening the structure of apartheid.

You have ordered an investigation, some of those results are up, is there any doubt in your mind?

In my own mind there is no doubt that there were deliberate attempts to inoculate our country with those organisms. It's a deliberate attempt at destroying the population. I would put it on the same level as ethnic cleansing.

You are aware, of course, of the current criminal proceedings against Dr. Wouter Basson of South Africa. Do you believe that there could be a connection between South Africa's Chemical and Biological Warfare (CBW) program, which was known as Project Coast, and the possible use of your country as a test bed?

Certainly, because all the areas which were affected were areas adjacent to areas of South African control and influence.

Do you have any prima facie evidence of a connection to South Africa--any of this at all which you can present now?

None at all...I think it's going to be very difficult to get concrete evidence. All the evidence will be circumstantial, but I think there will be people still alive who can be identified as knowing what actually happened.

If the people who are still alive are identified and the evidence is there, what do you believe should be done with those people, in terms of justice?

I think this is the highest form of inhuman murder ever known to man. It is targeted indiscriminately, mostly at innocent civilians and without any regard as to the future. Anthrax, for example, will remain contaminating out soil for at least the next fifty years, and we do not have the resources to remove it. There has been another outbreak of anthrax in the same area very recently, and we are sure that is because of spores left over from the previous epidemic.

How are you going to get rid of anthrax in Zimbabwe? You don't' know how or where it was sown. You know it stays in the earth for up to 50, 60, 70 years...how are you going to get rid of it?

Yes, I think that is a very difficult problem. In fact, the wild animals have now been infected, we've had antelopes who have anthrax, we have evidence of elephants who have developed anthrax. When it is as widespread as that, detecting it and eliminating it is a major task outside the capacity of a small country like Zimbabwe.

Anthrax is not readily available; where do you think the original spores came from?

I'm sure it was a laboratory-devised virulent type because there are some anthrax bacilli which are not particularly virulent, and I suspect that they were responsible for the sporadic cases we had in the thirty years before the major epidemic, and one suspects that these were specifically developed as a weapon against an overwhelming number of people who were regarded as enemies to those who occupied power at the time. If you can destroy a person's cattle, you can destroy his livelihood, if you can kill a few people in the process, the you can subjugate a large number of people. That is the evil of biological warfare.

The world has recently become aware of the use and dangers of biological warfare given the events in Iraq, etc. You've had it used here in Zimbabwe. What lessons are there for mankind in what you are undergoing now?

I get very worried about things like the big powers wanting to retain the smallpox virus. For what reason?...[I] think it is quite wrong that Russia and the United States still retain the virus of smallpox. Smallpox has been eliminated from the world in 1978, there can be no medical justification for continuing to retain even the smallest amount of smallpox virus unless people have an intention to use it as a potential backup to a war situation. We also need a lot more transparency on medical experimentation on the sorts of things like developing genetic processes. Even cloning really frightens me because of the possibility of genetic introduction of materials which are undesirable into particular unsuspecting communities.

As possibly the world's first modern victim of biological warfare, do you have a political view at all about the Biological Warfare Convention (BWC)? Its intention is benign and good, but there's no way of really inspecting it, there's no verification method. If you had the ear of the right people, what would you say to them about the BWC?

The contrast between the approach to the Iraqis and the approach to the general issue of biological warfare material held by other countries is so stark as to be frightening. Why are people concealing the fact that other countries have elements of biological warfare, and admit to having them, and these are not controlled or destroyed and the factories which are producing them are [not] eliminated?

So would you like to see an international inspectorate with real powers of immediate, sudden and unannounced entry?

Exactly.

And do you believe that something should be done about the international availability of these biological agents, that it should be stopped?

Absolutely, it should be an absolute prohibition, not a gentle code of practice or piece of advice. I am particularly incensed that my country has been used as a laboratory for evaluating the effectiveness of biological weapons on my people, my African people, and this is something which in my view is totally unforgivable.

Stamps's frankness in admitting Rhodesia's likely use of biological warfare against its own citizens, and its embeddedness in transnational webs of intrigue, speaks for itself. With such information from such a 'reliable' source--a white 'Rhodesian' no less--local theories linking pathogenic agents and their spread to supralocal agents and processes seem not so far-fetched. A word of caution here, though: Stamps is a politician. Moreover, as a white man in an overwhelmingly black government, he surely must feel a certain sense of insecurity in his position; and, as such, this precariousness must certainly color his public pronouncements.³ On more than one occasion, his efforts to 'fit into' local Shona culture have made people suspicious of his motives. For example, after a ribbon-cutting ceremony for the opening of a new clinic in Mafindifindi in Mashonaland West province, Stamps decided to "marry" a 14-year-old local girl who had assisted him with the cutting. He said his marriage to the girl was in appreciation of the community's initiative and also to reinforce Zimbabwe's "traditional values" which, ironically, he said were being threatened by "Western culture." A reporter dispatched to follow-up with the child bride months after the "marriage" had taken place, said the girl's first questions were: "Do you have any messages from my husband. Did he tell you when he is coming to take me to Harare? If he does not take me soon, I'll be too old to have children."⁴

His motives have also been questioned by members of his own cabinet. I remember meeting with then-deputy Minister of Health and Child Welfare, Hungwe, in

1996. She was upset that Stamps had not allowed clinical trials of the imported herbal palliative, Mocrea (see Chapter Fourteen), a concoction thought to be helpful in ameliorating some of the symptoms of HIV/AIDS. Stamps had dismissed Mocrea as a “mere tonic drink.” Deputy Minister Hungwe had already appeared on national television, explaining that those seeking help should not be discouraged from using Mocrea. Her explanation of why Stamps did not allow clinical trials boiled down to racism. “He only wants to focus on drugs created by the white man,” she said. “I told him, ‘You see this soil beneath our feet? I come from this soil. How dare you tell me we can’t have clinical trials of Mocrea, standing here on this soil that I come from, my country!’”

And so, Stamps’ public pronouncements must be taken with a grain of salt. This does not necessarily weaken the reliability of his discussion of biological warfare in Zimbabwe. Importantly, apart from Stamps’ interview, hard evidence supporting such claims is difficult to find. There are still others in government who do believe that AIDS has been utilized as a form of biological warfare against blacks. In 1996, for example, then Vice-President Joshua Nkomo told funeral mourners that his son, Earnest Thuthani, had died of AIDS. Several AIDS awareness organizations praised Nkomo for the revelation that they said would help the nation in fighting the stigma attached to the deadly disease. During the graveside speech, however, Nkomo blamed whites for bringing the killer disease into the country. He said the whites brought AIDS to wipe out the black population in order to take the country’s land and wealth. But this had backfired, he said, because everyone including whites were affected by the disease.⁵

While Nkomo was speaking out with a profound sense of grief and anger at the senseless loss of his son, part of him at least believed in the veracity of his statement. Clearly, such allegations are difficult, if not impossible to prove. However, there is hard evidence of this sort from Zimbabwe's neighbor to the south, South Africa, thanks to the deliberations of the Truth and Reconciliation Committee. It's a matter of public record that South African, white, right-wing extremist, Eugene Terre Blanch, for example, discussed plans to spread syphilis--caused by the protozoa *Treponema pallidum*, at the Sun City holiday resort in the Bophuthatswana black homeland. He wanted to infect anyone crossing the "colour bar." More recently, it was revealed that the apartheid government planned to give Nelson Mandela small doses of poison so as to cause him brain damage shortly before his release from prison. Evidence gathered during TRC hearings substantiates many local narratives which attribute outbreaks of disease to the interests of powerful local and translocal agents.

At the same time, vulnerable African populations are often utilized as subjects for testing by Western biomedicine. In 1997, for example, the US watchdog group Public Citizen's health research group alleged that the US government, through the Centers for Disease Control and Prevention and the National Institutes of Health, was funding AIDS trials in Africa that used placebos or unproven drugs. The studies were designed to compare interventions to prevent mother-to-infant HIV transmission. Public Citizen obtained data from CDC showing that in nine US-funded studies, a cohort of women were not being offered prophylactics such as zidovudine, which has been proven to reduce mother-to-infant transmission. The group pointed out that there were six additional placebo-controlled studies being funded by France, Belgium, Denmark, South

Africa, and the UNAIDS program. In its defense, CDC issued a statement on the difficulties of paying for and monitoring the recommended zidovudine regimen in developing nations. CDC said that an international panel in June, 1994, recommended that since "there are currently no interventions available to prevent perinatal HIV transmission to infants in most developing countries. . . placebo-controlled trials should be designed to provide rapid and scientifically valid assessment of alternative drug regimens."⁶

International outrage at such testing continues. A recent editorial in the *Guardian* compared the Third World to a "medical sweatshop," a cheap source of subjects for research into AIDS and other conditions:

Debate has been fueled by Public Citizen's 1997 exposure of unethical Aids research in Africa and Asia under the auspices of US National Institutes for Health (NIH) and the Centers for Disease Control (CDC). Thousands of pregnant women with HIV were given placebos rather than AZT, known to be an effective medication. A key clause in the Helsinki Declaration states that volunteers who take part in clinical trials must have access to "the best proven diagnostic and treatment methods." In other words, if you want to study some disease, you are supposed not just to monitor your subjects but also to treat them. In the African Aids studies, this requirement was set aside, something that could not occur in the developed nations. Researchers justify such omissions on the grounds that people in developing countries do not have access to advanced medications anyway, so there should be no obligation to provide such treatment. The WMA is not the only body considering these issues. Moves are also afoot to amend the guidelines of the Council for International Organisations of Medical Sciences (CIOMS), which set out how the Helsinki Declaration should be implemented. CIOMS deliberations are being conducted in near secrecy, which is outrageous for a body charged with upholding an important ethical charter.⁷

Another editorial pointed out the paradox of then-President Clinton's efforts at ameliorating the suffering of countless afflicted people in Africa and other developing countries and, at the same time, the need for clinical testing:

The issue has become highly contentious in the US, where public health doctors are privately agonising over the impossibility of reconciling President Clinton's call to help the millions dying of Aids in Africa with the fact that babies in Uganda and elsewhere have been left by researchers to contract HIV. These are the babies of mothers in the section of a trial group that were not given drugs to stop HIV transmission. Such trials would not have been allowed in the US; in western countries the different test groups in a trial must each be given some form of treatment. In a recent study of HIV and sexually transmitted diseases in Uganda antibiotics were given to half the subjects and nothing to the others. In China, people were deliberately infected with malaria to see whether this reduced the level of HIV infection - another study that would not have been permitted in the US.⁸

In another embarrassing public relations snafu, Columbia Labs admitted that a spermicide they had developed, which was touted as blocking HIV transmission, had failed to do so. Columbia provided the spermicide for the study, which was conducted by UNAIDS. The clinical study was conducted on 700 women working as prostitutes in South Africa, Thailand, Ivory Coast and a fourth African country between 1996 and May 2000.

Even when AIDS drugs have been made available to African countries, such offers are viewed suspiciously by local people. When drug companies have been so generous, it seems it is only during clinical trials that many activists claim aren't as well monitored as similar ones in the U.S. Perhaps equally damaging, some African leaders have used rare deaths among those taking AIDS drugs in clinical trials to justify opposition to countrywide programs to distribute the needed drugs. A recent death in

South Africa of an AIDS patient who was taking an experimental regimen being developed by Bristol-Meyers cast a shadow on such trials.⁹

Such studies are not surprising given that the interests of the powerful have long taken precedence over those of the powerless. Even here in the United States, African Americans have long been aware that people of color are especially vulnerable to the projects of science, a belief confirmed by the Tuskegee syphilis studies. Gilbert's (1996) work with male prisoners suggests similar beliefs. Examining the narratives of incarcerated men with regard to HIV/AIDS, Gilbert found that many viewed AIDS as part of a larger campaign to exterminate communities of color. In pointing out the pervasiveness of these viewpoints, he offers a couple of reasons: first, such narratives offer a political analysis of racism and disempowerment and, in this way, provide male inmates with a "seemingly militant rationale for not confronting their own dangerous practices" (p.57).

The same might be said of Zimbabweans--that such rhetorical counterattacks that cast Western powers as attempting to exterminate black people are really cogent critiques of an insidious Western racism that victimizes Africans in word and deed. But, too, such depictions provide an excuse for individuals to not confront their own risky behaviors--did Vice-President Nkomo question his son's promiscuity and adulterous behavior, ostensibly the reason for his infection with HIV and ultimate death from AIDS-related complications? Such depictions also succumb, ultimately, to an implicit fatalism and disempowerment where individuals feel they have no control anymore. "It's just God's will," people will say. *Zvimenge zvakanyorwa mubhuku*. "It will already be written in the book."¹⁰ This might help explain why, despite the fact that allegedly 80-90 percent of

the Zimbabwean population knows what AIDS is and how it is transmitted, there still seems to be no strong correlation between knowledge of the disease and a corresponding change in behavior that might put people at risk of infection. In the final analysis, Gilbert argues against AIDS-as-racist-conspiracy theories because they “divert energy from the work that must be done in the trenches if marginalized communities are to survive this epidemic” (ibid.), but not before seriously mining the meaning of such claims from the perspective of their adherents.

AIDS: American Invented Disease to Stop Sex

As mentioned earlier, the belief that AIDS as a biological condition did not really exist was common in Zimbabwe as the disease began to establish roots in the country. This certainly is not surprising. Because AIDS initially struck gay men in North America and Europe in the 1980s, the belief that the virus was strictly a “gay disease” circulated around the globe, especially given the porous nature of international boundaries with regard to the flow of information and disinformation. As one Harare-based AIDS activist said, “...of course, there was no information then, absolutely nothing. AIDS was something that was in America amongst gays and IV-drug users. It wasn’t here in Africa officially...that was the government line. There wasn’t any AIDS in Zimbabwe, so there was no information about it.” Such governmental rhetoric would have, and has had, disastrous consequences as the full weight of the disease began to accrue throughout the country.

But in addition to these interpretations and understandings, there is also the fundamental African stance of being pro-natal. In the past, a person’s wealth in many

ways was adduced by the number of children s/he conceived. Among the Shona, a wife did not typically get her own cooking stones until after the birth of her first child: prior to this, she shared the kitchen and food supplies of her mother-in-law. Barrenness on the part of the wife was, and is, regarded as failure by her family to fulfill their side of the marriage contract (Bourdillon 1998). Children were/are the physical embodiment of fertility as well as a much needed source of labor. One Shona women told me, "Africans are specialists in bed. In the past, wealth was measured by the number of children you had." As such, not engaging in sexual reproduction must be viewed not only as biological death, but social death as well. For the historical and contemporary Shona man, it remains important to have sons to support him in old age and to carry his name into posterity (Bourdillon 1998).

In such a context, not having children must be understood as deviant behavior-- and this has particular implications for how, for example, homosexuality is understood or misunderstood. Some people have linked the denial that AIDS exists to a more general denial of homosexuality in Zimbabwe; something which, even if there are pockets of it, is seen as something transplanted to African soil by degenerate Europeans and Americans. In a speech opening the Zimbabwe International Book Fair in early August of 1995, for example, Zimbabwe President Robert Mugabe publicly attacked gays and lesbians as "sexual perverts" who do not deserve to freely exercise their right to free speech. After gay-rights activists in South Africa and the United States urged Mugabe to respect the rights of gays, he reportedly responded, "Let the Americans keep their sodomy, bestiality, stupid and foolish ways to themselves, out of Zimbabwe.... Let them be gay in the United States, Europe and elsewhere. They shall be sad people here." More recently, Mugabe

has renewed his anti-gay attacks by saying that homosexuality "degrades human dignity" and "it's unnatural and there is no question of ever allowing these people to behave worse than dogs and pigs."

Similarly, family-planning initiatives, usually funded by translocal donors, must be viewed (locally) as assaults on the very social and reproductive fabric of Zimbabwean society. In the context of AIDS, unfortunately, such initiatives initially fed into the belief, common in much of sub-Saharan Africa that the so-called AIDS was the latest effort by a white global elite to control the reproduction of African people. Such attitudes clearly speak to a distrust of outside prescriptions for changes in local sexual behavior, prescriptions that were initially seen as part of population control programs.

The experience-near perspective helps illuminate how people understand their position in an ever-changing world. As Treichler (1999:222) suggests: "Some of the idiosyncratic, unreasonable, apparently demented meanings attributed to AIDS provide important insights into how people make sense of the world, collectively and individually, and how language works in culture. They reveal sources of mistrust, resistance, fear, and disempowerment." Zimbabwean narratives that suggested AIDS was really a propaganda tool of Americans intent on stopping the sexual reproduction of black people, from both historical and contemporary perspectives, appear to not be so demented and unreasonable; especially given the emphases of translocal actors on family planning and population control initiatives, ostensibly designed to "reduce Africa's excessively high fertility" (Green 1994:154).

AIDS Does Not Really Exist

Perhaps the most public representation of a version of this view is South Africa's President Thabo Mbeki who has allegedly expressed doubt that HIV causes AIDS. At the 2000 XIII International AIDS Conference in Durban, and perhaps the most internationally public venue for airing such beliefs, Mbeki did not acknowledge forthrightly that HIV causes AIDS. Instead, he focused on social factors such as poverty as a major force behind the epidemic. In an October 2000 African National Congress MP caucus meeting in Parliament, Mbeki admitted to a belief that the United States Central Intelligence Agency (CIA) was part of a conspiracy to promote the view that HIV causes AIDS. Mbeki also admitted that he thought the CIA was working covertly alongside the big US pharmaceutical manufacturers to undermine him because, by questioning the link between HIV and AIDS, he was thought to pose a risk to the profits of drug companies making anti-retroviral treatments. Mbeki also told the ANC caucus that the fact that South Africa under him was emerging as a leader of attempts by the developing world to get a better deal in the international economic system was a threat to the US and other major Western powers.

As for this notion that "AIDS does not really exist," there is once again more than meets the eye. Many scientists would, of course, scoff at such a theory. But, a careful reading of these understandings yields a not all that unbelievable rendering of the role of complex economic, social, and political forces which often conspire to undermine the health of the Third World's poor.

Dr. Richard Ngwenya, a self-professed doctor of 'natural' medicine and certified 'traditional healer,' shares this particular understanding of the 'so-called AIDS virus' (see

Chapter Fourteen for an in-depth discussion of Ngwenya). His literature, which he freely dispenses from his Avenues-based James Mobb Immune Enhancement Center, sums up this position well:

The formula being pursued to solve the AIDS catastrophe in Zimbabwe will not succeed until we seriously decontaminate the country of biological and chemical warfare agents that were used by the Rhodesians to eliminate or disable their political and military opponents using anthrax, mycoplasma, botulism, marburg, thallium, organophosphate, cyanide, and other agents as baits like the Liebigs lox and fray bentos beef poisoning, Bata shoes-super-pro footwear contamination, the socking of jeans denims from the University of Rhodesia Department of Zoology (now Biological Sciences) by Prof. Bob Symington's team, Selous Scouts, and their CIO friends. It is astonishing for us to be spending almost 97 percent of our health budget on AIDS-related expenditure as we deliberately bypass the real problem (BIO & CHEM WARFARE agents) depleting our financial resources plunging the nation into acute poverty (p.2).

As with the interview excerpt from Minister of Health Timothy Stamps, the above excerpt points out the Rhodesian government's use of biological warfare on its own citizens. Here, Ngwenya's literature surmises that AIDS, as such, is not the real problem, but rather a byproduct of the problem which is the devastating and continuing effects of chemical and biological warfare. Importantly, too, Ngwenya links efforts at combating AIDS to poverty. The literature continues:

Our organisation is committed to assist in clearing the AIDS dark corners to eliminate the so-called HIV virus and we feel its time to get cracking, adopting a therapy to kill the cause that we have identified as a composition of emerging altered plus old viruses (mycotoxins) parasites, bacterium, oxidopathy, alcohol abuse, stresses, poverty, casual sex, pollutants, etc. These pathogens and environmental hazards take advantage of genetic, environmental and lifestyle influences (ibid.)

Here, Ngwenya widens his analysis to not only include biological and chemical warfare, but the larger socioeconomic context as well.

It is our recommendation that the cost effective therapy designed by JAMES MOBB be nationally recognised by government and made available to detoxify our nationals suffering from fungal infections especially ex-combatants, political detainees and ex-war zone peasants who were repeatedly subjected to contaminants in operational areas, rear bases, detention camps, Gonakudzingwa, Whawha, and other prisons through food contamination, clothing and other baits that has left most ex-combatants and detainees with high levels of fungal infections causing arthritis, diabetes, cancer, chronic fatigue syndrome, obesity, cardiovascular, severe mental disorders and other degenerative ailments on the Kinovsky AIDS Indicator Scale.

As we will see in a later chapter, Ngwenya's views that ex-combatants suffer disproportionately from certain ailments--including those that western-trained doctors might classify as AIDS--resonates well with many healers' views that suggest AIDS is an affliction that was brought from the "bush" by soldiers.

As genocidal programs continue in various high-tech styles in pursuit of population reduction, political supremacy, wealth and resource control, racial/ethnic even tribal domination or genetic hybridization the unleashing of viruses will continue depleting populations if deterrence is not imposed. With the current evolution of numerous small criminal states now holding BIOLOGICAL AGENTS the leadership should quickly investigate the detrimental use of Bio Agent before other lunatics release more deadly strains especially looking at the ever-changing world political climate.

Forecast of Interventions and Stigma, cost of therapies and deliberate contradicting misinformation campaign from the international AIDS cartel have squeezed the sick into hiding as AIDS is said to be a disease of homosexuals, promiscuous characters, drug peddlers/abusers and other useless natives forming the so-called 80% of the world unwanted luggage that should be cleared by microbes (REAGAN'S STAR WARS). It is the industrialised countries sentiments that the third world's illegal immigrants are invading their countries in horrifying numbers to an extent of using ships escaping POVERTY should be buffered by invisible

weapons. Our own Zimbabweans are said to be flooding London and now invading South Carolina, some of these governments are mourning of spending over a US \$1 BILLION annually fighting illegal immigration excluding the foreign sad they have directed to indirectly stop this ugly immigration.

Regardless of the jobless and street kids roaming our streets, we are convinced that there are better methods of population stabilisation than culling. The reality remains that as long as our people continue breeding at current rates the boys that control the International Monetary System will never forgive us as they categorically say 5% of third worlders are useful 15% sort of productive the rest are just populating the veld causing environmental degradation, cattle manure being of better value. We should remember their placement of game at higher priority than human at the past Harare Cites conference.

In this rambling manifesto, a number of points stand out that are particularly salient. First, there is a very clear linking of past and current disease episodes in the country to a group of powerful actors, the goal being “population reduction, political supremacy, wealth and resource control.” In the past, this powerful group of people comprised members of the minority white population as the black population struggled for independence. As Minister of Health and Child Welfare Timothy Stamps’ interview suggests, the use of biological agents was indeed a reality as the minority white population sought to maintain its control over, and access to, resources. Second, while Ngwenya situates past disease episodes in the context of the struggle for liberation and the efforts of a minority population to maintain control, he situates current disease episodes in a similar context; that is, the struggle over resources. He attributes the current effort to “cull” “useless” African and other Third World populations to an unnamed set of powerful actors--though he does name the International Monetary Fund. The third theme that wends its way through this manifesto is the belief that these powerful agents have little regard for African life, “cattle manure being of better value,”

and that wildlife is placed at a higher priority than African life (as witnessed at the past Harare CITES conference). Finally, there is the theme of migration, of the porous nature of nations' borders and, as a result, an attempt, particularly by the United States and Britain, to develop new ways of controlling in-migration of "unwanted" or "unproductive" populations.

Many of the theories mentioned above, despite their similarities or differences, share a common theme; that is, the role of powerful translocal agents in either the genesis, spread, or rhetorical use of AIDS as a way of either annihilating African populations or controlling African fertility. Rather than dismiss as "paranoid" such theories as to the rise of AIDS, we would do well to listen closely to the voices of local people as they attempt to make sense of a historically unprecedented disease. Such narratives must be seen as the individual and collective efforts by people to explain an unusual event at a particular historical moment (the arrival and spread of the disease), especially as it is linked to other historical moments (e.g. the rearrangement of local and global labor inequities under colonial and postcolonial regimes, the war for Independence, and structural adjustment policies).

Given the above constellation of variables, making sense of the devastating trajectory of HIV/AIDS in Zimbabwe clearly has gendered dimensions. That men, women, and children are affected by, and make sense of, HIV/AIDS differently has been only recently appreciated by chroniclers of the disease. How each of these groups experiences and makes sense of the disease reveals a great deal about their understandings not only of the disease, but of the socioeconomic factors which place

them at greater risk of contracting it. The gendered nuances of the disease are the subject of the next chapter.

¹ *How to Have Theory in an Epidemic: Cultural Chronicles of AIDS*, 1999.

² "Canada investigates South African germ warfare experts." *Herald*, April 13, 1990.

³ In an unprecedented move, Stamps was summoned to ZANU-PF's Central Committee meeting to brief members on his ministry's position on AIDS/HIV and what they were doing to alleviate the problem. He was also openly castigated for the general decline in the health delivery system of the country--shortages of drugs and food for patients in government hospitals, high user fees, etc.

⁴ "Stamps Marries a Minor." *Herald*. June 6, 1996.

⁵ "Nkomo confesses." *Horizon*, May 1996.

⁶ "USA accused of funding placebo-controlled AIDS trials." *The Lancet*, Vol. 349, Issue 906, 1997.

⁷ "Medical sweatshops: The third world is providing a cheap source of subjects for research into Aids and other conditions." Margaret Wertheim reports on the west's double standards *Guardian* (Oct. 5, 2000)

⁸ "Row over drug tests on poor that leave some to die." *Guardian* (May 4, 2000):1.17

⁹ "Bristol-Myers Warns of AIDS Drugs' Use." *Wall Street Journal* Jan 8, 2001.

¹⁰ The expression is used by people as a way of escaping the truth. It's another way of saying, "If this happens to me, it's because it's predestined."

CHAPTER SEVEN

Gendered Dimensions of AIDS in Zimbabwe

The starting point is not to see the epidemic in isolation of the overall problems in the health delivery system in Zimbabwe and the next issue is to realize that women are still inferior socially, culturally, and economically. Women are also more easily infected by the disease because of their physiology and infants can be infected by their mothers and get HIV before, during, and after birth.

-Helen Jackson

And, if women themselves cannot make sense of the epidemic, articulate its influence on their lives, and shape interventions that embody their interests and perspectives, historic precedence holds little promise that anyone else--whether scientists, physicians, policymakers, media professionals, or politicians--will do it for them.

-Paula Treichler

Wherever women are heard and respected, the face of God is revealed and illuminated.

-Jean Bertrand Aristide

Understanding and charting the nuanced gendered dimensions of HIV/AIDS has, regrettably, only been a recent phenomenon. Now, at least in Western nations, Roth and Hogan (1998) point out that images of women and HIV/AIDS appear in activist writings; in women's health books and testimony; in novels, poetry, and nonfiction; on television, in magazines, and in commercial films. With regard to development of public policy, testing of treatment protocols, and promulgation of preventions, they suggest that gender issues are receiving increased visibility. Despite these hard won victories, they argue,

nothing can explain the deeply entrenched historical silences and gendered distortions that characterized the first decade of the HIV pandemic--both of which serve as templates for ongoing HIV/AIDS prevention efforts targeted toward women and representations of women and HIV/AIDS (ibid.).

If, however, Western women are enjoying a new visibility with regard to HIV/AIDS, their African sisters' experience with the pandemic is still very much a silent and distorted one. All too often, structural violence is conflated with cultural difference in summing up the experiences of African women and the disease--usually resulting in a blame-the-victim mentality. This fact was not lost on an African delegate, Chatinkha Nkhoma, to the recent XIII International AIDS Conference in Durban, South Africa, who noted:

Instead presentations after presentations, Africans were blamed for their suffering. Criticized for dying, African women insulted, called prostitutes for being poor and selling their bodies to feed their children and millions of the orphans. So African women had to close their legs to stop AIDS.

We were told that Africans had bad sexual habits and unless we change our behaviors, our culture, our customs, until we stopped being Africans, we would continue to die. We were told that become sexual angels first to get help, but American and Europeans did not have to become sexual angels to contain AIDS and stop its killings, they were given access to treatment.

Nkhoma's comments draw attention back to the socioeconomic forces that put women at differential risk for infection. Importantly, Nkhoma also points to the stigmatizing effects of the disease and the unequal distribution of health care provision and treatment--refracted through a pathologizing view of black sexuality and the lesser value placed on African life.

African women, in particular, have suffered disproportionately from such depictions. Initial epidemiological investigations in Zimbabwe, for example, focused almost exclusively on prostitutes, or commercial sex workers (CSWs), as dangerous vectors of the disease--often to the exclusion of their male clients (see Civic and Wilson 1996; Huni 1995).¹ Such studies follow a particular trend, especially among epidemiologists, in the focus on urban African women commercial sex workers as “core transmitters” or as a “core risk” in the spread of HIV/AIDS (see Kreis et al. 1986; Mann et al. 1987; Piot et al. 1987). Also, the high rates of infection amongst some groups of women who sell sexual services--in Harare CSWs have an estimated infection rate of 86 percent--is erroneously interpreted to mean that without them, the disease would not be occurring. Ironically, it is these very women, having been infected by their male clients, who are experiencing the brunt of the epidemic. And unfortunately, because these clients have not been adequately identified or studied, we do not know the extent of HIV infection among this group of men (Bassett and Mhloyi 1991). So, while certainly prostitutes contribute to the spread of HIV, it would be irresponsible and ignoble to attribute blame exclusively to them for the propagation of the epidemic.

Another way in which African women and their experiences with HIV have been distorted is through a focus on women in their pregnant state. As mentioned in Chapter Four, sentinel surveillance information gathered from this group is utilized for charting the course and impact of the epidemic. From an epidemiological perspective, this is an important endeavor. An unforeseen side-effect, however, is that due to the shorter natural progression of the disease in children, a woman may be often identified as seropositive because of a sick child, before she herself shows signs of being ill. This reinforces the

notion that the mother is solely responsible for the child's serostatus. It means that women often are identified as contaminated vessels bearing condemned babies. (Bassett and Mhloyi 1991).

This chapter is an attempt to unravel the complex gender dynamics of HIV/AIDS in Zimbabwe. I argue here that an understanding of the spread and growth of the disease is inseparable from an understanding of local constructions of male and female sexuality and, indeed, that such constructions have been deeply influenced by historic and contemporary political economy. The apparent 'disordered domesticity' of contemporary Zimbabwe, which some journalists and researchers (see Chapter Two) conflate with unbounded sexual license and promiscuity, is part and parcel of a historically-structured 'economy of risk.' Moreover, if, as Scheper-Hughes (1992:221) reminds us, in modern, bureaucratic, and welfare states, the institutions of violence generally operate more covertly, such is not the case when we take a close look at institutions of violence and their relationship with women and children in Zimbabwe. Such institutionalized and systemic violence directed at women and children has particular consequences with regard to their level of risk of infection with HIV.

Women and Children at Risk

During the summer of 1995, I was stunned while listening to an HIV/AIDS counselor recount a session she had had with an HIV-positive man and his HIV-negative wife. The counselor detailed how, during the session, the husband begged his wife to understand why he had to wear a condom when they now engaged in sexual intercourse, as a way of protecting her from contracting the virus. The wife's reply was terse and

chilling: “I’m not a prostitute. You don’t need to use a condom with me.” Even today, I struggle with the logic of the wife’s answer. And while certainly the husband’s admonishment of his wife over condom use is perhaps unusual in Zimbabwe--where, research has shown, men typically do not condone condom use--her reply speaks to the very complex sorts of issues surrounding a political economy of sexual relations and risk for HIV infection amongst women. Indeed, casting an analytical eye on Zimbabwean women and children brings into sharp relief how confluent socioeconomic forces are embodied as risk for HIV/AIDS. What are the immediate and systemic causes of risk for Zimbabwean women and children?

While HIV/AIDS does not discriminate as to who it effects, there are a number of biological and socioeconomic factors that put women and children at particular risk of infection. For example, research indicates that the risk of HIV infection is 2-4 times higher for women than men during unprotected sexual intercourse because of the larger surface areas exposed to contact. In the same way, women are more vulnerable to other sexually transmitted diseases, the presence of which greatly enhances the risk of HIV infection. STDs that have symptoms in men are often asymptomatic in women and therefore remain untreated. Younger women are at an even greater risk because the physiological immaturity of their reproductive system provides less of a barrier to HIV infection. As seen in the age-gender distribution of AIDS in Zimbabwe, much HIV transmission is from older men to younger women. AIDS cases among men peaked in the 25-39 year age-group, while the age distribution for women peaked in the 15-29 age group.²

Younger women and girls not only have a more difficult time insisting on protective measures such as condoms in intergenerational relationships; they have difficulty resisting sexual overtures in the first place. One study found that half of reported rape cases at two referral hospitals in Matebeleland involved girls below 15 years of age. Community groups suggest that girls are vulnerable to sexual abuse by male relatives and school teachers. In families where such abuses occur, a woman's vulnerability and economic dependence on men often in the family may mean that a girl's mother is afraid to speak out against the perpetrator. Instead, the incident may be covered up or denied, and may only come to public attention if the child develops an STD or becomes pregnant, and requires medical attention (Njovana and Watts 1996). In some instances, younger women and girls work hard to conceal the pregnancy, wearing loose-fitting clothes, for example. Some may then go on to commit infanticide in an effort to cover-up the pregnancy in the first place. Within a two-month period in Harare in 1999, there were some 18 incidents of infanticide reported.³

Girls are victims of sexual predators in other ways as well. There is, for example, a widespread rumor in much of southern Africa that having sexual intercourse with an adolescent girl will miraculously 'cure' a man of HIV/AIDS, and such cases have been documented in Zimbabwe as well as South Africa. N'anga have been implicated in spreading this rumor (see, e.g., Chapter Fourteen).

With regard to sexual politics within marriage, wives may often find it difficult to refuse their husbands sexual intercourse without a condom, even when they suspect that their husbands engage in extramarital sexual intercourse, either with girlfriends or prostitutes. Early in the epidemic, this situation was made worse by the fact that many

women had little information about the disease. Elizabeth, a patient at the Centre, an AIDS education and support organization, explained: “Early on, the government didn’t tell us we could get it. It led us to believe it was a disease of homosexuals and IV drug-users...who would think you, as a faithful wife, could contract HIV from your husband?”

As Njovana and Watts (1996) point out, rape within marriage is not generally recognized, legally or otherwise in Zimbabwe. This means that legally a woman cannot refuse her husband’s demands for sex, regardless of her own inclinations. This leaves married women vulnerable to violence if they refuse sex and can result in even extreme assault being endured.⁴ In one much-publicized case, a man raped his wife’s sister. The raped sister refused to report the case, so the wife went and reported it to the police, after first confronting her own husband who did not take any action. When the rapist-husband was arrested, the whistle-blower’s in-laws came to her house in one of the high-density suburbs of Harare. They beat her up and chased her away from the house she was staying in with her sister, stating that “our son (her husband) cannot continue to live with an enemy like you.” Rather than going to the police, the in-laws felt that she should have brought it to the family’s elders to deal with first.⁵ Similar cases occur in other families but they go unreported because families decide to deal with them themselves. Tsitsi Matekaire of the Women Action group said that “this creates problems because the cases are usually not adequately redressed, especially for the victim.”⁶

The very real threat of violence flies in the face of the rhetoric of ‘empowerment’ as espoused by some U.S. and European-based feminists, particularly where such rhetoric does not take into account structural violence directed at women. Early in the epidemic, for example, Elizabeth Reid, consultant for the Australian Department of Community

Services and Health, Canberra, called for an acknowledgment of women's "socialized passivity," particularly in developing societies. Pointing out the many problems that make women especially vulnerable to HIV infection and the crucial role of women's organizations in educating communities and households about AIDS and in fighting rape and alcoholism in men, Reid argued that one positive outcome of the global epidemic may be that women are required "to take a more active role in social and interpersonal relations...To survive uninfected, particularly from sexual or intravenous transmission, women must learn not only to be assertive but to choose or create relationships based on mutual concern and respect. This in itself should lead to an improvement in the quality of their relationships" (1988:21). Such initiatives are taking place in Zimbabwe as well. According to Lynde Francis, board member of the Women and AIDS Support Network (and director of The Centre, an HIV/AIDS support organization):

It's very difficult. What we're basically doing -- I work with Women and AIDS Support Network, I'm on their board -- is training women in affirmative action and advocacy, teaching them to be more aware, teaching them about their bodies, about sexuality, teaching them about their rights and hopefully getting them in a group where they can sustain and support each other with dealing with the problems that they have. Trying to make women more affirmative, more aggressive, so that they go back to the home and say, "Okay. No condom, no sex."

However, when I asked her what the consequence of such a stance would be, Lynde answered frankly and matter-of-factly: "Very often a fist in the face."

The theme of violence against women suffuses, in varying degrees, Zimbabwean society.⁷ A couple of characters, for example, in Zimbabwean author Charles Mungoshi's recent work *Walking Still* (1997:18) lament:

“Chizema’s children beat up their own mother,” VaMangai said. “This is one beating that I would forgive any child. Maybe this is one beating that the father hadn’t given the mother. It’s the one thing she wasn’t getting from her husband. Of course, the children had to pay her for beating her up. Paying her for doing to her what their own father should have done to her years before they were born.”

“Women,” VaJumo said, shaking his head. “Because the woman is a daughter-in-law, a stranger in the family, she must be beaten to tame her.”

This idea that a woman needs to be beaten to “tame” her has been challenged by other organizations as well, most notably the Musasa Project. Founded in 1989, the project is a non-governmental organization set up to offer refuge and counseling to abused women and their children. The name “Musasa” was chosen to embody the shade and shelter offered by the tree for which it is named after. Since its opening, the shelter has provided refuge for more than 300 women. The first of its kind in the country, the shelter offers a place of safety where women are free to consider their options with the help of trained counselors and legal advisers. It provides free counseling to women who suffer from domestic violence and children who have been sexually assaulted. Importantly, too, it seeks to educate the rest of society about the plight of abused and battered women.

A recent study⁸ of violence against women in Southern Africa reveals the senseless nature of much of this activity:

Reasons Given in Court by Accused as Justification for Murdering their Wives

- E. Chidzingwa was beaten to death by her husband with utensils for not having his sadza ready when he wanted it.
- C. Dube was beaten to death by her husband because he wanted to know where she was getting the food they were eating.

- J. Phiri was assaulted and her head crushed against a wall for arriving home late after having her hair done.
- I. Muzinga was struck with an iron bar over a missing pot.
- G. Nyere was assaulted to death with a piece of wood by her husband because she went to the rural areas without his permission.
- A. Manpindu was struck with a machete for refusing to allow her husband and his girlfriend, who had returned from a beer garden, to sleep in the marital bed.
- C. Chinamasa was stabbed to death by her husband after he accused her of seeing other men.
- R. Kashiri committed suicide after enduring severe violence for many years. Her husband assaulted her regularly after she had given birth to six daughters and no sons.

Such forms of domestic violence some women face are made worse by the possibility of HIV infection from an abusive husband or partner. Many such women find themselves involved in a cruel calculus: faced with divorce or dire poverty on the one hand and the risk of HIV infection on the other, the choice becomes one of “social death” or biological death (Bassett and Mholyi 1991). If a woman asks her male partner or husband to wear a condom, he may assume that *she* is involved in multiple sexual unions--or even a prostitute--and that her request for condom use is her attempt to protect *him* from infection. In such scenarios, silence is usually the only acceptable response. Often, women end up policing themselves, for assertiveness is not always a neutral strategy for self-preservation, but may instead constitute a source of material risk.

Additionally, much more emphasis is placed on male sexual pleasure than female sexual pleasure. Widely utilized herbs and other agents are believed to help facilitate such pleasure. A study of 212 women, selected from health care facilities in Harare, found that more than 90 percent admitted using various herbs and substances with the

belief that such substances would contract, dry, or increase the temperature of the vagina during coitus. Secondary consequences of use were thought to be an increase in male sexual experience (and in the females themselves to a lesser degree) and, importantly, strengthening of the marital and sexual bonds and maintenance of good health (Ruganga 1992). In another study of women health clinic attendees (HCAs) and nurses, 93 percent of HCAs and 80 percent of nurses reported using a variety of herbal and non-herbal agents before sexual intercourse. Many women reported using more than one herb: 18 HCAs used a total of 13 herbs and 6 nurses used 11 herbs. Forty percent of HCAs and 75 percent of the nurses used non-herbal agents, the most common non-herbal agent being cold water. Those women who used other agents often used a variety: the most commonly mentioned were Dettol in water, tissue paper, dry cloth, salt in water, and betadine antiseptic solution. Nurses also reported using pessaries and gauze (Runganga, Pitts, and McMaster 1992). Likewise, Wilson et al. (1993) found that 80 percent of the commercial sex workers studied recently used herbal agents to enhance male sexual arousal during intercourse. Very often, such agents are procured through n'anga.

A woman's ability to provide sexual intercourse for her husband is often viewed as a singularly important function in the marital relationship, and this has devastating consequences if the man is HIV-positive. I remember talking with a friend's wife, Conciliate, who works at Parirenyatwa Hospital in their prosthetics department. She spoke of AIDS and married couples and the tremendous social complexity it brings with it. "There is much shame attached to it...people will not admit they have it," she explained. "A man may suspect [or have already found out] he has it and start staying away from home and suddenly stop sleeping with his wife. And she will feel she did

something wrong. She will go to his relatives and tell them what's happening, and they will talk to him and convince him to come home. Then, he'll sleep with his wife, and she will be infected [and often accuse her of adultery and infecting him]. A man we know just died last year and now his wife is sick. They have a small child." Thus, even though considered the "weakest link" in the chain of HIV transmission, a woman still gets the blame.

The quotidian forms of physical violence many women have to live with find expression within a larger matrix of systemic societal violence directed at women. From a legal perspective, to cite one of many examples, under customary law women are not allowed to sue, are subordinated to the male head of household, and are not entitled to inheritance; they are considered juveniles and only men can inherit from a father. One effect of customary law is the perception that women are indeed juveniles or minors who should be treated as children--especially with regard to corporal punishment. Police, for example, will often dismiss wife battering as a "domestic affair," unless extreme (much as they still do in the United States). Likewise, wife-beating is not treated with the same seriousness by the courts as other forms of assault.

In June of 1999, women activists and their supporters marched through the streets of Harare, presenting a petition to the Supreme Court, and lobbied with Parliamentarians to ensure that the new constitution (being written at the time) enshrined gender equality without loopholes. The march was triggered by a Supreme Court ruling on Venia Magaya, 52, the eldest child of her father's senior wife, who was appointed heir to her father's estate by a community court.⁹ A younger half-brother, son of the junior wife, appealed in the magistrate's courts and won solely because he was a man. He

subsequently kicked Magaya out of the house in the high-density area of Mabvuku where she had nursed her parents until their death. She appealed to the Supreme Court which upheld the lower court's ruling in favor of the half-brother, arguing that under customary law, she was not entitled to her father's property; that the Legal Age of Majority Act (LAMA)--which declared both male and females majors at the age of 18--of 1982 did not apply to customary law, and that the constitution allows discrimination against women because it is "in the nature of African society."¹⁰ Adding insult to injury, the Supreme Court reversed previous judgments that upheld LAMA over customary law. Commenting on the ruling, sociologist Rudo Gaidzanwa said, "The Magaya ruling gives patriarchs, who are also not democrats, the ability to bring back terror into the conduct of everyday life in the families."¹¹

Customary law and its articulation with "African culture" is often used as a weapon against women, furthering the "everyday terror" of which Gaidzanwa speaks. "How can we overcome our culture, our tradition?" an HIV-positive woman, Rumi, asked me one day outside of the Centre. She continued:

My father was a good Christian...he loved God...he loved Jesus. He went to church every Sunday. When he knew he was going down [dying], he made a list of things he wanted and gave it to my mother. He wanted a Christian funeral. But, when he died, his brothers stepped in and said, 'None of this Christian stuff' and insisted on having a traditional funeral despite my father's written wishes. They said that his Christianity ended when he died. So, when I say it's difficult to overcome our traditional culture, you see."

As a woman--considered a minor under customary law--Rumi's mother had little, if any, power in fulfilling the wishes of her deceased husband.

Indeed, the Legal Age of Majority Act itself has been under fire by some traditional leaders. Chiefs and community leaders attending a one-day promotion of responsibility among youth conference just outside of Masvingo stated that the Act should be done away with so that parents might be able to chastise their children and thus help reduce promiscuity among the youth. They argued that the Act effectively nullifies their ability to properly discipline their elder adolescent children without recourse from the courts. Without such disciplinary measures in place--now discarded "traditional" practices such as corporal punishment--children were more likely to engage in promiscuous behavior, thus increasing the incidence of HIV/AIDS, the leaders argued. Of course, it is not only traditional leaders who blame youth for the spread of HIV/AIDS. Dr. Justin Maeda, UNICEF representative to Zimbabwe, spoke of the factors inhibiting children's development in Zimbabwe. He spoke of the severe economic deterioration of the country which compromised the proper development of children. He went on to say: "Another big problem [is] that of the HIV/AIDS pandemic which seems to be on the increase due to the *negative social behavior among the youths as evidenced by the high rates of teenage pregnancy and early sexual activities* (italics added)." Pointing a finger at the perceived negative social behavior of youth does little to retard or explain the progressive march of AIDS through the country and its impact on youth, however.

In fact, such finger-pointing diverts attention away from the real impacts, and root causes, of the disease on youth. In Harare, HIV-related infection was the number one cause of death of one to four year-olds and the second largest cause of deaths in infants aged one month to 11 months in 1991 and 1992.¹² Apart from the devastating reality of mother-to-child transmission, there is the equally devastating reality of hundreds of

thousands being orphaned as their parents succumb to the disease. In 2000, Zimbabwe was estimated to have some 600,000 so-called “AIDS orphans,” resulting very often in what the Zimbabwean press has dubbed “child-headed families.” Walking through downtown Harare’s bustling streets, it is impossible not to notice the huge throngs of young and adolescent children either laying in doorways, begging for money, or engaging in some other form of income generation such as watching parked cars. In one instance, one of these orphaned youths was burned to death by another youth after fighting over a place to sleep--a niche in the underground world of the city’s drains.

Many Harare residents will tell you that these “street children” are a nuisance and a blemish on their Sunshine City. Residents and visitors alike complain of being accosted by blank-eyed children begging for money. Motorists say they are harassed by youths who “own” parking bays and want them to park and have their cars guarded for a fee. And most annoying to residents in some of the low-density suburbs is the increasing appearance in the prim and proper shopping centers in some outlying suburbs. Ironically, it is these “annoying urchins,” having lost their parents to AIDS, who are also becoming victims of the disease as they are preyed upon by older infected men (many of whom are looking for younger, allegedly uninfected, girls), and sometimes women.

Steps have been taken to aid this vastly growing population. In the high-density suburb of Highfield, for example, the Child Protection Society has begun to encourage foster parenting. A number of women have come forward to be trained as foster parents to take charge of orphans. Such coordinated effort is, however, few and far between as yet.

Blame, stigmatization, discrimination, isolation, and domestic violence are disproportionately placed on the shoulders of women/wives and children as the above examples intimate. In the context of HIV/AIDS, this same process begins with a woman's/wife's pregnancy where, medically, it is necessary to test the mother to see if the baby may be HIV-positive.¹³ In such a scenario, it is likely that the wife's status will be known before the husband's, meaning that wives are more likely to be rejected by their husbands if they disclose their positive status. As locally-based AIDS researcher Helen Jackson points out: "There are cases of women being blamed by the extended family for deaths of children and their husbands. Women who may choose not to have children because they are HIV-positive may face pressure from society and family to have children and they also face pressure on the deaths of their husbands to be inherited by their husbands' brothers in the African culture (*kugara nhaka*)."¹⁴

Knowing her HIV-positive status can help a woman determine whether to go ahead with a pregnancy or to terminate it. Legally, the positive status of a mother falls within the ambit of conditions, or grounds, through which a termination of pregnancy can be carried out under the Termination of Pregnancy Act. The Act, however, does not expressly, in clear language, state HIV-positive status to be grounds for termination. Also, the fact that a woman can use her positive status as grounds for termination is not widely publicized or known. This problem is only exacerbated by the fact that the vast majority of women do not know their status due to limited access to health care facilities and the fact that the Mashonaland AIDS Counselling Centre is the only voluntary counseling and testing institution in Zimbabwe.¹⁵

Even when women visit such counseling centers and medical facilities in search of care and information, they are sometimes faced with stigmatization and inadequate care. Such treatment only increases the likelihood that they will not return, or further utilize, such facilities. The comments of 'Bongi,' an HIV-positive Matebele woman are characteristic of such encounters:

About six months after my second results, I went to see my family doctor, Dr. Z. I asked him to do an HIV test for me. He wasn't too keen on the idea, but he did it anyway. I didn't tell him I'd already asked Dr. X to do it. A week later, I went for the results. I collected my card as required then went through to Dr. Z's consultation room. It was then that I saw it, written just below my name was 'Sero-positive.' I was shocked. By the time Dr. Z walked in I was fuming. "What is this?" I asked him. "And why is it written on my card for everyone to see? Don't you see you have violated my rights. I walked out of his office in a daze. Seeing 'Sero-positive' on my card had shaken me. I was sure those girls in the cards room would talk. That meant the whole town would know within months. I dreaded going back to Dr. Z's.¹⁶

Particularly devastating and insidious is the economic impact of AIDS on the lives of women when it strikes a family member. A study of 21 female care givers, between the ages of 20-40, in the high-density residential area known as Mbare demonstrated that 52 percent of the care givers supported their families through informal trading, 24 percent were dependent on their spouses, 12 percent were dependent on income from their lodgers, and another 12 percent were formally employed. Generally, the productive and reproductive age group was burdened with care of patients and 75 percent were not aware from what their patients were suffering. The most common problems that the care givers identified were: lack of adequate financial resources, school fees, enough proper food for the patients and a lack of drugs. Another study (Matenga

1996) which estimated the cost of health care--including consultation with doctors, hospital admissions, drugs, laboratory tests, and X-rays--in the last 12 months of life of an AIDS patient, found that the average expenditure per patient was Z\$8,017. The current national health budget only provides Z\$30 expenditure per head.

A woman may also have reduced ability to be a provider for the family if she needs to spend a significant portion of her time caring for family members who are sick with AIDS. It invariably reduces the time she has for household tasks and other productive work and affects the amount of time she can spend caring for children and other family members, not to mention the time she needs to take care of herself. In this way, HIV/AIDS places a tremendous extra burden on women and girl children, yet there are few resources, training opportunities or support systems available to help (NACP 1998). In many cases, women do not have a secure occupation that can provide a steady and adequate income and may not even have rights of inheritance. Thus, if the husband dies, the surviving wife and children can be particularly vulnerable and subject to exploitation.



A 1985-86 survey, for example, found a greater recourse to prostitution among female-headed households, usually as a way of supplementing meager informal sector incomes from sale of food, clothes and mats during periods of diminished income.¹⁷ Rural female single heads of household are often the poorest of the poor and depend on children to become wage earners.¹⁸

Prostitution within Zimbabwe, as well as other parts of Africa, is ill-defined and understood. The exchange of sex for money or for other goods and services includes a variable range of transactions, many of which are not socially defined as prostitution. While some women may sell a single sexual encounter, others sell ongoing sexual and domestic services, ranging from sporadic arrangements to live-in partnerships. Women who live apart or are divorced from their husbands may supplement their low incomes with gifts from male friends. Youstine, a young woman in-between jobs who lives in the medium-density suburb of Cranbourne, exchanges sex for gifts from some of her male friends. One of these male friends complained to me that “she only comes around when she wants something.” This particular male friend had just lost his job and still, when she came to his flat, he gave her Z200 to get her hair done at a local shop. Would Youstine consider herself a prostitute? I doubt it, though I never asked her. She would, I think, see herself as having a number of male friends who give her gifts--and her remuneration for such gifts is the only thing she has to give away freely, sex. Moreover, with few prospects for other employment--Harare's unemployment rate hovers around 50 percent--“gifting” from male friends is a means of survival. Schoepf (1993:57) notes:

Women, who often lack access to cash, credit, land or jobs, engage in “off-the-books” activities in the informal sector. Some exchange sex for

the means of subsistence. Others enter sex work at the behest of their families, to obtain cash to purchase land or building materials, to pay a brother's school fees, or to settle a debt. Still others supplement meager income with occasional resort to sex with multiple partners. [Whether these women are] married or not, the deepening economic crisis propels many to seek 'spare tires' or "shock absorbers" to make ends meet."

Even women who hold full-time jobs, as mentioned above, may engage in sex work to make ends meet. This can be particularly true for domestic workers, often referred to as "Tsitsi" or "sister" in Shona, who usually make the paltry sum of around Z500 per month.¹⁹ Some of these domestics enter into sexual relationships with men--usually husbands--in the households in which they work, often against their will. When this happens, as a recent article points out, it is often the wife who is blamed by all for the turn in her marriage because "she was not a woman anymore."²⁰ Blame is shifted back and forth between the wife and the domestic worker, but the husband is usually not blamed.²¹ Women police other women.

In 1999, full-time commercial sex workers in Zimbabwe began to organize themselves, seeking legalization of prostitution before the turning of the century in 2000. Under the current Sexual Offences Bill, sex workers convicted of prostitution are fined Z10,000 or two years imprisonment or both. Those who knowingly spread HIV can face a 20 year jail sentence. Women's rights activist, Rudo Kwaramba of the Musasa Project, in a 1999 interview likened criminalizing commercial sex to treating only the symptoms of the disease. "I would urge government to desist from resolving to passing laws as solutions to some of the country's socio-economic problems. Some of these so-called prostitutes are on the street because they cannot find alternative employment."²² Others take a different view on the legalization of prostitution. Zimrights executive director,

David Chimhini, has argued that legalizing the trade will increase the spread of HIV, as people tend to be careless when under the influence of alcohol.

Meanwhile, the International Labor Organization warns of an increasing number of women resorting to prostitution due to severe economic hardships. "Our message is prostitution is an economic sector activity like any other sector," wrote editor Dr. Lim Li. While there are no statistics on the economic strength of Zimbabwe's sex industry, commercial sex is very much alive and thriving within the country. The trade is so lucrative that some women who are formally employed work as prostitutes after hours to supplement their salaries. More to the point, an overly-narrow focus on prostitution as an "economic sector" that should be legalized as any other or as a primary vector in the spread of HIV conceals more than it reveals about the nature of HIV; that is, the trajectory of HIV is very much influenced by the trajectory of the economy and the subordinate status of women.

The above examples challenge pat explanations which place the burden of the transmission of AIDS in Zimbabwe squarely on the shoulders of women--and, in particular, prostitutes. Procedural guidelines for sentinel surveillance--which identify HIV antibodies in pregnant women--automatically mean that a pregnant woman's sero-status will be known before that of her partner or husband. This procedural measure contributes to women being blamed for the spread of HIV and, moreover, may contribute to their further victimization at the hands of husbands, partners, and extended family who often blame the woman for the infection. Blame, stigmatization, victimization--this is the lot of many HIV-infected women in Zimbabwe. So while, for example, a research focus on commercial sex workers and their social networks is an important step in

understanding the spread of HIV-infection in Zimbabwe which may ultimately lead to behavior change, such research also deflects attention away from the real causes of the AIDS pandemic within the country: joblessness, poverty, and sexism. In other words, structural violence.

“A Bull is Known by His Scars”: Men, Sex, and The Reproduction of Disease

There is an old Shona proverb that says, “A bull is known by his scars.”

Contemporaneously, this refers to the idea that a man isn’t really thought to be a man until he has had sexual relations with a number of women, one side-effect of which may be a series of sexually transmitted diseases (scars). In other words, STDs may be seen by some men as a rite of passage into manhood, and there is usually little stigma attached to male sexually-transmitted infection. This particular construction of masculinity in Zimbabwe can have potentially devastating effects since STDs not only indicate where AIDS may be spread, but they are also very often a cofactor for HIV infection.

Presently, STDs are very common in Zimbabwe. In 1997, more than 800,000 cases of STDs were reported countrywide (NACP 1998). With an estimated population of almost 12 million (and assuming one case per person), this means almost 20 percent of the adult population has been treated for STDs--approximately reflecting the number of HIV sero-positive individuals. STDs among men are often proof of sexual activity, coterminous with “being a man.” Consistent with both data and belief, a study on HIV infection among male factory workers found that a history of prior STD was common among both seropositive and seronegative men: 100 and 75 percent, respectively (Bassett, et al 1990). Other risk factors, now documented in numerous studies of AIDS

in Africa, were also common in the HIV-positive group, e.g., multiple partners, a history of payment for sex. What was unexpected was the high prevalence of high-risk activities among the seronegative men: 40 percent reported an STD in the previous year, and the majority (67 percent) had paid money for sex. Sero-positive men were more likely than sero-negative men to report a history of genital ulcer (*ibid.*). In light of these data, it's difficult to characterize the sero-negative comparison group as "low risk."

In another study (Mupanbieyi 1996) regarding the socioeconomic factors associated with high risk sexual behavior among males in Harare and Buhera, high levels of promiscuity were noted among both populations. Almost 76 percent of the respondents reported losing a friend, a relative, or neighbor through AIDS-related mortality. Alcohol consumption, spousal separation, place of residence and home ownership were all found to be related to promiscuity. For example, 66 percent of those who consumed alcohol showed a higher tendency to be promiscuous. Non-home ownership was found to be positively related to high-risk sexual behavior ($OR=1.758$). Harare-based males were 1.8 times more promiscuous than those in Buhera. There was a higher prevalence of STDs among divorced men than in either married or single men. Those who resided with their spouses were less promiscuous (25 percent) than those who did not (37 percent). Males in the 55-59 year age group had the highest percentage of lifetime promiscuity. The 25-29 year age group had the highest (54.9 percent) measure of current promiscuity.

Researchers for some time now have pointed to the role of concurrent infection with STDs in enhancing the risk of heterosexual transmission of AIDS in Africa (Latif, et al 1989; Cameron, D., et al 1989; Kreiss, J., et al 1986). Of particular concern is

chancroid, an STD common in Africa but not in the United States or Europe. In Zimbabwe, about half of all genital ulcers is due to chancroid. The central role of such ulcers in HIV transmission is biologically plausible, since disruption of the mucosal barrier and the presence of HIV-infected white blood cells would explain the increased likelihood of infection. In a Harare clinic, where HIV referral patients have been attending for years, clinic staff found that among those couples in which the male partner was the index case, a history of genital ulcers was three time more likely among men in couples where HIV infection was concordant rather than discordant (Latif, et al, 1989).

There are possibilities and perils to such a narrow research focus on genital ulcer disease. While it certainly demarcates an area for targeted intervention programs, it nevertheless shifts concern away from the broader social context in which STDs occur to more narrowly medical concerns. It could be argued that interventions that result in reduced rates of STDs will also mean a lessening of HIV transmission. Importantly, however, such a focus is tantamount to placing a Band-Aid on the real problem. To reduce the problem of HIV transmission to the problem of controlling genital ulcers is to search for a “technological fix” that fails to address the social factors that jointly underlie both problems (Bassett and Mhloyi 1991).

So, it is within the context of high rates of STDs that we see AIDS transmission occur, and it is usually the male partner who introduces HIV into the family unit. Clinics throughout Harare typically ask that married patients to bring their spouses and about half eventually appear for screening. The main reason other partners do not come is that they live in another, usually rural, area. Among the initial 75 couples at one clinic (Bassett and Mhloyi 1991), reported risk factors were more prevalent among men than women,

who universally denied having multiple partners. Only in two cases was the wife sero-positive and the husband sero-negative, in both cases the wife having an identifiable risk factor--blood transfusion, first marriage to a partner who died of an AIDS-like illness. The low number of female-positive/male-negative couples supports the hypothesis that wives are most often placed at risk by their husbands, lending more credence to the idea that women are the “weakest link” in transmission. And because women are more likely to use health services before men, referral patterns seem unlikely to explain the small number of women as the index cases.

As with women who attend hospitals and clinics, men attending these facilities are very sensitive to the type of treatment they receive. Confidentiality, intertwined with preserving a sense of dignity and protecting oneself from humiliation, are typical concerns. Gordon (1991:9), for example, shares the story of “Conrad,” an HIV-positive Harare-based man and his anxiety over visiting a clinic. Reminiscent of my earlier discussion of the gardener, Alex, and his experiences with a clinic, Conrad described standing in the waiting room of a clinic in which people lined up for various health problems. Conrad had hidden his real affliction to avoid embarrassment, thereby jeopardizing his own appropriate care. Confidentiality is also threatened by “treatment cards” on which employees are required to have their doctors write a diagnosis only to then be returned to the patient’s employer. Fearing harassment at work, Conrad felt compelled to erase the diagnosis on his card.

Discussions of sex and sexuality (and, by extension, AIDS) are plentiful in Harare’s many bars and beerhalls, where alcohol often loosens a man’s tongue (and often his libido) and brings out his need to brag about his conquests. As I sat with friends in

one of three bars at the George Hotel one evening , it didn't take long for one of them to engage in such banter. Dete, a 30-something hospital technician, began commenting on how busy he was with his job, his wife and children--and his multiple girlfriends ("too many to count"). And he liked his girlfriends young. "I like professional women," he began. "And under 20 years old."

"How can she be under 20 AND a professional?" I asked sarcastically.

Celestine, a doctor at Parirenyatwa Hospital, waved his hand around the room, indicating the numerous women chatting with men at the bar, and said, "But, they're all *professionals*."²³

"No," Dete responded. "I mean a woman who is about something. One that doesn't wake up with a hang-over wondering where her next beer is coming from and using this thing [at which point he grabbed his crotch] to buy one."

"And how many condoms do you use?" asked Celestine with a devious smile.

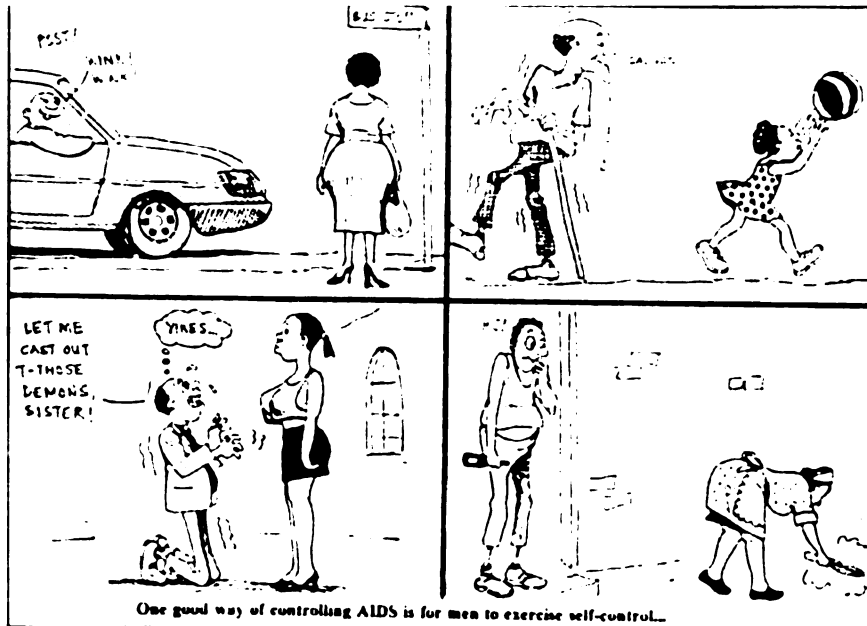
For a split second, Dete acted as if he didn't understand the question. "At most one!" he chuckled finally.

"Because I don't want to have to go to Marondera [where Dete was from originally] crying."

Less Celestine get too self-righteous, Dete leaned closely into Celestine to tease him about his own alleged infidelity. Dete mentioned a woman Celestine had been attracted to and whom he had invited to his flat for coffee. Celestine protested saying that he thought she could get him a good deal on the latest model of a Nokia cellphone. Celestine pointed out that she already had a boyfriend anyway, a pilot from whom she would be getting the phone.

“And where was your wife when this girl came over for coffee? Was she home?” asked Dete grinning.

“She was next door,” Celestine explained sounding defensive. “I did not sleep with that girl!”



Alas, keeping mistresses is not uncommon, particularly with wealthy men. “This is not a new phenomenon at all,” said broadcaster Jabulani Mangena in a recent interview.²⁴ “Polygamous marriages date back to time immemorial. Our forefathers had many wives. The only difference now is that the marriage laws prohibit these marriages, resulting in people getting into them secretly. Look, there are many issues at play here. On the one hand, men naturally have this inherent ‘macho’ love for conquest. They believe one way of achieving this is to have many women under their control. On the other hand, love relationships that precede marriages are likely to continue after marriage

if one marries someone else.”²⁵ No man wants to be approached by his friends with the phrase *akadyiswa* which literally refers to the act of being fed by your wife. It is a common belief that protective wives will feed their husbands *muti* that prevents them from cheating. And if a husband is seen by society always with his wife, his friends are likely to say *akadyiswa* as a way of letting him know his wife seems to be in control of the relationship. In other words, the statement is a good-natured affront to a husband’s manhood--the bull’s scars fading, so to speak.

In addition to public pronouncements of sexual conquest, some men will share accounts (albeit edited ones) of their sexual practices in private as well. Concerned that my friend, Precious, was engaging in unprotected sexual intercourse with commercial sex workers, I asked him about his ‘girlfriends.’ I told him I was concerned about his health. He told me he protected himself when he had sexual intercourse.

“I wear two condoms, Diva. Trust me,” he said. “You know Barbara [one of his girlfriends] has asked me why I wear them. ‘Don’t you trust me?’ she asked me. She said I should get her pregnant and that the child would bond us together.” Barbara already had two children, each with different fathers. According to Precious, Barbara used her friendships with various men as means of supplementing her income--she worked as a receptionist for a meat-processing factory, often providing Precious with discounted cuts of meat. Precious said that her mother also earned money in the same way and had probably introduced Barbara to it at an early age, either directly or indirectly.

“Even Youstine [another girlfriend] asked me not to use condoms, asking me didn’t I trust her,” he continued. “You know, Diva, I asked both of them if they asked all

their boyfriends not to use condoms, and they said 'yes.' Barbara said she would know if he [one of her boyfriends] was sick by looking at him. I asked her if she knew if her boyfriends were faithful [monogamous] and she said she 'trusted' them."

Precious' comments seem, at the very least, to suggest his girlfriends are not particularly interested in protecting themselves from HIV infection, especially with boyfriends that they 'trust.' But what did trust mean in such instances of non-monogamous relationships? Both Precious and his girlfriends knew that each was involved in multiple sexual relationships. Was it simply a matter of trusting that the other would not have an unprotected sexual relationship with someone who appeared obviously ill? What did trust mean in such a context? In an interesting inversion, it is his girlfriends who ask him not to wear a condom because he should trust THEM. It is impossible, of course, to completely unpack the meanings undergirding Precious' explanation. One glaring message, or rationale, at least for Precious, is that women he has sexual intercourse with are not interested in his wearing condoms.

Precious' pursuit of girlfriends was very much fueled by a recent break-up with his long-standing girlfriend, Patricia, who stayed in the Eastern Highlands of Mutare. He said she had been cheating on him. Moreover, she had a baby girl who was now about a year old.

"Is she yours?" I asked one day.

"I don't know," he said shrugging his shoulders. "Everyone says she looks like me--big ears, big head. My name is the only word she can say. Every time I go to Mutare, she sticks her fingers in my mouth and says, 'Precious.' You should see me, man. I cry when she does that."

He speculated on whether or not he should visit a n'anga, one he didn't know, to discern if the baby was his. "Then I might go and have a blood test at the hospital," he said finally. He, with the aid of his younger brother, had already studied the baby's palms and both decided that the baby had his palms [I had suggested he look at her palms after an older man I met at the George Hotel's outdoor bar suggested it, saying that's how they used to tell in the past]. "Ah, sha [short for *shamwari*, or friend in chiShona], the baby's palms don't even look like Patricia's."

Precious said he still really cared for Patricia and that when he speaks to her he feels "happy and free." Prior to her cheating on him, he felt she was the woman for him. I asked, given the obvious depth of his feelings for her, if he could find it in his heart to forgive her, to allow her back into his life.

"I've already forgiven her," he said. "But forgiveness aside, I could not take her back."

"Why not?! She obviously still cares for you [he had mentioned earlier that she calls him every day and takes the baby to his mother's home, also in Mutare, everyday to visit]."

"We Africans, David, we have our traditional beliefs," he said dismissing the thought. "A man cannot take back a woman who has cheated on him...I would be a laughing stock. I would lose the respect of everyone, especially my mother."

We continued talking late into the evening. His younger brother, Lewis, who he was sharing a flat with, prepared dinner, first frying a fillet of fish, then skinning and cutting up potatoes and tomatoes for a stew. He then put on some white rice. As he

prepared the food on the small electric two-eye stove behind my rattan chair, he also chimed into the conversation occasionally.

Precious talked generally about his loneliness--not having a permanent girlfriend whom he really cared for and who cared for him. There was a girl who worked in the local video store he liked, "but she doesn't take me seriously," he concluded. "I think she's the type who has many boyfriends...but we're still friends. She gave me \$Z1,000 earlier this week to get my car repaired [he had swerved to avoid one of the city's ubiquitous potholes and ran into a tree that crushed the left front end of the car]. I take it for polishing next week."

Precious had just recently lost his job and, as the eldest son in his family, he felt a great responsibility for helping support his family. His younger brother, who was living with him, felt compelled to find work to help make ends meet, even though this interfered with his schooling. This fact further added to the pressures Precious felt. Against such feelings of despair, I wondered if Precious might be more likely to engage in casual unprotected sexual intercourse as a form of escape; or perhaps, given his difficult situation, a form of benign suicide. His brothers and mother were very concerned about his well-being and constantly asked me to talk to him, to help him, to see if I could find him a job.

Though not as obviously sexually predatory as Dete, of whom I spoke earlier, Precious would seem to fit into that category of men who uses sexual intercourse as a way of emphasizing their manhood--a manhood that has become increasingly tenuous in Zimbabwe's harsh economic climate. If 'being a man' is contingent on one's ability to have sexual relations with many women--which usually takes some capital input in the

form of money or gifts--then, the ability to be a man is becoming increasingly compromised as the economic outlook of many men continues to deteriorate. Alternately, I suppose, the need for being, and especially appearing, as a man, becomes greater when access to capital is diminished. In other words, if a man is feeling emasculated in his professional life--either because of a loss of a job, unemployment or underemployment, wage freezes, etc.,--he may feel the need to make up for these feelings of unmanliness in other ways. This seemed to be the case with Precious. Consistent with some of the other major risk factors for STDs--and hence, HIV--Precious was in the age range men considered to be the most promiscuous (ages 25-29), was unmarried, a non-home owner, and Harare-based. One noticeable risk factor Precious did not have was alcohol consumption--Precious did not drink alcohol.

In many ways, Precious is both the exemplar and the exception to the many men who either place themselves--or are placed through circumstance--at greater risk for HIV infection. It would be easy to see him as sexually irresponsible, engaging in admittedly risky behavior by having multiple partners--partners who allegedly insist he not wear a condom. It would be easy to see him as the emissary for the spread of a deadly disease. But this would only be a partially correct reading of Precious and his behavior. Seen within a greater context of economic malaise and suffering--joblessness, limited possibilities for employment, high rates of inflation, despair over feeling responsible for caring for family, etc.,--his behavior, while still careless perhaps, takes on a certain intelligibility. That is to say, within the context of poverty, joblessness, and limited access to resources, Precious' apparent sexual promiscuity and recklessness begin to make a certain amount of sense.

So far, Precious has managed to avoid contracting HIV, though he has many friends and family who are infected or have succumbed to the disease. It is the narratives of people living with HIV/AIDS that are the topic of the next chapter.

¹ There are some notable current exceptions to this lack of focus on the male clients of CSWs. See, e.g., Wilson, et al 1991. This ethnography illustrated how closely interwoven trucking and prostitution are: prostitutes know truck stops often provide companionship and sex in return for free transportation, and brothels are often adjacent to trucker hostels. The authors argue that the nature of transport work underpins risk of sexual transmission of HIV and other STDs. I remember in 1996, I hitch-hiked from Harare to Mutare and was picked up by a trucker. In Rusape, a town along the way, we stopped at just such a brothel, the driver only stopping long enough to have sexual intercourse--which wasn't very long at all.

² NACP 1993

³ "Shocking increase in infanticide." *Herald*, July 9, 1999.

⁴ In 1999, the issue of domestic violence was gaining more visibility in the Zimbabwean press. In an interesting turn, more and more newspaper stories began focusing on abused husbands as well. A July 4, 1999 *Herald* article opined: "Hardly a month passes without reports of a husband or a wife shooting or setting ablaze his or her spouse." In the same article, Rumbidzai Nhundu, assistant director of the Women's Action Group, speculated that the increased press coverage of domestic violence was the result of men now also being victims.

⁵ "Woman pays for in-law's crime." *Herald*, April 15, 1999.

⁶ *ibid.*

⁷ The Musasa Project reports the following statistics on the extent of domestic violence in Zimbabwe: one in 12 women is assaulted with a dangerous object or weapon. One in four married women is raped by their husbands. One in five women is threatened with physical violence. One in four women is kicked, beaten, slapped or hit. One in 25 women is pushed, kicked or hit in the belly while pregnant. One in four women is prevented from seeing family or friends. One of every six women's partners boasted about or brought home his girlfriends. One in six women is prevented from getting a job or going to work. Source: Musasa Project's brochure *Domestic Violence and Its Magnitude*.

⁸ From *The Private is Public--A Study of Violence Against Women in Southern Africa*. Compiled and edited by Charlotte Watts, Susanna Osam, and Everjoice Win for Women in Law and Development in Africa (WiLDAF).

⁹ Community courts are usually attached to district administrative offices where presiding officers receive formal government training for their work. They also function as central courts of appeal from primary courts. See, e.g., Bourdillon 1998:127.

¹⁰ "Zimbabwean women challenging customary law." *Daily News*, June 2, 1999.

¹¹ *ibid.*

¹² Harare City Health Department, 1993.

¹³ There is an approximate 30 percent chance among HIV-positive women that the fetus may be infected in the womb, during pregnancy or childbirth. This can have serious implications for women's reproductive choices (McFadden 1992).

¹⁴ Jackson, n.d. "Observations on key problems facing women in the context of HIV/AIDS."

¹⁵ *ibid.*

¹⁶ Bongi (1994) *My Story*.

¹⁷ Loewenson 1992.

¹⁸ Thompson 1991.

¹⁹ In 1996, this was the US equivalent of less than \$100. Under the Social Dimensions Fund, this would qualify such workers for government medical and school aid.

²⁰ "Wives to blame for maids' flirtations with husbands?" *The Sunday Mail*, June 27, 1999.

²¹ Such scenarios reveal the tension for many working mothers--that is, balancing a career and caring for a family. A general survey conducted by the *Sunday Mail* revealed that women are expected to be very involved in the upkeep of their homes despite the fact that they are employed full-time. This has led to a number of strategies on the parts of working mothers. Josephine Guramatunhu, a school teacher, said: "There should be limits to the duties that the maid is expected to do. For instance, my bedroom is a no-go area for the maid and she does not wash my bed linen. In fact, if it is anything for the husband then it is my responsibility to see that he gets what he wants. A maid should know her place and under no circumstances should she be allowed the opportunity to get close to my husband. I do as much work as I can when I get home from work." Another working mother, Dorothy Chari concurred stating that a maid should be kept at arm's length if marital harmony is to be preserved in the home. "My husband prefers me to wait upon him, which is why I never allow the maid to serve him food. In the same vein I do not involve the maid in any issues that concern my marital affairs," she said. In this same article, the author argues: A woman who employs another woman to do that [providing food and house work] is seen as trying to usurp the authority of the man so she has to be "cut down to size" by [the husband's] having an affair with the housekeeper. In the same context, a man who is seen doing "feminine" chores is considered to have been bewitched" (*Ibid.*).

²² "Commercial sex workers demand recognition." *The Daily News*, April 12, 1999.

²³ The George Hotel was/is locally known as a place that prostitutes frequent, often because of the large numbers of local businessmen and foreign tourists who often stay there.

²⁴ "Keeping mistresses the in-thing." *The Daily News*, May 31, 1999.

²⁵ *ibid.*

CHAPTER EIGHT

Voices of People Living with HIV/AIDS

The above discussion paints an aggregate picture of AIDS in Zimbabwe, its social and economic impacts. Here, I introduce the voices of people living with HIV/AIDS as a way of putting a human face on the disease. As mentioned earlier, HIV/AIDS carries a great stigma and most people are loath to admit having the disease to themselves, let alone others. Apart from the great individual shame attached to contracting the virus (with its implications of sexual promiscuity and recklessness), there is the very real threat of social and economic marginalization and violence attached to disclosing one's HIV-positive status. I have already discussed the very real social price of disclosing one's HIV status in the case of Gugu Dlamini from Kwamushu, on the outskirts of Durban, South Africa. What is the social meaning of living with HIV/AIDS in Zimbabwe? What sorts of coping mechanisms do such people employ? The following narratives offer some insight. In particular, both of the following individuals--despite coming from different class, racial, and gender backgrounds--utilize n'anga as part of their treatment for their disease. How they incorporate n'anga is, however, very different and speaks to the complex forms of treatment-seeking behavior of people living with HIV/AIDS (PLWHA).

Tichafa

I first met Tichafa while visiting a Harare-based HIV/AIDS support organization where he was the receptionist and library assistant. Tichafa had a pleasant and affable air about himself, greeting visitors with a warm smile and offering them tea or coffee. He had been working at the organization for slightly more than 3 months--the standard probationary period--and seemed pleased with his working environment. He was 32 years old and married (though in the midst of an obviously painful divorce after 9 years of marriage) and had two children, one 10 years old, the other three, both boys. He had completed his O levels and, prior to his current employment, had been working as a professional draftsman. There was a slight shuffle to his gait which, I later learned, was the after-effects of two recent automobile accidents. He was currently undergoing physio-therapy and was hopeful that his slight limp would disappear in time.

Tichafa first learned of his HIV status in 1993. "I would look in the mirror and I could just see myself going down," he said. "People at work started noticing, too, asking me if I was alright because I had lost so much weight and I just didn't look as bright. They started treating me like I had a horrible contagious illness. If I attempted to hand them some papers or a folder, they would ask me to place it on the desk or table first. Then, they would pick it up from the corner I hadn't touched. I know people began talking behind my back, saying that I had AIDS. Eventually, I just resigned from my job. I couldn't stand people talking about me," he concluded.

Tichafa's concern about his working environment and the his perception that his office mates were talking about him is reminiscent of the case of "Conrad" in the previous chapter. In particular, preserving a sense of dignity and protecting himself from

humiliation were centrally important to Tichafa. Added to this was his real need to protect himself from possible harassment at the office, especially given the fact that employee treatment cards, which plainly display the employee's HIV status, are returned to the patient's employer.

Tichafa had a number of pimple-sized bumps on his face which he said he developed after he contracted HIV. They weren't very noticeable unless you stared at his face for extended periods of time, something perhaps he felt people were wont to do. One bump on his lower left eye lid was quite bothersome to him. During our many conversations, he would absent-mindedly pick at it. I wondered if it obscured his vision (it was about the size of a pea). He said no, it didn't. But, he had, nonetheless, scheduled an out-patient procedure to have it removed. "Why have a procedure if it doesn't bother your vision?" I asked.

"Because I don't like the way it looks," he responded matter-of-factly.

"And your medical aid society will pay for a cosmetic procedure?" I inquired, knowing, at least in the United States, that most insurance companies would not foot the bill for what amounted to a cosmetic procedure.

"It's okay. I know somebody there. Since I've been with them I've had no windfall [meaning out-of-pocket expenses]. And I'm thinking about getting this tooth fixed, too," he said opening his mouth and touching his front tooth which had a deep chip in it. "People tend to see your character in your face, and I don't want people thinking I'm a rough character because I have a gap in my front teeth." Apparently, his wife had pushed him down at home during an argument -- he said his balance wasn't very good of late -- and that's when he chipped his tooth.

How he looked and how he appeared to other people seemed to be very important to him, particularly because of the effects of his illness. "I don't like mirrors," he explained. "If I'm in an office building with big mirrors, I try not to look into them. My face, my body -- they've changed. And I just don't like what I see."

He said sometimes he wishes he'd never gone for an HIV-test. Sometimes it's better not knowing. "Not many people want to go for a test," he explained, "it's a death sentence. And people treat you as an outcast." He didn't want to accept the test results initially and instead began drinking heavily. "I used to like my drink...I'd have 6 pints of beer for breakfast. I could say that I was an alcoholic. I drank because I was told I would die. I was hopeless."

His initial denial of the test results and his heavy drinking probably jeopardized his own appropriate care early in his experience with the disease. Moreover, his depression and subsequent heavy drinking, mainly done at beer gardens which are often frequented by commercial sex workers, may have made him more likely to have unprotected sex, perhaps infecting them. As Chapter Seven pointed out, alcohol consumption tends to be positively correlated to promiscuity. This is, of course, only speculation as I didn't ask Tichafa if he had unprotected sexual encounters with commercial sex workers while he was on his drinking binges.

Despondent over his condition, and wanting a change of environment, he left Zimbabwe--though his wife and children stayed behind. He went to South Africa, but he had problems securing a work visa, so after a few months he had to leave.¹ He then went to Botswana to sell clothes. The work was arduous. He had to walk long distances -- he said 15-20 kilometers a day. "It was just too demanding for someone in my condition,"

he said. Eventually, he came back to Zimbabwe. The question of whether or not he had had unprotected sex with women while he was traveling crossed my mind, and I made a mental note to ask him about it later. But, of course, I forgot to do so.

I asked him if he had disclosed his HIV status to his family and/or friends.

“When I told my wife, she promised to stay by me -- I just found out her status last September when she voluntarily aborted.² I didn’t want to have more children, knowing my status. Abortions here are only carried out in the case of a parent testing sero-positive or in the case of rape. I told my wife we needed to abort -- our doctor is a teaching doctor which made things easier. I found out after the abortion that she was HIV-negative. She doesn’t know yet,” he added with a chuckle. Curious as to why his wife didn’t know her status, I asked Tichafa why he hadn’t told her that she had tested negative. He smiled to himself, “Well, you know, we aren’t on the best of terms right now...” It seemed cruel to me to keep such a secret from someone with whom he’d shared much of his life already and who was the mother of his children.

Since his wife had pledged to stay by him throughout his disease I wondered why now she wanted a divorce. “She’s leaving because I can’t [financially] support the family like when I was healthy,” Tichafa said. In his current job, he made Z3,000 per month. He said he made 6 times more than that as a draftsman (before he voluntarily resigned!). While the extra money from his former job would have been useful for his continuing medical care and the support of his family, such financial security must be measured against the significant social and emotional *insecurity* he felt from other employees at his former place of work. It is likely that had he not voluntarily resigned,

his employer might have found some reason for “retrenching” him. At least, that is what Tichafa thought.

Because he didn’t want the divorce, he was working with a couple of n’anga to halt her imminent departure. “Look at this,” he said one day in my apartment reaching into the pocket of his black jeans. He pulled out a small square of carefully-folded newspaper with a white string tied around it. Unfolding the tiny square to reveal what looked like small, crushed and dried leaves, he went on, “A n’anga gave me this. Whenever I speak to my wife, I’m supposed to put some of this in my mouth. Then, whatever she has to say to me will be nice.”

“And does it work?,” I asked unable to contain the question.

“So far. I called her the other day to arrange to see my children, and she was very nice,” he said with a self-satisfied smile. A couple of weeks before, his wife had come to his office demanding more money for child support. Her visit turned violent when he said he didn’t have any more money. She picked up a glass coffee mug from his desk and hurled it to the floor, shattering it, and when he tried to restrain her, she raked her nails across his neck, the deep wounds still evident. “How could she just come into my work place and act that way?,” he asked. “I went and filed for a restraining order.” Given his wife’s actions over the past few weeks, he felt he needed the intervention of n’anga to make his wife more amenable to him. “The problem is that I’m working with more than one n’anga -- I’ll have no way of knowing who’s muti is effective.”

His parents were not supportive of he and his wife getting back together, which caused him some grief. He said he needed their support for some of the rituals involving n’anga. For example, he had bought a hunter’s knife [symbolic of ‘hunting’ his wife] and

some cloth -- at a price of Z500 -- as requested by a n'anga. He was later told by the n'anga that his parents were supposed to have paid for it. He spoke with them afterwards and they agreed to reimburse him.

With the disintegration of his marriage, Tichafa began to speculate that his wife had been unfaithful to him from the beginning. "I'm not sure she was even a virgin when we were married," he said. "N'anga can give them herbs that tighten their vaginas (see Chapter Seven) and they can cry out in the wedding bed to make you think you're taking their virginity. I'm beginning to wonder if my second child is really mine," he said with a distraught look on his face. His speculation was only fueled by his bother's admission that he had seen his [Tichafa's] wife with a new "husband" at the market the other day.

He continued talking about disclosing his status to the rest of his family. "It was a mistake telling my family I was HIV-positive," he explained. "They said, 'We've been told that your brain doesn't function properly.' You're put in a position where you don't make your own decisions. My parents said I got this from not being responsible...that I got it from not controlling myself which is not necessarily true. I've had a lot of work done on my teeth over the years and gotten many injections from doctors. It's possible I could've picked up the virus from them." He said that whenever he went to visit his parents now, they had a special cup for him to use and that no one else was allowed to use, the pain and anger on his face apparent upon recounting the story.

Curious to know if he engaged in risky sexual behavior in the past, I asked him if he'd had sex without condoms in the past. "I didn't use condoms in the past. Why eat your sweets with the wrapper still on them? In the past, STDs were easily treated. You'd just go to the doctor and have it treated." A bull is known by his scars.

“My parents asked me to visit spirit mediums to figure out why this was happening to me. I’ve had a lot of bad luck. I have to buy some red and black cloth and what what,” he explained. “I’ve also visited those church people [*Mapostori* or Apostolics], fortune tellers -- they say something is wrong with my blood. They gave me some blessed water and oil and some stones [referred to as *muteuro* in Shona], which were gathered from a holy place, that I keep in my pocket. They [the stones] carry prayers. I shouldn’t mix them with the coins in my pocket. If you believe it’s true, it is. I’m walking a tightrope,” he continued, aware of how strange such practices might sound to me. “To be a young person who went to school, it’s difficult to believe such things. I visited Burombo [the n’anga with a short-lived career for “curing” AIDS patients] in the early days when his medicine was working. After I asked so many questions [about his treatment strategy and its efficacy], he stopped entertaining me. I think he thought I was an investigator from the government.”

“Ahhh, but those spirit mediums...fairy tale people. Most spirit mediums and faith healers, they can make up a good story. I don’t believe them 100 percent. I just agree with them to end the conversation. You know they do things to make you scared. I try to keep it short [his consultations] and get out of there. A snake might come out or something,” he said shaking his head.

“I’d rather be with the Western people with regard to health. There’s no checklist with traditional healers. You can even overdose. I’ve lost lots of money through these people [traditional healers]. They charge you lots of money for things not proven. The Western way is better -- good vitamins and good diet. I had TB once and went down to 47 kilograms. Vitamins and good diet saved me and constant visits to doctors. When

you have diarrhea, you don't go to a faith healer for herbs! Right now I'm on a triple combination therapy of DDI, Crixovan, and Zerid. I've been on so many combinations, I can't even remember. I was on AZT, but my red blood cell count got too low." Initially, he said, he hadn't stuck to a proper drug regimen in terms of taking the drugs at prescribed times. Then, one of his doctors told him how expensive his drugs really were (he was receiving them free through the HIV/AIDS support organization he worked for) and that gave him the incentive to take them regularly.

Tichafa's coping mechanisms for dealing with his disease reflect a certain level of ambivalence toward both Western and "traditional" medicine. After becoming ill, he sought the council of his family, or "therapy managers," to use Feierman and Janzen's (1992:18) term. His family recommended that he visit a spirit medium as a way of locating from whence came the bad luck or evil spirits (*mamhepo*) that were manifesting themselves as physical illness. He also visited healers from an Apostolic church as a way of cleansing what they identified as his "bad blood." It is not quite clear in his narrative when he went to a doctor, took an HIV-test, and discovered his HIV sero-positivity. However, it is clear that, even prior to visiting a doctor, he may have suspected that he indeed had HIV. It is equally possible that visiting n'anga and faith healers was a form of denial--that he knew they would not tell him directly that he had HIV, instead using metaphors such as "bad blood." As he stated earlier, the very words HIV were a death sentence; the end of life, the death of hope. Barring a blood test, of course, no healer could or would tell him that he was suffering from HIV.

With regard to the efficacy of traditional medicine in treating his disease, Tichafa, to use his words, feels he is "walking a tightrope." "If you believe it's true, it is," he

says. His approach to traditional medicine is pragmatic and questioning. Though he held some doubts about the stones he carried in his pocket, he nonetheless still carried them in his pocket, not mixing them with any coins. Why not avail myself of anything and everything that might have some success in curing me? he seemed to be saying. His visitations with the healer Burombo were equally measured--he did, for example, ask questions about treatment and the nature of Burombo's curative practice, causing Burombo to think he might be a government mole. While such inquisitiveness on the part of traditional healers' patients in the past would have been unusual, Tichafa's inquisitiveness may signal the changing nature of patient/healer relations in the current disease climate.

In the case of the physical treatment of his HIV and related symptoms, Tichafa seems to be in favor of Western medicine. When he contracted TB, he feels it was good vitamins and diet--not the intervention of spirit mediums or faith healers--that ultimately cured him. Likewise, he attributes his continued stabilized health to a Western-derived triple combination therapy of protease inhibitors. The efficacy of traditional medicine, on the other hand, he argues, has not been proven. Apart from feeling physically scared while consulting some spirit mediums ("a snake might come out or something"), he also has a fear of overdosing on local concoctions which have not been submitted to scientific and clinical trials as to their efficacy and toxicity (see, e.g. Chapter Fourteen).

Underlying his concern with his physical condition, there is of course, his concern with his holistic condition. Of particular concern is his ailing relationship with his wife. His recourse for healing that part of his life is his use of n'anga. The "bad luck" which plagues Tichafa may explain his strained relationship with his wife or, alternatively, his

bad luck may be the result of this strained relationship--perhaps his wife bewitched him? Whatever the causal relationship, for Tichafa, misfortune has somatic consequences. And it is to this more general, inchoate sense of misfortune that Tichafa turns to n'anga to help ameliorate.

Lynde

Lynde is an HIV-positive White woman and director of The Centre, an HIV/AIDS support organization. My initial meeting with her took place at her house in one of the city's low-density northern suburbs. Her large, white-washed house is situated in a cul-de-sac, two blocks west of a jacaranda-shaded main street. As I arrived on foot, I had to call out at the gate--there was no bell to ring and I would've stepped into the yard, but there was a rusty "Beware of Dog" sign hanging from the black wrought-iron fence. Shortly, a "garden boy" came forth from a thick wall of green vegetation, his uniform's color matching the abundant greenery in the yard. Through the large picture window, as we approached the front door, I saw the back of a woman with cascading brown hair, the sides pulled back and falling down the center. She stood at a large oak dining room table with a laptop computer on it. The gardener and I entered the house and were greeted with suspicious barks by two dogs, one a white poodle, the other a large black terrier with an obvious flatulence problem.

Lynde appeared, muttering to the dogs to be quiet, and introduced herself. She led me into the living room as the gardener silently vanished. Before I sat down, she asked me if I wanted something to drink. Tea? "Sure," I reply. She has fruit tea, Early Grey, Twinings...I was not in a very decisive mood, especially given such choices, but I

settled on the fruit tea. Her absence, as she went to prepare the tea, gave me a chance to study the room -- “traditional” African art, ceramic bowls, and carvings interspersed with European decor. Hardwood floors.

She returned shortly with a large mug of tea. I re-introduced myself and talked about making the rounds in Harare. I mentioned ZINATHA and “Dr.” Ngwenya. She interrupted to say that she knew his “heart was in the right place,” but that he needed to work on his public relations skills because he often comes off as abrasive and combative. “You know he’s ex-military,” she remarked as explanation of his behavior. “He’s actually had some success there [at his clinic]. His focus on diet and ridding the body of toxins--it’s important. You know we use Mocrea at The Centre, too. It was actually used in China as what they call a ‘liver tonic’ to treat hepatitis. With immune-suppressant diseases, the functioning of the liver is very important. We don’t prescribe Mocrea, but if a patient asks about it, we let them know that we do have it available. And it’s actually quite effective at stimulating appetite and helping out with fatigue.”

Initially, I thought Lynde was a White Zimbabwean, but she was actually born in Trinidad and raised in the United Kingdom, coming to Zimbabwe in ‘68 or ‘69 with her first husband, a White Zimbabwean. Her third husband, a White South African, was one of the founding members of *Horizons* (a well-known local magazine) which, apparently lately, was falling on hard times because of a lack of subscribers. Her fourth husband was the well-known Shona musician Tobias Arketta of Tobias Arketta and the Shazi Band. It was from “Tobi” that she contracted HIV. As elucidated in the last chapter, Lynde fits the risk model in which a usually monogamous wife is infected by her non-monogamous husband.

“If I’d known then what I know now, I would’ve known that he had AIDS. He had terrible fevers, real night sweats...like someone had thrown a bucket of water over him. And the doctors just kept treating him for malaria...and then he had sores that just wouldn’t heal. And the doctors kept giving him more and more courses of antibiotics...he had rashes, real itchy rashes, that would come up all over him and they couldn’t find any reason for. And so he had quite a number of symptoms that one would’ve known now indicated that he had AIDS. But, of course, there was no information then, absolutely nothing. AIDS was something that was in America amongst gays and IV-drug users. It wasn’t here in Africa officially...that was the government line. There wasn’t any AIDS in Zimbabwe, so there was no information about it. When he didn’t seem to be getting any better, I took him to my doctor in the UK and she said, ‘You know, you might want to have an HIV test.’ We got tested in ‘86--Tobi wouldn’t take the test unless I took it, too. And we both tested positive.”

“He was terminally promiscuous. To give you an idea, at the funeral there were thirteen children by 11 women. Everywhere Thomas Mapfumo’s band played Tobi left a baby. I think that people who want to develop a following of admirers tend to be drawn to the music industry...I think it was in the nature of the animal as much as in the nature of the industry. Tobi was basically just a complete lover of women and sex. There were only three things, well four, in his life: women, sex, music, and booze.”

I asked her if they visited traditional healers early on in Tobi’s illness:

He went to a lot of healers for a lot of reasons. The music business relies a lot on traditional healers to give them luck and to deal with bad influences that come from other bands who want them not to win and so on. So, it’s quite traditional in the music industry to visit n’angas and he went to

n'angas quite often and he took me with him. The funniest one was the guy, when I walked in, who started cackling to himself. He was absolutely doubled up with hysteria. Eventually, the assistant translated what he was babbling about and said that he's laughing because Tobi thinks he's got a White woman and she's not. It was amazing. And they [n'anga] always picked up on that. But, one time he was given muti which made him actually hemorrhage from the penis. I was watching him on the stage and saw that his jeans were sort of going red and he wouldn't stop the song. Then, I managed to get an ambulance. And so, that was certainly one of the less successful treatments that he had.

Despite the negative outcome of that particular treatment, Lynde began to develop a greater interest in traditional medicine as a way of ameliorating symptoms that Tobi was experiencing. She continued:

A lot of the treatments...that was when I really got interested in the herbal side of traditional healing was because, he'd had no success dealing with these rashes he would get. He used to get these terrible, itchy rashes behind the knees and in his elbows and in the backs of his ears and it used to drive him absolutely mad and the gel that the traditional healer gave him solved it straight away. It was amazing. And he used to have recurrent diarrhea and, again, Immodium never worked as well as the stuff the traditional healers gave us to put in porridge. So, it really whetted my interest in herbalism as part of treatment options.

Visiting different traditional healers, and doctors, became a central strategy in their quest for health--similar to Tichafa's pragmatic approach above. Unfortunately, they also visited some expedient n'anga as well: "We went to Burombo (see above and Chapter Thirteen). He had quite a reputation. He treated people with what really amounted to water for which he charged a great deal of money. People would say the initial treatment was very effective, but subsequent treatments were less effective. And people just started dying. This guy [Burombo] drove nice cars and had body guards and quite a reputation for treating people from all over the world. Now, I think he's discredited."

Lynde said that Tobi visited Burombo “incognito.” She exhorted Tobi to be open with his HIV status, so that he might be able to use his celebrity to draw attention to the disease. But, he was reluctant. He said he wanted to be known and remembered for his music, not for having HIV/AIDS.

As for her own feelings about testing HIV-positive, Lynde said:

...I went through a period of denial when I thought it wasn't true until I went for a re-test. And went through a period of anger and suicide...I made very careful plans for a suicide, set up my suicide kit. I was determined I wasn't going to die of AIDS and that my kids would not have to deal with the shame of having a mother who died of AIDS. One knew so little then and the pictures, the images of someone with AIDS were these skeletal, emaciated creatures with drips and tubes in their noses....and all the stigmatization. It took me really three years to begin to come to terms with it and to start getting information.

Like Tichafa, Lynde met the news of her HIV sero-positivity with a mixture of denial and depression. In many ways, the turning point for Lynde's suicidal feelings was gathering more information about the disease, arming herself with education.

I had a partner in my business who was a macrobiotic vegan and when I told him, he sent away to the macrobiotic foundation for info on how they were dealing with it and that was a kind of breakthrough for me because I'd always been interested in nutrition. So, it was a reinforcement that I could use nutrition for HIV as well. And that sort of started me on a search for more information.

As she began collecting information for herself, she also began to share it with others:

And then, of course, it was quite natural that once I started getting information that I would share it with other people. As people in the music industry started to fall with HIV, it was quite natural to them to come to me and see what I could tell them and so I became kind of de facto counselor before I really started doing it formally, as it were. That pointed me in the direction I was going to go and then Jim took the bull by the horns. I was in England in '90 and he decided to see what would

“happen” if he put an ad in the Sunday Mail that said “AIDS? HIV-positive? There is hope. Phone Jim or Lynde at...” such and such a number. You can imagine what happened. I got back and The Centre had been born. It was a trickle to start but it quickly became a deluge. And people were coming who’d cut the ad out six weeks before and been carrying it around in their breast pocket, sort of getting up the courage to phone and find out what it was about.

I asked her why, in 1999, there was still such a stigma attached to AIDS:

I think we haven’t gotten over the initial messages yet. The first messages that went out were very stigmatizing messages: AIDS kills; you’re next partner might be that very special one -- the one that gives you AIDS; get drunk, get stupid, get AIDS. These were the messages. They were alienating and stigmatizing messages that basically made it that anyone who had AIDS was a stupid, drunken, promiscuous, reckless somebody. And that is still very much attached to the label. That you only get AIDS if you’re promiscuous and reckless. You get AIDS from prostitutes (if you’re a man). If you’re a woman and you get AIDS, you must be a prostitute. And people are still very afraid, they still don’t know a lot about AIDS. When I go into the workplace, like tomorrow I’m going to give a talk in a school, with first formers, and you’d be amazed at the level of ignorance. People don’t know how AIDS is transmitted, or not transmitted.

Her initial efforts to get the word out on AIDS were met with some difficulty. Lynde admits that some of the most hurtful comments came from other Whites when she decided to publicly disclose her HIV status:

It was a magazine...that was on the one that provoked a big response...and I’ve been on TV, but this magazine, which has a very large circulation, that was the one that provoked the most response and that was the first time I had a negative response. Which shocked me. I’d kind of gotten to the point where, “I’m Lynde Francis, and I’m impervious to this sort of negative thing, everything goes smoothly for me.” And when I got these terrible phone calls, I was like, “But, they don’t know who I am? This can’t be happening to me.” I had one white woman who phoned me up and berated me for letting the side down and ended her conversation, slamming the phone down and saying, “But, I suppose I shouldn’t be surprised because I believe you were married to a black man.” I had another person phone up and say I was providing a wrong role model for “our girls.”

I had one black guy phone up and say that I was romanticizing AIDS. That by putting my picture, looking so beautiful and fat, in the magazine, I was making it out that it was okay to have HIV. So, I asked him if he'd read the article and he said, "Yes, I have." And I said, "Do you think the article says it's okay to have HIV?" And he said, "No." He said he understood that in the article I said it was a terrible thing to have to deal with. But all the same, he said most people would just skim the article and just take away the impression that it was okay because somebody white and plump and nice, you know, had it. He was different because we talked for about an hour and really had a good conversation and by the end of it, he made an appointment to come in and it turned out that he was HIV-positive. But, I had mainly very positive responses. People coming up to me and saying "I'm so glad. I thought I was all alone out here. It's made all the difference in the world to know that you're there and that you're doing okay. But I was quite shocked. One woman phoned up and said, and it was the first phone call so I didn't link it to the article at all. I didn't know, at first, what it was. And I just heard this voice on the other end saying, "Are you Lynde Francis?" And I said, "Yes." "What is your profession?" And I said, "Well, professionally, I'm a builder. But I'm also a counselor and I counsel people..." And before I could finish, she said "And you're a bloody fucking prostitute!" and put the phone down. And I'm still like, "Excuse me? What was that!?"

Given the multitude of symptoms Tobi was experiencing, I wondered if Lynde was also experiencing them.

No, I had absolutely nothing. That's one of the reasons that I was so shocked when I got my result and I didn't believe it. I thought it was a false positive because I was completely healthy. And in the following three years, I got ill a couple of times -- I had pelvic inflammation disease -- PID -- which nearly wiped me out. Actually, it was touch and go for nearly 48 hours. But that was because of repeated STIs which Tobi brought back. And of course no one said to us, "Use a condom," because we were both HIV-positive and in that day and time they didn't know about the dangers of re-infection. So, I had PID and I had pneumonia, both of which I got over. Well, with the PID, I had to take antibiotics. The antibiotics that they gave for the pneumonia caused a terrible rash from my scalp to my toes, so I stopped taking that and I got through without any more of it.

Given the fact that Tobi was re-infecting her with STIs, I gathered she must've been pretty upset. She began to develop ways of policing Tobi's actions and movements:

It was very difficult and you know he would swear that he was never going to do it again. The problem was that I loved him and it was so much a part of his way of life and who he was that it was really a question of you accept him as he is he or you don't accept him at all. So, I joined the band and performed with the band on stage and basically policed him, which helped. But he still got groupies coming down to the rehearsal places in the day. 'Cause I was doing a job in the daytime and performing with the band in the evening, so it was stressful, very stressful.

I was curious as to some of the places where she performed.

Small villages, village halls, beer halls, football pitches and nightclubs -- anywhere. All over Zimbabwe, And people had never seen a White person on-stage playing traditional music before. I was a real seven-day wonder. Men used to come and tuck 5 dollar notes in my grass skirt... which Tobi didn't mind as long as I gave him the five dollar notes.

The image of Lynde performing in a grass skirt seemed not so unbelievable after I spent a couple of days around her. I meant to ask if she had any pictures of her performance days--or perhaps she still had that grass skirt stored in a closet--but, again, I forgot to inquire. I asked her when she began seeing healers for herself:

I think when we had...I've always been interested in the spiritual side originally...right back as far as 1971, the first time that I visited a traditional healer who completely shocked me by telling me that I had healing abilities and that I'd better do something about it and that I had been brought here to Zimbabwe to replace what was stolen from Africa which I took to mean my grandmother, my grandparents, who had been brought as slaves from Africa. And that my role in things was to be a bridge between cultures. This was all to the huge surprise and consternation of the people that I was with who had warned me that she would not see me at all, because she didn't see murungus. For them to go into the hut and then be told to go outside the hut and fetch me...So, that was the first one that I ever saw and she told me right then, "Be careful because if you don't do what the spirits want, they will force you." And over the years, I met others through various different people. And they all said pretty much the same thing. Even when I went with Tobi as he was

seeking his treatments, they would say the same things very often. But when I really got into the herbalism part was when we did phyto-therapeutic trials here and we had 28 people from the Centre here working with four traditional healers.

I had read brief articles in the newspapers regarding these tests, had heard whispers of them at the University of Zimbabwe as well as at HIV/AIDS public forums, but I had never heard or seen anything substantive about these clinical trials. I asked Lynde if these were through Blair Research Laboratories:

And the results that we had were so good, that I continued to send people to a couple of those healers after the trials finished. And I do, myself, go to one of them quite regularly. Like if I get a bit anemic, I go and get this root that she has for building up the red blood cells and platelets. It's absolutely much better than anything in Western medicine. It works like a charm. She has very good medicine for diarrhea, for rashes, a wonderful salve that works on genital herpes. So, she has some really good stuff in her armament.

Still curious about the clinical trials, I asked if there had been anything published about them. What were some of the findings?

They've never published them...because they proved that it [traditional medicine] works. I think they supported those trials because they thought it would prove once and for all that traditional healers were a bunch of charlatans and that it didn't have any effect. And when the trials clearly began to go the other way, I think they backed off because they ran out of funds and they couldn't complete...and they didn't analyze the data. They said the data were flawed. They did publish some preliminary data and it was good, it was really good. It really showed a difference that people were getting higher CD4 counts, better full blood counts, gaining weight. In the year that it ran, they had only, like, 4 deaths out of something like 150 people. It was very very few. And these were people who were coming from the main hospitals outpatients. They were really ill, people with CD4's of 14 and 13, you know. And yet, they were not dying. And that alone, I thought they would really want to trumpet from the rooftops, but, no, they have never really published it. They've never really made much of it at all.

What explains the government's relationship with traditional healers -- it seems to be a negative relationship...?

I think it's very difficult to say. I think a lot of it has to do with the fact that most of the top people in the government were Catholic-educated. They're the product of mission schools. They were taught that traditional healing was witchcraft and to undervalue it. But, I still don't think that explains it enough. In this day, they should be aware of it. You know there's more to things than just Western practices. They should have a much more open mind to their own tradition and culture. So, I can't say that that's the whole answer, but it's obviously part of the answer.

It seems they [the government] would be more open to it, I wondered aloud. Lynde responded:

I don't know the answer to that question. It's something that frazzles and puzzles me tremendously. Why there's this resistance, why there's no real effort to investigate more. ZINATHA is doing stuff on its own, but it's not getting government support for it.

What was the response of the government, or of the formal health sector, to what you're doing here at The Centre?

Initially, I was the lunatic fringe. And that's official...it's what the Minister of Health said about me on television.

That's quite an endorsement!

[laughs] Well, that's how I took it. There was [sic] a lot of problems. Initially I was a mid-class White and I was interfering with stuff I didn't know enough about. There was a suspicion I was only working with people who could afford to pay. Then, there was the whole issue of GALZ, Gays and Lesbians of Zimbabwe. I was involved in training counselors for GALZ because there was absolutely no information or support getting out to the gay community here at all. There were no messages for homosexuals whatsoever and there was no one who specialized in counseling gay people. So, I was doing counseling and safe-sex workshops and things. So, then there was the suspicion that the Centre was a front for gay and lesbian activities.

As eluded to in Chapter Six, gay and lesbian lifestyles are not seen as viable by most Zimbabweans. As such, it is not surprising that there are no government-generated education campaigns targeting this population of Zimbabweans.

And then, I was accused of trading false hope. Telling people that they could stay well just by eating properly was obviously nonsense. So, there were a lot of reasons why the Centre was initially ostracized and we found it very difficult to get funding because we couldn't get NACP's support. If the funders went to the NACP and said "Is it okay if we fund the Centre?", they would say, "No, they're a bunch of charlatans and they're involved heavily in lesbian and gay activities." And because of the climate around lesbian and gay activities, funders would back off. So, it was very difficult. I just took a fairly aggressive stance. So, I would arrive at these meetings and say, "You forgot to invite me" and challenge them to throw me out, which they didn't do usually, because it would have been embarrassing for them. So, I got to speak and eventually, and only now, they've accepted that the Centre is doing valuable work. I think also because more and more doctors have begun to see that what we do works. We have quite a number of doctors that now routinely refer [their patients here]. So, that's made a big difference as well.

What do you think of the government's response to HIV/AIDS in Zimbabwe?

What response? There isn't one. That's the whole problem. There's absolutely no political response whatsoever. The NACP even admits that it's a toothless bulldog. It doesn't have the government backing and the budget to do effective work. The Ministry of Health is struggling to deal with a completely pathetic budget and it's escalating. The health system has basically collapsed and the government seems to be sitting back and saying, "Well it doesn't concern us. Let's just play hit or miss as long as we can." Mugabe never speaks about HIV/AIDS, he just never uses the words. I think the only time in living memory that he ever used the words was on World AIDS Day when he opened the football match. There's no political will at all, there's none.

What accounts for that? Other African countries -- Uganda and even South Africa -- their response seems to be different.

I don't know. I think we have a government in residence that is old, stuck in the mud, Catholic, very capitalist, totally self-centered, and couldn't

give a damn about the country. That's the only way I can look at it. I know it's very cynical and depressing. But, those are the conclusions that one has to draw. The difference in Uganda is Musaveni. His one man band has really made AIDS something that Ugandans are dealing with because he speaks about it everywhere every time and he's set up an AIDS Ministry. It's been given the kind of permanence that it needs to have. Even in South Africa, that is beginning to happen. They had an AIDS policy as soon as they came into power. We still don't have a national AIDS policy. It's, um, ...depressing.

Given the situation, where does the hope lie in effectively dealing with HIV/AIDS in Zimbabwe?

What's happening is that there's more and more grassroots work. Communities are beginning that nothing is going to come from the top, that is they're going to do anything about it, they can have to do it themselves. The problem is that they lack the resources. We're in an economic crisis as well. One has to say that one is depressed about the prognosis for the next ten years.

Apart from your work here, what other organizations do you see making an impact on peoples' lives in terms of either living positively with HIV or in terms of prevention?

I think there are some good NGOs, really excellent. And people doing home-based care programs. People who do peer education programs, support groups throughout the country that are doing home-based care. All of these are having an effect. It's only that if they had the support of government and the resources to really start it, they could be much more effective. They are effective within their small scope, but it needs to be spread so much further. Like Women and AIDS Support Network, for instance, which is doing sterling work in terms of prevention.

Women and AIDS is a very important topic. The terms of sexual intercourse, for example, seems to be an area where women have little control...

I don't think they have little control, I think they have no control. Sex workers probably have a certain amount. But even then, men will offer a sex worker double or triple their normal price to have sex skin to skin. You've got two children to feed and you're offered three times your

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**MANAGING MISFORTUNE: HIV/AIDS, Health Development, and
Traditional Healers in Zimbabwe**

VOLUME II

By

David Sean Simmons

A DISSERTATION

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PART II

Genealogy of a Problem: The Historical Constitution of N'anga as Objects of Knowledge

In the chapters that follow, I attempt to analyze, within the historical context of British colonialism in Zimbabwe, the processes both of objectification and of the creation of subjectivities, through an analysis of development discourses on n'anga--from those of early medical missionaries to contemporary development organizations and agents. By "discourse," I mean the multiple ways of seeing, knowing, and saying that link the conceptual practices of knowledge and the material practices of control (Pigg 1995; Foucault 1979). Missionary and colonial discourses sought to define and delimit the person and practices of n'anga in an effort to curtail, subdue, or destroy local peoples' belief in, and reliance on, them. This, after all, from the standpoint of missionaries and many colonial officials constituted "development." By narrowing the analytical gaze, I attempt a critical epistemology of this development, locating it in a particular social and political context. In doing this, I hope to assemble a portrait, not so much of the hegemonic nature of development, but a more nuanced and fuzzy one, which incorporates resistances and ruptures with received knowledge and practice.

The historically contested nature of health development has important implications for the contemporary role of n'anga in combating HIV/AIDS in Zimbabwe--in terms of their response to this new disease and in terms of the conditions of their involvement in educational interventions. More specifically, I will argue that their historical and contemporary encounter with health development (and, more generally, with 'modernity') has shaped their understanding of, and responses to, the epidemic in

particular and diverse ways. As Vaughan (1991) argues, African healing traditions and “self-representations...have been forged not in total isolation from the discourses and practices of biomedicine, but rather alongside them, sometimes through them, and some in reaction against them.”

In Chapter Nine, I attempt to illustrate the role missionaries played in the construction of n’anga as dangerous subjects. An analysis of this particular construction of n’anga helps illuminate how they have been articulated to a broad diversity of issues, perspectives, and agendas--particularly those that stood at risk of contravening missionary projects. The inventory of discourses discussed in this chapter surrounding n’anga illustrates the degree of consistency of meanings they have inspired up to the present time; and yet, despite these often hegemonic and much-stereotyped meanings, the nature of n’anga was, and also remains, fraught with some ambiguity.

This ambiguity is evident in Chapter Ten. The ambiguity and ambivalence with which the colonial government viewed African therapeutic systems involved a number of points. First, there was a general suspicion and ignorance of the efficacy of indigenous medicine and practice in effectively treating afflictions--broadly defined. Second, like their missionary counterparts, some government officials felt that n’anga encouraged a belief in witchcraft which was regarded not only as a hindrance to Christian missionary work, but a real threat to colonial production in mines and large-scale commercial farms (especially since imputations of witchcraft usually meant slowdowns in production and general social unrest). Both of these beliefs on the part of the colonial government resulted in legislation which worked to curtail, directly and indirectly, the activities of n’anga whom, in many cases, were also assumed to encourage an active belief in

witchcraft. But here, too, we see that colonial conceptions of n'anga and African therapeutic systems was far from hegemonic. Moreover, some whites also availed themselves of these practices or, in other cases, found themselves in direct transgression of colonial laws designed to curtail a belief in African therapeutic systems.

Because, in part, of the constraints many n'anga felt from both missionary and colonial powers, they began to organize themselves. The historical rise of one of the most durable healer organizations, the Zimbabwe National Traditional Healers Association (ZINATHA), is the subject of Chapter Eleven. ZINATHA currently plays a central role in the education of healers about HIV/AIDS.

How to best involve traditional healers in health development in Zimbabwe is the focus of Chapter Twelve. Historically and contemporaneously, the greatest opposition to seriously involving traditional healers in, for example, national health delivery programs has come from Western-trained doctors, who often contend that traditional practitioners lack basic knowledge of anatomy and physiology, of disease, and the accurate prescribing of medicine. It has also been said that traditional practitioners work in unhygienic environments and that their curative practices are shrouded in mystery and not falsifiable or reproducible by scientific measures. These criticisms, as we have already seen in previous chapters, have been around since the first arrival of medical missionaries in then Rhodesia. Much like missionary and colonial discourses regarding n'anga, contemporary development discourses draw on many of the same ways of seeing, knowing, and speaking about African healers and therapeutic traditions.

Collectively, these chapters attempt to analyze and illustrate ways of seeing, knowing, and attempts at controlling African indigenous medical practitioners. Healers,

of course, were not passive actors in this process. Their resistance to, and contestation of, missionary and colonial received knowledge is testament to this fact.

CHAPTER NINE

Godly Medicine and Pagan Superstition: The Development of a Problem

I often wonder if the natives are grateful for what the white men did for them during the dark days of last October. I fear most of them are not, for gratitude is a thing to which the natives of South Africa are usually strangers.

The terrible visitation is now a thing of the past and one can only hope that it made people reflect and pray, and that thoughtless and giddy souls, of whom there are too many in this land, will at times reflect that the epidemic was sent by God to remind them of His power and to bring sinners to repentance.

If such a manifestation of the Divine power and wrath has failed to bring people to their knees one can only fear that some worse evil may ere befall us.

-*The Zambezi Mission Record*, 1918.

The prejudice of our Natives against hospitals and scientific methods of medical treatment resists all reason and argument with stubbornness of a natural instinct. It is really a morbid symptom arising from an outlook on life in which disease itself is made an object of worship.

-Rev. Father A. Burbridge, S.J. 1930

Christian missionaries have attempted for many years to discourage the use of traditional medicine in Shona country and in many parts of Africa. Firstly, the missionaries felt that traditional doctors encouraged the belief in witchcraft which was one of the great hindrances and stumbling blocks in the way of Christian missionary work...[Secondly, the] traditional doctor was conceived of as a death-dealing charlatan, a rogue and a deceiver preventing patients, who would otherwise be treated effectively with scientific drugs and surgery, from reaching mission hospitals.

-Gordon Chavunduka, 1980

Much of the contemporary understanding of n'anga has its roots in the initial encounter between n'anga and early missionaries, though such understandings certainly are not reducible solely to this history. Missionaries, along with travelers and traders, were the first to insinuate themselves into the lives of Africans, giving them a unique vantage point in understanding local languages and customs. A special area of interest, particularly for those emissaries of the Gospel referred to, albeit loosely, as 'medical missionaries', was African therapeutic systems. This interest shared two competing logics, the first pragmatic; the second ideological. From a pragmatic standpoint, missionaries realized the practicality of some of the treatment strategies of local n'anga (especially herbalists), particularly for those afflictions that were locally-specific (such as "fever," etc.).¹ In these cases, missionaries worked actively to understand and emulate such treatment strategies--a trend that continues today with various international actors and institutions. From an ideological standpoint, missionaries often classified the therapeutic knowledge and practice of n'anga--usually spirit mediums and bone casters--as sub-standard and certainly un-Christian. The end result of these competing logics was, usually, great ambivalence.

However, there also arose, for many missionaries, the notion of reformation of their would-be African charges, a project whose ideological tentacles stretch into the present day. For themselves, and their followers at home in Europe or America, medical missionaries saw themselves as the "vanguard of the 'battle against superstition and witchcraft', persuading recalcitrant patients and sceptics of the superiority of western medicine" (Vaughan 1991:65). This healing of the body, of course, took second place to the winning of the soul and the fight against the 'evil' of African society (ibid.), evil

being most often located in the person of the n'anga. It is beyond the scope of this dissertation to offer a full historical account of the encounter between missionaries and n'anga. However, I would like to offer some general themes, fragments drawn from primary and secondary documents, as a way of sketching the contours of this relationship, and particularly for the implications it has for contemporary understandings of n'anga and their role in combating an epidemic. In short, I hope to illustrate the role missionaries played in the construction of n'anga as dangerous subjects. An analysis of this particular construction of n'anga helps illuminate how they have been articulated to a broad diversity of issues, perspectives, and agendas--particularly those that stood at risk of contravening missionary projects. The following inventory of discourses surrounding n'anga illustrates the degree of consistency of meanings they have inspired; and yet, despite these "dominant" meanings (Treichler 1999), the nature of n'anga was, and remains, fraught with some ambiguity.

The most thorough account of European (missionary) medicine in Southern Rhodesia are Gelfand's (1988) *Godly Medicine in Zimbabwe* and his (1953) *Tropical Victory: An Account of the Influence of Medicine on the History of Southern Rhodesia, 1890-1923*. The latter, written as a tribute to Cecil John Rhodes on the centenary of his birth, is a melange of historical fact and missionary propaganda where the "establishment within the southern tropics of a civilization and a way of life which is true to the Rhodes tradition and ideals proved to be an unremitting, relentless struggle against savagery, death and disease..."² Throughout this account, Africa becomes and remains a negative trope and provides the "rhetorical ground on which a new sense of heroic history could be acted out."³ Within the narrative of the book, that heroic history takes the form of the

European medical victory over African disease and suffering. Despite Gelfand's evident bias, however, there is a great deal of information in his account, culled from primary sources; and it is these sources that help paint a picture of the medical world of Europeans in Southern Rhodesia.

Medicine and religion are inseparably intertwined in the context of the first encounter between the Matebele and the missionary Robert Moffat.⁴ After years of sporadic visits to Matebeleland, and its king, Mzilikazi, Moffat made a special visit in 1857 to obtain permission to set up a mission in the area.⁵ As harbingers of Christianity, Moffat and other missionaries were also harbingers of medical knowledge and practices that may have competed with that of local *n'anga*, or indigenous religious and medical practitioners. Gelfand⁶ notes that, "in spite of their fear of the witch-doctors, the Natives frequently sought medical aid from the white man. Even the mighty Mzilikazi and Lobengula both respected the white man's magic and never hesitated to avail themselves of European treatment when it was at hand."

Despite the triumphant medical light in which Gelfand paints these medical missionaries, it is probable that they had little formal training in medicine. Standard missionary medical training consisted of a six month internship at a hospital to learn the basics of diagnosis and treatment of disease, simple surgery and maternity work.⁷ It is probable, too, that little of this training could prepare early missionaries for the unique and geographically-specific types of diseases they would come into contact with while in Africa. What medical knowledge missionaries did have was the by-product of the developing European conceptions of disease and its causation and prevention. In this vein, medical knowledge was generated by recording and ordering empirical biological

reality.⁸ Diseases may, thus, vary from culture to culture, but medical knowledge did not (based as it was on the “facts” of nature and the causal-functional integration of biological systems).

Evidence for this nascent empirical ordering of biological reality can be found in David Livingstone’s (1865) *The Zambesi and its Tributaries*, where Livingstone speculates on the best prevention methods for malaria. He writes:

Whatever may be the cause of the fever, we observed that all were often affected at the same time, as if from malaria. This was particularly the case during a north wind: it was at first commonly believed that a daily dose of quinine would prevent the attack. For a number of months all our men, except two, took quinine regularly every morning. The fever sometimes attacked believers in quinine, while the unbelievers in its prophylactic powers escaped. Whether we took it daily, or omitted it altogether for months, made no difference; the fever was impartial, and seized us on the days of quinine as regularly and as severely as when it remained undisturbed in the medicine chest, and we finally abandoned the use of it as a prophylactic altogether. The best preventive against fever is plenty of interesting work to do, and abundance of wholesome food to eat. To a man well housed and clothed, who enjoys these advantages, the fever at Tette will not prove a more formidable enemy than a common cold; but let one of these be wanting -- let him be indolent, or guilty of excesses in eating or drinking, or have poor, scanty fare -- and the fever will probably become a more serious matter.⁹

A number of interesting themes emerge from this passage. First, is the importance of observation in determining the causal-functional relationship of the fever and other biological/environmental factors (e.g. the north wind, the lack of proper nutrition, over-indulgence in drinking or eating). Second, is the relative “belief” or “unbelief” in the efficacy of quinine as a preventive measure, such belief or unbelief being based on

empirical observation. At another point in his account, Livingstone offers another observation regarding malaria and its causes:

This lakelet is ten or twelve miles in length, and five or six broad. It is nearly surrounded by a broad belt of papyrus, so dense that we could scarcely find an opening to the shore. The plants, ten or twelve feet high, grew so closely together that air was excluded, and so much suppured hydrogen gas evolved that by one night's exposure the bottom of the boat was blackened. Myriads of mosquitoes showed, as probably they always do, the presence of malaria. We hastened from this sickly spot, trying to take the attentions of the mosquitoes as hints to seek more pleasant quarters on the healthy shores of Lake Nyasa.¹⁰

Here is the rudimentary linkage between mosquitoes and malaria. A definitive linkage would be forthcoming, as European bio-medicine continued to develop its orthodoxies and institutional base in Southern Rhodesia.

As a side note, it is worth pointing out that David Livingstone was, in many ways, a proponent of n'anga. While other early missionaries and travelers focused on the evils of so-called paganism and witchcraft, Livingstone did not view the n'anga he encountered as necessarily a part of this alleged evil and, instead, insisted that they be shown the respect which one professional would accord another (Vaughan 1991:57). It was desirable, he wrote, to keep on good terms with "local medicine men" at all times, and not to "poach" patients from them. All slight cases should be referred to local doctors and "severe cases before being undertaken should be inquired into of the doctor himself and no disparaging remark ever made on the previous treatment in the presence of the patient" (ibid.). Livingstone's apparent collegial respect for African healers is noteworthy and certainly exceptional.

The developing medical infrastructure of the country was intimately tied to missionaries, hospitals being linked to the main mission of a particular area, clinics being tied to minor mission stations. Missions provided one or two completely equipped medical centers at the main mission stations with qualified (European) doctors and African personnel; male medical assistants (usually African) and/or nuns (also referred to as “sisters”) staffed rural outposts. Such medical facilities proved to be a powerful socializing tool, both in preparation for Christian doctrine as well as incorporation into the cash and moral economy of the growing colony. In many hospitals, for example, regular morning prayers and special services were held for disseminating the Gospel. Vaughan (1991:62) points out, at least with medical missionaries from the Church Missionary Society, prayers were said morning and night in the hospital, and lessons given on Sunday. Little opportunity was lost in arranging patients in such a way as non-believers of the Gospel were placed next to converts. In the magico-medical context of the mission hospitals, mission doctors, like local n’anga, were the embodiment of the sacred and the secular worlds. The missionary efforts of a Dr. M.H. Steyn, circa 1924, at the Dutch Reformed Church mission hospital at Morgenster eventually resulted in the local appellation “*nganga huru yenyika*” (the great ‘diviner’ of the country).¹¹

Such appellations were not surprising given the blurring of curative practice and sacred healing between medical missionaries and traditional healers. Gelfand (1988:73), for example, notes that “Africans regarded the missionary as a spiritual person comparable with his own n’anga and so believed that he had the same powers of healing. The only difference he could see was that the white man knew a different set of medicines, so he was anxious to try the new remedies.” For some Africans, especially in

the early days of missionary medicine, the apparent enthusiasm they had for missionary medics and medicines is indistinguishable from their faith in other magical devices. As Vaughn (1991:60) points out, a belief in the scientific and the supernatural were part and parcel of many African communities, as their own medical systems contained both the herbalist and the spirit medium. But, at least early on, patients were more interested in the immediate benefits of mission medicine, rather than the theological theories of healing which went with them.

The connection Africans made between science and the supernatural was, of course, not lost on medical missionaries. Some scholars speculate that missionaries sometimes unconsciously expropriated the habits and customs of traditional healers as a means to further their evangelization. Kibongi (1969:52-53), for example, notes:

For good or ill, Christianity has not always escaped the heritage of the nganga. The Christian missionary drew part of his authority, without knowing it, from the psychological state which the nganga had created. The missionary was called nganga Nzambi [God's priest], as distinct from nganga nunkisi [the fetish priest]. It goes without saying that the missionary benefited from the respect which was formerly due to the nganga vankisi...The Congolese priest or minister is also called nganga Nzambi. He profits from the situation created by nganga and the missionary. Nganga has not only assured to some extent the social status of the Church workers; he has also left them the legacy of religious and conceptual moral tools; it is undoubtedly nganga who created words such as Nzambi [God], munuka [to defile oneself; hence masumu, sin]...Nganga's work partly enabled the Bible to be translated into Congolese languages. The Christian preacher consciously or unconsciously uses part of the vocabulary left by nganga. This is where Congolese priesthood confronts biblical revelation.

This "legacy of religious and conceptual moral tools" left by n'anga in the current Democratic Republic of Congo is the very stuff missionaries used to translate Christian

Bibles into local languages. The availability of the Bible in local languages was thought to hasten conversion. As I have argued elsewhere, however: “Translation was much more than the simple exchange of English words into local words; it was the insemination of a particular American [and European] worldview...into a particular African worldview...” (2000:11). Such insemination was of course not complete.

Indeed, Kubongi’s above insight sheds light on the affect local languages and worldviews had, and have, on American- and European-based Christianity. “As a process, translation cannot be reduced to a simple statistical word-to-word ratio, a word in one language equaling a word in another, for language is more than the sum of its words. Languages contain their own particular internal logic, syntax, grammars and modes of symbolic ordering that defy direct translation” (ibid.: 11). In fact, the ability of local religion to infuse itself into Christianity and, in a sense, replicate, was a constant source of anxiety for many missionaries. The possibility of converts lapsing back into a belief in traditional medicine was a constant source of frustration to some missionaries. Such frustration and disappointment is apparent in narratives collected by Denys Shropshire in the 1930s. One narrative includes a letter written by one Fr Callaway in 1935:

It may be good to begin by telling you of the two recent happenings that have come upon us with quite a shock and forced us to realize, not only the tremendous hold that witchcraft still retains, but also that it has begun to take weapons from the Christian armoury and to use them with considerable effect. Although there is much effort to conceal the fact, every experienced missionary in these parts knows how tenaciously the old beliefs in sorcery cling to the minds of our Christian people, and how great is the temptation in times of sickness to believe that they are the victims of sorcery, and that only the witch-doctor, so called, can protect them. What is new to some of us is that some of our Christians

themselves are being captured by witch-doctors, to be themselves trained for the profession. In such a case it is not David who slays Goliath and wields his sword, but Goliath who slays David and adds his sling and stones to his weapons of offence (The Cowley Evangelist, 1935, p. 36, quoted in Shropshire, 1938, p. 407)

Here the conflation of 'witchcraft' and traditional medicine is apparent and neatly encapsulated in the catch-all term 'witch-doctor.' The above lament pertains to a young (African) girl and boy who exemplified Christian ideals, real success stories. After a long illness, however, the girl left the Christian confines of her mission school and consulted a n'anga.¹² Efforts were made by local Christian priests to bring her back to the mission school, but the girl resisted. Adding insult to injury, the female n'anga with whom the girl consulted was herself a lapsed Christian. Likewise, the boy, Julius, after visiting relatives for a couple of weeks, did not return to the mission school:

The fortnight expired but no Julius arrived...At the end of the third week a parcel arrived for Brother Gordon containing some of Brother Julius' 'clothing' and his crucifix...A day or two later the rest of his 'clothing' arrived...I wrote fully to an African (Christian) priest who ministers in that neighborhood and begged him to find out all he could. On the very next day a letter came for Brother Ambrose from Julius to say that he had been ill and that 'they' (presumably relatives) had gone to the 'doctors'...We then decided to send Brother Ambrose, together with one of our most reliable preachers, to try at least to open Julius' eyes to the danger of his action to his own soul. They returned after a week, having failed to see him. He was, they were told, about the country with his gqira (witchdoctor) (quoted in Shropshire, 1938, p. 407).

As with the girl, Julius consulted n'anga after suffering from a long illness. Acting as therapy managers, his family determined that he should consult a n'anga regarding the nature of his affliction. No doubt, the n'anga determined that a healing spirit was attempting to manifest itself in Julius; that is, he was 'chosen' by the spirit to

become a healer. Given the propensity of Africans to revert to, or be “captured” by, such beliefs, at least in the minds of missionaries, Christian education was seen as a central tool in eliminating such beliefs and practices. At the center of this belief system, stood the n’anga--usually referred to at the time simply as “witchdoctor.” In 1925, for example, Fr Burbidge recommended:

Is the power of the witchdoctor waning?...His spiritual power is as active as ever amongst the great mass of the people. To what extent the atrocious customs for which it stands have in fact been suppressed it would be rash to judge. This much is certain: its sinister shadow will rest in sunny Rhodesia for many a year to come and can only be chased away by religious education. The greatest importance therefore must be attached to religious teaching and moral instruction (Burbidge, 1925, p.31).

The above quotation nicely summarizes a popular way of seeing, understanding, and talking about African healers. These conceptual practices of knowledge--that is the understanding that healers were “sinister” and “atrocious”--were linked to the material practices of control in a number of ways, an important one being religious education. In other words, the question of whether to consult with n’anga was not only a medical question; it was a question of good versus evil (cf. Ranger 1978). Medical missionaries saw themselves as following in the steps of Christ the Healer. As a result, many saw African choices of therapy as choices of theology (Feierman and Janzen 1992).

In this sense, religious teaching and moral instruction provided the model for conversion; conversion, the model for schooling. As Comaroff and Comaroff point out (1990: 233): “Each aimed at the systematic, moral reconstruction of the person in a world in which individuals were increasingly viewed as capable of being formed and reformed

by social interactions.” Or, as Ranger points out (1992:259), one claim of missionary medicine was that the “hospital instilled time sense, work discipline, sobriety--those invaluable preconditions of rational thought and action.” Missionary hospitals and clinics were much more than simply healing institutions: they were a few of the many sites available for European social engineering. Such engineering projects were based on small, almost unnoticeable gestures: in the rules of hygiene deployed at clinics and hospitals, in the policing of domestic space under regimes of public health, in the required Christian rituals for patients attending clinics and hospitals (cf. Comaroff and Comaroff 1997; MacLeod 1988; Burke 1996; Thomas 1990). And as the above quotation from Burbridge intimates, there was no greater threat to this underlying moral order than the person of the “witchdoctor,” whose shadow of evil threatened the very light of Christian order, morality, and modernity. This point was echoed by Shropshire:

Not until a truly Christian and scientific education has corrected the balance of the present Native psychological complex, and enabled the Africans to meet their phobias with a critical mind, giving them confidence in themselves and ability to control their own environment, will they come to see that the wonders of magic and sorcery are not so marvellous as the wonders of a truly and proportionately developed personality, the more especially if that personality at the same time maintains the true ‘abandon’ of the fullest Christian life (1938, p. 422).

Conversion and schooling as inseparable processes were thus an effort to reform the African worldview, particularly as it related to the perceived power and centrality of the n’anga. For missionaries such as Schropshire and Burbridge, n’anga were a particular focus of concern and both missionaries codified their thinking on the dangers of n’anga through a series of published articles. For both missionaries, education was seen as a key

tool in eliminating African peoples' dependence on, and belief in, n'anga. Burbridge (1930:85), for example, wrote: "Now, admitted that the best minister to minds thus diseased is a course of medical study in the school above referred to, the mass of people among whom its students are to find their patients would remain still stupid in the old ideas...In like manner, no Native patient will call science to his aid until a light dawns on his mind by which he will see that the witch doctor is an unwholesome charlatan, and that from the crown of his head to the sole of his foot there is no soundness in him. For this it is essential that the whole spirit system be thrown out the doors."

The tropes deployed by Burbridge are, by now, common: education versus stupidity; the light of missionary education versus the darkness of African vernacular systems of thought and practice; the unwholesome trickery of the n'anga versus the wholesome honesty of missionary medicine. These recurring and durable dualisms inscribed African therapeutic practice as a repository of disease, backwardness, and immorality in the minds of European and American missionaries alike.

Such obstacles could only be overcome through the aggressive and sustained reformation of the African from the inside out. In their overt forms, these efforts at reformation comprised sermons, lessons, and at times, outright intimidation. Such teaching was designed to bring about conversion to, and acceptance of, a moral, civilizing order through exposure to a Christian sacred narrative. In their covert forms, such missionary instruction was meant to reform--from the inside out--the African spirit, mind, and body through engagement "...in an argument whose terms they regulated, and whose structure bore the hegemonic forms, the taken-for-granted tropes, of the colonizing culture" (Comaroff and Comaroff 1990:199).

The imperialistic nature of missionary medicine is hinted at by a number of early missionaries. Bishop Smythies of Zanzibar, for example, defined a medical missionary as “a doctor who uses all his medical knowledge for a missionary end, whose aim it is to use the great influence to which his professions gives him to draw his patients to the love of God” (Ranger 1992:258). The tropes utilized by some missionaries in their encounter with “traditional” medicine were those of “battle” with African superstition. Many of these tropes had practical consequences as missionaries utilized their medical knowledge, at times, as a veritable weapon. A missionary nurse in Tanzania, for example, after beginning a successful treatment of a child’s skin disease, was taken aback when she found the child’s mother had also taken it for treatment to a traditional medical practitioner:

I doctored it and the places were healing beautifully when I found that the child was wearing charms. I told (the mother) that I could do no more for it till they were removed. But it was no use; she refused to take them off, so I put the ointment away...Eight months or so have passed since then, during which time the child has worn the charms and has been getting very much worse. Over and over again the mother has begged me to cure it...It has been very hard to see the poor little thing growing worse and to hear its piercing screams when they put on native medicine, and yet do nothing to relieve it. Now, I am only too thankful I did not yield...I told her once more that I could do nothing till she gave up *the medicine of the devil*. Greatly to my surprise she cried, “Give me a knife” and immediately cutting off the charms from her child’s neck gave them to me. I joyfully went in and prepared the ointment. You will be glad to hear that the healing has been very rapid (quoted in Ranger 1992:258).

Perhaps the fact that sister Williams would deny care to a suffering child for so long was testament to her great faith, conviction, and compassion. Perhaps not.

The above quotations illustrate the underlying models some missionaries utilized in their dealings with African populations. In this instance, these are social pathological models; that is, the view that disease--of the mind, body, and spirit--could only be conquered through the advancement of Christian morality and a sanitized modernity (Vaughan 1991). As such, n'anga served as the counterpoint to these worthy states of being: they were immoral, pathological, and backwards.

Such a viewpoint is further illustrated by a mission doctor's entries in the journal, *Central Africa*, in 1942, after his encounter with a "witch doctor":

I asked him if he had any medicine that would make a man live for ever. He fumbled in his basket, drew out one of the bundles and undid it with great deliberation. Inside he showed me some earth, scraped from the surface of a cliff on a river bank, and told me that it should be mixed with castor oil and used for anointing the body, so that the body may prosper. 'But even so', he added pathetically, 'we still die.' I told him that WE HAVE the Medicine of immortality and where and what it is. I told him that it was to be had in Church, but of course he did not know what I meant. Still, I don't think it would be very difficult to teach him. Perhaps I might begin by pointing out gently the inefficacy of his own medicines...¹³

As Vaughan (ibid.) points out, though a far cry from the respect for local "professionals" advocated by Livingstone, the above entry is perhaps more representative of medical missionaries' attitudes toward African therapeutic systems. The site, par excellence, of such encounters was usually a mission-run clinic or dispensary: "What are the curious bits of wood hanging on that baby's hair, or those dirty pockets on that woman's neck...they are heathen charms, warn to keep off the various diseases..." In the face of African witchcraft and superstition, the clinic embodied Christian morality,

domesticity, and order--a site for the reformation of the sickly African body, mind, and spirit.

The question remains how much real power missionaries had in enforcing such programs, particularly for those Africans not living in the vicinity of missions. For Africans inhabiting mission lands, however, the situation was much different. Like other missionary groups that had been granted huge tracts of land by Rhodes, the Dutch Reformed Church (DRC), for example, wielded a great deal of control over local peoples living on these lands, effectively subverting the historic authority of chiefs. At their discretion, missionaries could effectively eject individuals or villages based on “bad conduct, persistent poor cultivation of the land, or the refusal to educate their children” (Daneel 1971:207). While never forced to attend church services, local peoples were, nonetheless, subjected to “Westernized Christian ideals of orderly behavior” (ibid.). In the developing mission economy, local peoples soon came to realize that their material interests would be best served through strategic relationships with the DRC and its missionaries.

Initially, of course, many African people did not see their material interests best being served in this way. As the following story illustrates, some medical missionaries were aware that their medical practice (which, while free, carried its own costs) stood in competition with local n’anga. This competition can be seen in the case of Doctor and Mrs. Owen of Zimunya, a mission station on the summit of a high mountain in Mashonaland, about twenty-five miles from Umtali. The September 25, 1897 edition of *The Lancet* carried a story of how one early morning, they found themselves under attack by “the witchdoctors”:

Dr. Owen fired at the miscreants, but they made a hasty retreat, and unfortunately escaped. The Rev. Mr. Caulfield [who had been visiting when the attack occurred] attributes the attack to the jealousy of the native witch doctors, who for many generations have attended the sick, and, it would seem, have been well paid for their services--sometimes, it is said, the equivalent of 4 or five pounds a case. They found their occupation gone and their reputation eclipsed by the enlightened treatment of Dr. Owen, for which no charge was made. It is inevitable in Africa, as elsewhere, the witch doctor must be superseded by the educated physician, and we congratulate Dr. and Mrs. Owen on the happy ending of what might have been a serious disaster. We are not entirely without sympathy with the superseded local practitioners. They upheld the dignity of the art in one respect--they charged for their services, and it is open to them to say that their successful competitor owed his success rather to the fact that his advice was gratuitous while theirs was not. The missionary uses of medicine are most legitimate and beneficent, and in the case of the poor they must be applied without money and without price, but the more free from pauperising abuse it is the better. If the natives can pay, as apparently was the case with many of the people there, they should be required to do so. In introducing the virtues of religion into barbarous countries we must try not to introduce its vices.

As with Gelfand's (1988) *Godly Medicine in Zimbabwe* and his (1953) *Tropical Victory: An Account of the Influence of Medicine on the History of Southern Rhodesia, 1890-1923*, mentioned above, this account of a "witch doctor" attack utilizes the common tropes of the day and is a fitting final image with which to conclude this chapter. It paints Dr. and Mrs. Owen as the saintly saviors of local peoples: they suffered gently at their isolated mission station; they provided free medical care as compared to the "pauperising abuse" of the local n'anga; and the medical care they provided--it is implied, at least--was more efficacious than that of the local n'anga who, after watching his business become threatened, decided to attack the goodly medical missionaries. Readers of *The Lancet* must, no doubt, have been impressed by the continued efforts of the Owens given such obstacles. Their apparently heroic efforts take the rhetorical form of the European

medical missionary's victory over African disease and suffering--afflictions local n'anga are interested in ameliorating solely at great expense to their patients. In short, the above story encapsulates the idea of n'anga as dangerous subjects, subjects who stand as obstacles to a modernizing, Christian, moral order. As we shall see in later chapters, this particular construction of n'anga has turned out to be a particularly durable one.

¹ Cf. Etherington (1987) for the Nguni; Comaroff and Comaroff (1997) for the Tswana.

² From the preface.

³ Jean and John Comaroff, *Of Revelation and Revolution: Christianity, Colonialism, and Consciousness in South Africa*, (Chicago, 1991), p. 86.

⁴ One can only speculate as to what place Moffat occupied in the African imagination and how he was incorporated into the local sign and symbol systems. One would think that because he was a religious practitioner as well as a rudimentary medical practitioner, he fit easily into local conceptions of religious/medical specialists (e.g. the historical role of n'angas).

⁵ Gelfand, p. 5.

⁶ *ibid.*

⁷ *ibid.*, p. 7

⁸ The language of natural science had already captured the imaginations and intellects of Europeans through the firmly entrenched works of Linnaeus, Buffon, and others whose works had established the hard facts of organic form. See Good (1994), p. 8. See also Comaroff and Comaroff (1991), p. 99.

⁹ Quoted in Gelfand, p. 9

¹⁰ *ibid.* p. 10.

¹¹ M. L. Daneel, *Old and New in Southern Shona Independent Churches, Volume I: Background and Rise of the Major Movements*. (The Hague, 1971), p. 230-231.

¹² This is the standard narrative for how a person becomes a n'anga. It often happens that a person destined to become a n'anga gets sick, the sickness either taking the forms of a mental disorder or chronic ailment which does not respond to conventional Western-derived medicine. Recovery usually only takes place after the patient has consulted with a n'anga who is able to diagnose the true cause of the illness--that either an ancestral or other healing spirit is attempting to make itself known (cf. Gelfand 1985).

¹³ Quoted in Vaughan 1991:72

CHAPTER TEN

Colonial Control and Natives Making Noise: The State and Traditional Healers

The prejudice of our Natives against hospitals and scientific methods of medical treatment resists all reason and argument with the stubbornness of a natural instinct. It is really a morbid symptom arising from an outlook on life in which disease itself is made an object of worship. Obviously such a malady lies beyond the province of the physician. To whom then should we look for a remedy?

Rev. Father A. Burbridge, S.J., 1930

It is a great paradox that the evidence for the nature of the relationship between n'anga and the colonial state is relatively scant. An assumption I held, before poring through the Zimbabwe National Archives and talking with n'anga who had lived and practiced during colonial times, was that the colonial state worked actively to stamp out a belief in, and practice of, local African therapeutic systems (ATS) much as the medical missionaries before them had done. Viewed as a threat to the developing colonial social order, I assumed, the practice of ATS was actively discouraged by government officials (again, along with early Christian missionaries). This assumption was supported by some literature (notably the work of Chavunduka 1999, 1994). An alternative explanation, however, is that the colonial state practiced a form of "benevolent neglect" (cf. Beck 1981; Waite 1993), symptomatic of the great ambivalence they felt toward African therapeutic systems and its practitioners.

The ambivalence with which the colonial government viewed African therapeutic systems involved a number of points. First, there was a general suspicion and ignorance of the efficacy of indigenous medicine and practice in effectively treating afflictions--

broadly defined (Chavunduka 1999; Waite 1993). This concern found legal expression in efforts to control or curtail local healing traditions and practices. Second, like their missionary counterparts, some government officials felt that n'anga encouraged a belief in witchcraft which was regarded not only as a hindrance to Christian missionary work, but a real threat to colonial production in mines and large-scale commercial farms (especially since imputations of witchcraft usually meant slowdowns in production and general social unrest). Both of these beliefs on the part of the colonial government resulted in legislation, namely through the Medical Council of Rhodesia and the Witchcraft Suppression Act of 1899, both of which worked to curtail, directly and indirectly, the activities of n'anga whom, in many cases, were also assumed to encourage an active belief in witchcraft. However, as one n'anga who practiced his trade under colonialism told me, "As long as we weren't making noise, they [the government] didn't bother us." Relying on primary and secondary sources, these various ways of seeing, understanding, and talking about African healers are handled more fully below.

Representative examples of all of these beliefs are evident in an incident which took place over the span of a couple of years in 1912-14 concerning "Mlimo" worship and the concern it generated among colonial officials. As the following correspondence illustrate, the colonial government's response to local practices deemed "witchcraft" were legalistic in nature; that is to say, there was an assumption on the part of some officials that such beliefs and practices could be legislated away. One of the Chief Native Commissioners of Salisbury, concerned over the alleged sacrifice of girls to the Mlimo, linked the emergence of Mlimo worship to difficulties caused by a drought, writing, "The supplying of girls to the Mlimo was a common practice before the advent of civilized

Government. The hardship caused by the drought is no doubt driving natives to turn to the Mlimo for relief, and although our interference will no doubt cause much dissatisfaction, and may even be attributed to a desire on the part of the Government to prevent the Mlimo giving the people relief, I presume traffic in human beings cannot be tolerated, and the Native Commissioner should be instructed to pursue his investigations with a view to the recovery of the girl."

Part of the problem in controlling such activities was the fact that they were carried out with a great deal of secrecy. A letter from one of the Superintendents of Natives from Salisbury, dated December 6, 1913, captures this sense of frustration:

I have the honour to inform you that it is a well known fact that the natives in Mashonaland practice witchcraft to a great extent, but it is almost impossible to discover cases owing to the secrecy that prevails. Cases described by the Acting Native Commissioner, Wankie, have been heard of in this territory. They are not general, but I am of the opinion that legislation is necessary on the lines suggested by the Acting N.C. so that the Witchcraft practices adopted by the natives may be stamped out.

Other colonial officials were also of the mind that legislation was the key to eradicating the belief in what they termed witchcraft.¹ For example, a Superintendent of Natives from Bulawayo, in a letter dated December 9, 1913, wrote: "It is my experience that threats of injury by occult means are frequent. I have thought for some time that the Witchcraft Suppression Ordinance needs re-drafting by reason of its being generally inadequate. This would in my opinion be preferable to patching it up by penalizing the class of acts now under report." Another Superintendent of Natives from Salisbury concurred in a letter dated December 18, 1913: "...I do not think that the practice alluded to by the Acting Native Commissioner, Wankie is very general, but I think it would have

a beneficial and a deterrent effect if provision by legislation could be made for those natives convicted of such practices.”

In a letter summarizing the various opinions on the matter of furthering legislation to suppress witchcraft activity, the Chief native Commissioner of Bulawayo wrote:

With reference to your...correspondence from the Acting Native Commissioner, Wankie, and the Solicitor General, on the subject of witchcraft among Natives, and asking for an expression of opinions as to whether the practice alluded to therein is so general as to justify legislation, I have to inform you that, with a view to obtaining a consensus of opinion on the subject, I communicated with the Superintendents of Natives and attach there replies hereto.

The practice would appear to be more common in the Districts comprising the Umtali circle than in the remainder of the Territory.

With the exception of Mr. S. N. G. Jackson, who is somewhat doubtful as to the advisability of introducing further legislation in this direction, the opinion is in favour of the Witchcraft Suppression Ordinance being amended in order to provide against the practice alluded to.

While agreeing generally with the opinion expressed, I do not know whether the law can be so amended as to confine the provisions thereof to such instances as quoted by the Acting Native Commissioner, Wankie.

Natives are inclined to construe any unusual occurrence in their homes or elsewhere to threats by some person or persons portending some form of calamity to themselves.

Bringing closure, if only temporarily, to this debate, the Attorney General responded on January 26, 1914:

A perusal of the Witchcraft Suppression Ordinance establishes the fact that what we have to prevent is the infliction of material injury of some sort to the individual. All the offenses mentioned would lead to the infliction of physical harm, in some cases probably death, or in the very least to the driving away of the person accused from his kraal and a refusal

of his friends and family to associate with him [in the event that it was divined that a witch was causing the drought]. The endeavor of the law is to prevent actual injury to the person or property of the individual through an accusation of witchcraft being laid against him. I might point out that our Courts have refused to convict where “spirits” of persons have been designated as causing the mischief alleged, even though this result may lead to untoward consequences to the person responsible for the propitiation of these spirits.

If we go further it appears to me we would be in danger of rather establishing the belief in witchcraft than suppressing it. We would by legislation of the nature sought exaggerate the very idea and convey the impression that we ourselves believed that these occult powers existed and were real.

Legislation has this further objection, that it would be almost impossible to define what acts or threats were punishable. Any adverse remark or threat of any sort would grow into a threat of witchcraft. Every unusual circumstance, or even natural death, would be referred back to some supposed threat however remote either in time or expression.

I am fully aware of the very real nature of this superstition among natives and how important a part it plays in also every action and event in their lives, but we cannot eradicate this belief by law. It is the belief that is the cause of trouble, not the pretended exercise. *This mental condition exists among many of our own class and can only be removed by time and education* (emphasis added).

The above response illustrates a certain level of ambivalence with regard to--and more particularly, the legal responses to--a belief in the practice of witchcraft. From the above argument, it appears to be a feeling of ambivalence based on pragmatism: 1)

Pursuing amendments to the Witchcraft Suppression Ordinance for the further punishment of people conducting anti-social and harmful acts (i.e. “witches”) might give local people the idea that the colonial government and courts were indeed formally acknowledging the existence of witches; 2) Developing consensus as to the definitions of acts or threats as punishable under the Ordinance, especially when such threats were an everyday occurrence in most communities, continued to confound colonial officials; and

3) Beliefs could not be eradicated by law, but rather, according to the Attorney General, through education and time.² The above exchanges seem to indicate that unlike the medical missionaries, the colonial administration had no moral imperative spurring them into a holy crusade against African vernacular beliefs and practices.

Oddly enough, a few days later at the Wankie Colliery, the above conclusion would be put to the test as two African men were accused of inciting a belief in witchcraft. As the following correspondences demonstrate, the real concern was not so much the illegality or immorality of the men's actions, but rather the impact their actions had on the general state of mind of other Africans working in the area which, in turn, could potentially impact production at the mines. Below is the story in the words of one of the Superintendents of Natives in Bulawayo in a letter dated February 14, 1914:

With reference to previous correspondence on the subject of witchcraft, returned to you on the 10th instant, I have the honour to inform you that a peculiar case has arisen in the Wankie Colliery Compound. The matter came to a climax on Sunday morning, 8th instant, on the death of a Compound Police boy from double pneumonia.

The facts of the case are as follows: When the Compound Manager visited the Compound on Sunday morning, he found the Natives considerably excited, and elicited from his head police boy and his clerk (an intelligent Yao native) that the Natives accused two others of having caused the death of the police boy by means of witchcraft, and had likewise caused the death of several other natives, including women. They were clamorous for the removal of the two men, and owing to the strong feeling existing, the Compound Manager deemed it prudent to secure the two Natives. He asked me to investigate the matter; thereupon I proceeded to the Compound, and made enquiries among the Natives. The information I gathered was that the two in question were in the habit of boasting of their pretended supernatural powers, and claimed to have been instrumental in causing the death of certain Natives who recently died from various causes. Later on a woman appeared, who deposed that one of the two accused had made immoral overture to her, and as she resisted, he had handed her a piece of stick coloured red at one end, and had

threatened she would die, if she threw it away. The woman held the stick all night, and on the return of her husband the following morning from work, she reported the matter to him. He was incensed and with difficulty restricted from assaulting the man.

Since then another woman has deposed that the same man handed her a charm--consisting of a small white cloth bag--after she too had resisted his solicitations. On the bag being opened by the Compound Manager, to whom the woman complained in the first instance, he found a piece of paper therein with writing in the Swahili language. I understand that the translation is to the following effect: "I am giving this to you to put on your neck. I do not want to find you going with another man, and if you do I will do something to you to make your heart hurt. These words are true Mahomet knows." Signed Side Bowoza.

Of course, Natives are prone to exaggerate minor occurrences. But I certainly believe that these two Natives have been intending mischief of some kind; and to me it seems very probable that they may have endeavored to get women to consent to sexual intercourse, by means of threats of witchcraft. It is extremely difficult to get the facts of each case. Now that the two Natives are branded as wizards in the Compound, it is very likely that many things will be imputed to them, that they will be accused of various practices and be made scape goats generally.

In dealing with cases of witchcraft, we must distinctly bear in mind, however, that with Natives it is terrible reality, though absurd their conclusions may be to our mode of thinking. The most trifling or harmless incident is often construed as proof positive of the magical machinations of the person suspected of witchcraft.

The aspect which I desire to submit for your consideration is this: There is considerable excitement among the Natives employed on the Colliery, who regard generally (with what reason is not necessary to consider here) two others as practicing witchcraft. If they are permitted to remain in the compound, it is probable a number of Natives will desert out of fear, and very likely cases of assault, or charges of rape, will be preferred. On the other hand there does not appear to be any means by legal process of deporting the two Natives as undesirables.

The question of threats to bewitch has already been under consideration; possible it may yet be found advisable to reconsider the whole of the existing Witchcraft Ordinance. What seems to me as essential [sic] is the consideration of the matter from an industrial point of view: the effect of such threats, and the consequent fear or excitement caused to Natives in service.

The concern voiced above is the impact of imputations of witchcraft on industrial production at the mines. Interestingly, too, the Witchcraft Suppression Ordinance (WSO) --written on the belief that witchcraft did indeed not exist--did not provide a legal means to indict, convict, and deport the two “undesirable” men because it was written to punish the *accusers* of alleged witches, not the witches themselves (as they did not really exist).³ Subsequent correspondence from colonial officials focused on the production impact of these accusations, especially in light of the above restrictions under the Witchcraft Suppression Ordinance. One Superintendent of Natives from Bulawayo, on February 18, 1914, wrote: “As the law stands no criminal action seems possible, but the management of the mine can secure peace by getting rid of the two men.” The Secretary of the Law Department in the Chief native Commissioner’s office, on February 24, 1914, wrote: “In order to allay an industrial disturbance resulting from this incident, the safest plan would be for the mine authorities to dismiss the two natives concerned and responsible.”

Part of the conundrum for colonial officials trying to regulate witchcraft and witchcraft accusations was the slipperiness of their own legislation with regard to these practices and accusations. As Chavunduka (1998) argues: “In the Witchcraft Suppression Act, witchcraft is defined as, ‘the throwing of bones, the use of charms and any other means or devices adopted in the practice of sorcery.’ As a matter of fact, this definition says nothing about witches and witchcraft.” Legally, of course, for colonial officials, witchcraft *per se* did not exist. Of course, if witchcraft did not exist legally, it did very much exist in the life of the average black African. And it was this sustained belief in the reality of witches and the omnipresence of witchcraft on the part of black Africans that continued to thwart colonial efforts to the contrary.

Another incident which sheds some light on colonial understandings of, and reactions to, vernacular medicine and practice can be seen in the “muchapi” craze that swept much of southern Africa at various points in time, most notably in the case of Rhodesia in the 1930s. An analysis of the muchapi phenomenon helps shed light on the colonial government’s developing sense of African medicine, broadly defined. Additionally, muchapi, as a form of African medicine, and the diverse responses it drew, foreshadows responses to other contemporary African--and non-African--medicines and HIV/AIDS (see, e.g. the response to Mocreia in Chapters Six and Fourteen). Richards (1935), for example, discussed the work of witchfinders in Northeast Rhodesia among the Bemba who used “mchape,” “a fine red powder which gave a soapy solution when shaken with water in a bottle” (1935:449). Anyone identified as a witch was given the medicine to drink which would, presumably, prevent them from any further witchcraft activity.

The origins of mchape are said to date back to the year 1930. Allegedly a local chief in the Mulanje area--in the south of Malawi--had bought a medicine in Mozambique from a European to cure the illness of a member of his family (Fields 1985:79). It was this concoction, allegedly, which later became known as mchape. Another story holds that the concoction originated with a man named Kamwembo--a Lazarus-like man who was given the secret of the concoction while in the grave. It was said he could resist poisons of all kinds. The March 28, 1931 *Herald Sunday News* reported it this way: “A great witch doctor died, and was buried with due pomp and ceremony. A few years after his death he reappeared on earth, bringing with him a wonderful ‘muti,’ (Muchapi), which he averred had been given him by the tribal spirits to

bring to earth for the benefit of his people. Such were its wonderful powers that its popularity was immediate and rapidly spread southwards, till to-day [sic] great trade in it is done in Southern Rhodesia, although prohibited by the white man's law." As news of this spread, the demand for mchape grew. Distributors assembled to take advantage of the demand and began traveling around the region to administer the new medicine (Probst 1999:120).

The following extract is from the Native Commissioner of Fort Victoria in 1932 regarding the fraudulent selling of "muchape" (also variously referred to as "muchapi" and "ncape") by three Africans, George, Rice, and Robin.⁴

An interesting illustration of the general survival of primitive beliefs in spite of many years of close contact with Government and Missions is afforded by the wide-spread [sic] sale towards the end of the year of a concoction known as "ncape." The ingredients of which this "medicine" was composed were believed in the first place to have been brought from the coast near Quelimane, but it was found out afterwards that it was manufactured from the bark of the Cape Mahogany (*Trichilea emetica*) which contains neither harmful nor medicinal properties. Its vendors claimed for it the power to cure all ills and render the drinker immune to poison and witchcraft, alleging also that any witch who drank it without first destroying the utensils of his trade would surely die. Hundreds of horns, tails and other component parts of the paraphernalia of the witch were surrendered voluntarily within a short period and it might be supposed that much could be said in favor of a medicine which could stamp out that haunting fear of witchcraft which the Africa is obsessed.

Incidents like the one mentioned above appear to be few and far between; and while one reading might be that the prosecution of the sellers of "muchape" signaled the colonial government's attempted eradication of African therapeutic systems, another reading would point to a more pragmatic concern with social control. This concern with social control is hinted at later in the N.C.'s report:

...it was sampled so widely that anyone who refused to partake immediately became an object of gravest suspicion. The question of witchcraft has recently formed the subject of a protracted discussion in the public press, and it has been stated repeatedly and with unassailable truth that acts committed with implicit faith of past generations cannot be judged by modern civilized standards. But in Nyasaland the suspected witch has short shrift. He may become the victim of poison secreted in his beer, or he may be impelled to declare his innocence by taking "mwabvi", or he may be forced to drink medicine to purge himself of his witchcraft, and even in the last alternative he may not survive the ordeal.

For these reasons the act of accusing any person of witchcraft was made a punishable offense under the Witchcraft Ordinance, 1911, and in some cases arising from the sale of "ncape" it was necessary to have recourse to the law. For the most part, however, when the fraud appurtenant to the origin of the medicine was exposed, the natives were quick to realize that they had been duped, and although one middleman believed so firmly in the efficacy of his wares that he gave a demonstration of drinking poison after a prophylactic dose of "ncape" with immediately fatal results, little real harm was done beyond relieving the credulous of their wealth, and the wave subsided rapidly after passing through each district in its turn.

Witchcraft was generally viewed as a threat to the colonial government mainly because, as I mentioned above, it led to social unrest which impacted the colonial economy through work stoppages. Such social unrest usually took the form of the suspected witch: being driven out of the local environs (or killed); or asked to drink a witch-finding elixir; or alternately, to drink an elixir that would "purge" the suspect of their witchcraft. As a result, great care was taken by the colonial government in dealing with imputations of witchcraft.

However, it was not only the "natives" who believed in the possible powers of muchapi. A *Herald Sunday Times* article (the same quoted above) entitled "Money In

Muchapi,” under the banner “Queer World,” sounds like an open advertisement for the medicine:

If you suspect a person of evil intentions against you, think of him while taking a swig of muchapi, when he will (or ought to) immediately drop dead, no matter where he is. or sprinkle some on the threshold of your dwelling, and anybody entering with the intention of harming you, or stealing will likewise drop dead. They may be revived, if you wish, by administering a dose of the same medicine.

Similarly, you may protect your garden, orchard, or crops from the depredations of animals, and also from the vagaries of the weather.

If your wife runs away from you, drink some muchapi whilst thinking of her, and she will fall senseless, wherever she is, remaining so until you arrive on the scene to administer a reviving dose of this amazing ‘muti.’

As the above account demonstrates, White colonists were also very interested in local Black beliefs and practices surrounding witchcraft and therapeutics--whether from the perspective of “exotic” beliefs, as threats to colonial economic endeavors, or in some cases for usage in their own lives (see also Chapter Fourteen). The following story of a Gerard Peirce, recorded by the Rhodesian National Archives in 1972, illustrates the pragmatism with which some white colonial officials treated African vernacular belief and practice:

Gerard Peirce served as a police man, stationed at Chibi (a relatively isolated post), and according to interview transcripts, took a great interest in African superstition and witchcraft. At the time of his appointment to Chibi, one of the most terrible customs was the killing of twins, or of one of the two. The baby would commonly be placed in a beer pot filled with hot ashes and buried in a stream with running water. In conjunction

with the minister of the local Dutch Reformed Church, Peirce tried to put a stop to the practice but had little success. Perhaps two or three cases were brought to justice. Letting both children live was, of course, a crime in the eyes of the African people, transcripts acknowledge.

Peirce was of the belief that “witchdoctors” had the power of second sight. Whilst serving in Gwanda, for example, Pierce was walking along a path and came across a bag of tools, obviously those of a “witchdoctor.” He made his way to the nearest headman, whose son was a (relatively young) “witchdoctor,” and asked him if he had lost anything. He was told that the loss of the tools was causing a lot of trouble in the district. Elephants were destroying the lands. When he handed back the items the man was more pleased than any African he had ever seen. In due course, Pierce made his camp nearby and used to regularly ask the “witchdoctor” to throw the bones (*hakata*) before he went on hunting expeditions. Peirce’s own domestic servant would report the results to him-- “Today you will not see anything,” or, “Today you will be successful.” The “witchdoctor” was invariably right. On one occasion the “witchdoctor” accurately predicted that he would slaughter a female nyala carrying a male calf.

He was 250 miles from the police headquarters and supplies sometimes ran short. The witchdoctor would be able to report that the gang had left and would be arriving on such-and-such a day.

Peirce had a discerning interest in vernacular medicine and practice, recognizing that some “witchdoctors” were definitely evil. For example, there was one man in Chibi area whose hands had been chopped off by the Matebele in the old days. Allegedly, this man had a remarkable power over a flock of wild birds that lived in the area. A Native

Commissioner had reputedly not believed his power and had made him kill and eat one of the birds--shortly afterwards, though some may call it coincidence, his child died. The local Africans certainly believed that the "witchdoctor" could send the birds to sit on an enemy's roof and this would bode ill for him. His son wanted a certain girl but another youth married her; within a month--possibly through suggestion--the couple were dead. When Pierce came to the district, this witchdoctor brought him half a dozen small elephant tusks as a present. He declined them politely. The Native Commissioner, A.T. Holland, complimented him on the decision. If he had accepted he would have had trouble; the tusks were, perhaps, poisoned (Oral/PE 1).

In other instances, whites and other non-blacks have been involved directly in cases of witchcraft as either alleged victims or, in a few cases, direct transgressors of the Witchcraft Suppression Ordinance. In 1921, for example, in the Matopos (an area in the southwestern portion of the country) a white trader and an African man had a long-standing unspecified disagreement. The African man had a local reputation, in the English vernacular of the day, as a "witch doctor." After several suspicious fires on his property, the trader attempted to have his nemesis removed from the area to no avail. Eventually, one of the trader's African employees was murdered and evidence pointed to his rival. Following the arrest of the "witch doctor," the trader began acting strangely, eventually divesting himself of his clothing and taking to the hills. Colonial authorities speculated his mind had become unhinged after the damage to his property. Local people, however, believed that the trader had been "tagata-ed" (perhaps a corruption of "targeted"), or bewitched, by his rival.⁵

In another case, a Colored woman was charged with contravening the Witchcraft Suppression Ordinance in 1954. Apparently, she had had a fowl stolen from her and, under the advice of some friends, went to a “witch doctor” who divined the identity of the thief. After confronting and reporting the alleged thief to authorities, the woman--not the alleged thief--was charged with transgressing the Ordinance, found guilty, then reprimanded and discharged.⁶ Likewise, a white man who forced his black employees to drink a blue liquid (a “witch-finding” elixir) after a work stoppage in 1951, was also convicted of contravening the Ordinance.⁷ These cases, in part, speak to the blurring of boundaries between black and non-black, to an ontological overlap of what were previously thought of as very discrete systems of belief/knowledge and practice.

Such ontological blurring was perhaps the exception rather than the rule. In other spheres of activity, great care was taken in essentializing differences between blacks and whites--particularly with regard to medical traditions and practices. The Rhodesian Medical Council, for example, developed policies to suppress the practice of African vernacular medicine. They did not recognize African vernacular healers as medical practitioners; and they forbade medical doctors to refer patients to healers or to work with them in any way. If doctors did so, they did so at their own peril: they might be accused of a breach of ethics and were liable to penalties through the Medical Council. Patients who visited hospitals and clinics after consulting healers were often insulted by doctors for doing so. In commerce and industry, some workers lost their jobs or part of their salaries because they had been absent from work while consulting with healers. Meanwhile, workers absent from their jobs while consulting medical doctors were not

dismissed or given reduced salaries, provided they produced a letter or certificate from a biomedical doctor. Letters given by healers were not accepted (Chavunduka 1998).

Some colonial public health campaigns shared a similar logic. In her discussion of colonial health education films and the question of identity amongst Africans, for example, Vaughan (1991) reviews a film on venereal disease that was produced during the second World War. Made by the African Film Production Company in South Africa, and sponsored by the South African Red Cross, the film was screened in much of southern Africa. The story was a simple one, tracing the fate of two brothers, both of whom contract syphilis during a spell as labor migrants in Johannesburg--the film is now almost prophetic given the well-documented role of labor migration and the spread of HIV/AIDS. There is much to comment on about this film: the representation of Africans and African cultures, the assumptions about “traditional” practices, discourses on morality, sexuality, health and nationhood. I set these themes aside to focus on a particular aspect of the film, that is its depiction of “traditional” healers.

The film regards to brothers--“Mr. Wise” and “Mr. Foolish”--and centers on their different responses to the discovery that each has syphilis. Mr. Wise heeds a friend’s advice, after receiving a pamphlet about syphilis from him, and visits a hospital for treatment. At the hospital, he is received by a white doctor and an African assistant. After some preliminary education about the disease, he is given a shot in the arm and, with a smile and some instructions, dismissed. Mr. Foolish, on the other hand, after seeing the same brochure, instead visits with a traditional healer. Vaughn (1991:81) writes:

The next scene takes place in a ‘witchdoctor’s’ surgery, bedecked with skins, horns and bottles. The witchdoctor is shaking up a bottle of liquid,

which he then gives to Mr. Foolish, with instructions as to how much to take. Mr. Foolish thanks and pays him, and we are shown a close-up of the coins on the witchdoctor's palm, and a parting shot of him counting the money.

As the film progresses, there is a scene of the two brothers meeting, Mr. Wise saying that he has been cured and that he will soon be marrying the woman to whom he is betrothed. Mr. Foolish, however, appears noticeably ill, with lesions on his face. Mr. Wise advises his brother to go to the hospital for treatment, which his brother refuses. In a later scene at the hospital, Mr. Wise thanks the white doctor for curing him and offers him money, which the doctor benevolently declines (this scene is reminiscent of *The Lancet* article, discussed in the last chapter, in which medical missionaries are seen distributing free medical treatment as opposed to the local traditional healer who is seen as charging exorbitant prices for sub-standard medical care). The final scene of the film depicts Mr. Wise as being rewarded with health, fertility, and prosperity--the fruits of following the instructions of his friend and seeking proper medical treatment. Mr. Foolish, by the end of the film is, however, sick, blind, and poor--the punishment for being stubborn and willful in the matter of treatment and persisting with a superstitious belief in the efficacy of the "witchdoctor."

This colonial film on venereal disease, and its attempt to fashion a particular construction of traditional healers is evocative of Foucault's notion of objectification which draws attention to the role of discourse in explaining and naming reality. Inherent in this classificatory process is a sense of cohesive patterning, or what Pigg (1995) refers to as 'translation,' which produces a sense of truth and fact (remember the scene of the "witch doctor's" surgery) which, in turn, gives rise to particular techniques for managing,

organizing and disciplining people. This process relies heavily in the creation of discourse accorded a scientific status (Foucault 1979:24). The desired end result of the colonial venereal disease film was ostensibly 'rehabilitation' of those Africans who felt the need to visit traditional healers when illness struck. Much as was the case with missionary efforts at reformation in the previous chapter, the rehabilitatory process implicit in this colonial public health campaign film was supposed to instill in its African audience the qualities of good patients: to refashion healer-visiting-patients into enlightened, biomedical-seeking citizens who could resume a normal place in modern society. In the case of colonial medical campaigns as in mission medicine, health practice reflected as well as shaped broader patterns of social and cultural change.

As Foucault shows, however, the constitution of objects of knowledge is an inherently unstable process. Far from reforming criminals, for example, penal institutions appear to create and intensify forms of criminality. From the perspective of colonial planners' intentions, such results would have to be seen as a failure. However, Foucault argues, such an outcome must be viewed within the systemic nature of the social reality which resulted in these outcomes in the first place. Viewed from this perspective, the construction of a delinquent group within the prison system, for example, serves the useful purpose of domesticating 'popular illegalities' and, to quote Ferguson (1991:19), "transforming the political fact of illegality into the quasi-medical one of pathological 'delinquency.'" In the case of this colonial venereal disease film, such public health campaigns did end up serving as a form of social control, but not in the way that planners envisioned. As Vaughan (1991) explains, for example, during screenings around southern Africa, the film was not well received by African audiences, some

openly laughing as the film played on the screen. The creation of a “dangerous” traditional healer, just as in Foucault’s discussion of the prison, serves the purpose of domesticating the popular belief in the efficacy of healers by transforming this belief into the medical one of pathological backwardness and medical ineptitude. In Ferguson’s (who is writing about “development”) schemata, such outcomes can be viewed as ‘side effects,’ the end result of “unintended outcomes that end up, all the same, incorporated into anonymous constellations of --authorless ‘strategies,’ in Foucault’s sense (1979, 1980)--that turn out in the end to have a kind of political intelligibility” (Ferguson 1991:20).

Healers were neither passive nor silent in this assault on their craft. Demonstrating a great deal of creativity and dynamism, healers began to utilize many of the very forces that were wielded against them in an attempt to (re)gain the very recognition and respect that had been stripped from them. Organizing themselves into associations which held more political clout was one way to do this. The rise of one of these organizations--the Zimbabwe National Traditional Healers Association--is the subject of the next chapter.

¹ Chavunduka (1998) defines witchcraft as the practice by some people in Africa that includes the use of medicines, poison, harmful charms, magic and any other means or devices in causing illness or death in any person or animal or property.

² As we saw in the previous chapter, this focus on education was very much in line with the thinking of medical missionaries of the time.

³ I have written elsewhere that “Colonial hard-line efforts to legislate away from African belief in witchcraft met with little success and, perhaps, had the unforeseen effect of

making Africans believe that whites were actually working to protect witches” (Simmons 2000:2).

⁴ After being charged, convicted, and serving a prison term, the three were subsequently deported from the colony.

⁵ “Strange ‘Tagati’ Story: White Trader’s Black Enemy--Native Belief in Witchcraft,” *Salisbury Herald*, December 17, 1921.

⁶ Regina versus Annie Meyer, Court of the Magistrate for the District of Charter at Chilimanzi, no. 168, (1954).

⁷ Rex versus Ernest Ronald Davies, Court of the Magistrate for the District of Charter at Chilimanzi, no. 74, (1951).

CHAPTER ELEVEN

The Rise of ZINATHA

In response to growing colonial efforts to suppress African vernacular systems of knowledge and practice through legislation, healers began to organize themselves in earnest during the early part of the nineteenth century. The founding of the Zimbabwe National Traditional Healers Association on July 12, 1980, was the culmination of years of effort on the part of Zimbabwean n'anga at governmental and legal recognition. Prior to this time, there existed a number of unconnected n'anga organizations which were usually regionally- and/or ethnically-based. Efforts had been made before independence to organize and unite the various associations, but poor leadership and lack of governmental support made it difficult. In addition, there was a great deal of fighting between organizations as each claimed to be the original, and thus primary and true, indigenous medical association.

One of the better-documented beginnings of n'anga organizations can be found in the oral narratives of Macheka Gombera. Gombera, a practicing n'anga from Chitungwiza, was a founding member of the pre-cursor to the Zimbabwe National Traditional Healers Association--an organization called the African N'anga Association founded in 1957. Gombera (Go) was interviewed in 1979 for the Rhodesian National Archives by Dawson Munjeri (Mu). Gombera's narrative sheds light on the complex relationship between traditional medical practices and Western biomedicine, between Black Africans and White Africans, and between Africans of different ethnicities. Below, I include part of the transcript of the RNA interview with Gombera:

Mu: Now when you left there?

Go: I then came here after traveling from there. I went to the native commissioner's office to tell them my permit had expired. Prior to this, I had come to the native commissioner and was given a permit, I again renewed and renewed it again. On the last occasion I told the native commissioner I and other colleagues have thought of having a place where we can build a home where all of us can carry out our practice. We want a musasa.

Mu: I was coming to that. All the time you were treating cases had your...

Go: I had already been given an authorizing letter. I was given a letter each year.

Mu: At Marondellas

Go: Yes.

Mu: So you now wanted to be given some more permits?

Go: We said we want to form an association. The native commissioner asked, "Can I give you a letter to enable you to see Gelfand?" I was given the letter at Marondellas and I saw him [G]. At that time the general hospital was in North Avenue. Dr. Gelfand received me and he told me, "Let us travel together around and show me the medicines." I was given a letter by Dr. Gelfand and went back to Marondellas. I traveled in farms and collected medicines which I showed to Gelfand.

As with the discussion in Chapter Ten, there were many colonialists interested in African vernacular medicine. Though very much a proponent of European biomedicine and its role and power in ameliorating afflictions in Africa, Gelfand went on to conduct research on "traditional" medicine that is still highly regarded. The interview continues:

Mu: So you had first of all to show Gelfand the muti?

Go: I was told go and see him. Dr. Gelfand then said, "I want to see what kind of muti you use so that we can conduct a research." So I went around collecting the medicines and this necessitated my going into farms and collecting them for him. Gelfand wanted the leaves of the muti.

Mu: The leaves?

Go: Yes.

Mu: He did not want them stamped or ground?

Go: He wanted them in leaf form.

Mu: Did you then explain the functions of the different kinds of leaves?

Go: That is what he wanted. I then asked him, "Are we not allowed to have a place where we can treat cases?" He said, "You are allowed. In fact you are advised to have such a place - how can authorities bar you when you are healers? You obtain written permission from the native commissioner." That is how I came to form the association in 1951.

Mu: Who was the native commissioner at that time when you formed the association?

Go: There was Mr. Ling.

Mu: Mr. Ling?

Go: Yes.

Mu: Is he the one who gave you permission?

Go: He is the one who gave us the go-ahead.

Mu: I see.

Go: I agreed and I came to Dr. Gelfand for a time I was with him. I was given a letter authorizing me to form an association by Dr. Gelfand. I went to Marondellas and the native commissioner at the time was Mr. Ling. He told me "You must know that if a person wants to begin such a venture he must do that in his own council area. So your case must be with the Chihota council area." I then took the letter mentioning this to Dr. Gelfand. Dr. Gelfand said "It's alright take the matter to the council." The Marondellas native commissioner told me, "Go and explain this to the chairman of the Chihota council." I went and spoke to Isaac Samuriwo and he presented the matter to the council. The matter was presented to chiefs Chihota, Nenguwo, Nyandoro, and Mudzimurema. They were in the council. It was debated and they told us, "You are allowed to carry on." They also said tell us your objectives and after that in 1957 they gave us the go-ahead.

Gelfand was apparently supportive of n'anga having their own association, as the above commentary suggests. His support of African-descended medicine problematizes past characterizations of colonial doctors being systematically opposed to such forms of medical practice. The interview continues:

Mu: In 1957?

Go: Yes. We were told there had to be an association. This meeting with the aforementioned chiefs was held on 2 February. The chiefs said, "Yes, you have shown us your medicine, but if you carry out your organization, without some European participation we will be at a loss as to what exactly you are doing. Some of you might go to Nyasaland to get some dangerous makona and bad muti. We don't want Nyasaland muti here."

Mu: They did not want?

Go: Yes. They said they can practice their muti in Nyasaland and those in Northern Rhodesia can do that in their country. Just because it is the federation does not mean you can work together. We want you alone.

Mu: Were these chiefs saying so?

Go: Yes. We want those of Matebeleland, Mashonaland, and Manyikaland. We agree to that and we went to Gelfand and he said I will attend the meeting. We invited him on 6 April 1957. There were 369 n'angas gathered there.

Mu: How did you manage to get all of them together?

Go: The story was written in the paper by Mbofana [Phillip W. G.]. It was in the African newspaper. Mbofana was the first to write about it.

Mu: Did he say a society had been formed?

Go: He wrote that an association had been formed and on the first day there were 150 of us. On the second day were we 369. There were n'angas from Malawi and from this country. The chiefs said "All of our n'angas stand up. Those who do not belong to this country stand aside." Those from Northern Rhodesia (e.g. Enela and those from Nyasaland, e.g. Josum stood aside). The chiefs said, "We do not want those from

Nyasaland in the association. We want them to practice on their own. We do not want the association to have medicines that are obtained from outside the country.” This is because such n’anga will obtain some makona. You see because of n’anga practice chiefs do not greet each other [by hand].

Mu: Why did they not?

Go: This is because they were told if one chief greeted the other than his chietainship would allude him.

Mu: Allude?

Go: I do not know exactly what was meant.

MU: So there were people with such muti?

Go: There were certain avoidance rules connected with that. Each Chief had his own n’anga and so each chief had to follow what his n’anga told him. They said, “Look now everything is alright.” Samuriwo and Chirimuuta the Shawasha man organised for us a meeting of chiefs and we are able to greet each other and we have our body that is good. Now we do not want you to go again and get makona that will spoil our chiefly relations and lives. That is what he said

Mu: So in fact the chiefs intervened because they feared for themselves?

Go: Yes.

A 1973 interview with one of the founding members of the African N’anga and Herbalist Association encapsulates the organizational efforts of n’anga at the time:

My aim was not only to help sick people personally, but to improve the service of ngangas by bringing them into an organisation which would benefit both the ngangas and the patients who go to them. First I gathered a group of other practicing ngangas--F. Gombera, G. Kaunda, K.G. Ntopa and P. Mhlanga, and together we went to the Government to seek recognition of our organisation as a doctors’ organisation. The Government authorities laughed at the idea of recognising what they called witch doctors. Our claim that herbs could cure diseases just as well as European medicine was summarily dismissed.¹

Part of the strategy of n'anga involved getting respected community leaders to attend large public gatherings and speak on behalf of African vernacular medicine. Healers were aware that similar sets of counter-actions were being undertaken by missionary and colonial authorities in their various spheres of activity--churches, missionary schools, hospitals, and clinics, Parliament, etc. Chavunduka (1998:31) writes of attending one such public meeting in Rusape where Acting Chief Makoni spoke, saying:

I thank all ngangas here because you have done a good job by forming an association which is bringing back the ancient customs into practice. The association is good because it is coordinating African doctors together and it is capable of driving out bad spirits...I ask you to send your medicines to the laboratories so that it can be tested and used to help other patients. The nganga was sent by God to help people on earth.

And though there is great distrust of medical doctors and scientists in contemporary Zimbabwe with regard to clinical testing of African herbal concoctions, such distrust did either not exist, or was cast aside, as healers worked to organize themselves. In fact, medical scientists and doctors were invited from the University of Rhodesia to visit healers and inspect their medicines and practices. The hope was that these "experts" would in turn offer some legitimacy and influence government to grant healers legal recognition. Healers would send letters of invitation to hospitals and universities. One, sent to the University of Rhodesia by the president of the True African Nganga Herbalists Association, in 1971, reads:

I would like to make a special moving invitation to your staff members; the University of Medical Professors, Doctors, other top school officials and some of your students; to join us on a research course tour during Rhodes and Founders Days. We will be in Gwelo on the 10th July, 1971. Saturday, as from 9:30 a.m. to 5:00 p.m.; and that same night we will be also at Chief Chiwundura Village and will be healing diseases, and also will be showing the great and highest Powers from our Ancestors' spirits in herbs and new spirits will be converted. And if possible for you, you could also be with us again in Gatooma on Sunday the 11th of July-- healing and herbs will also be performed.²

In retrospect, such transparency was remarkable. As curative practices and medicines became more politicized, of course, such transparency would all but disappear (see next chapter). Even so, most doctors and scientists were not up to the challenge anyway; the exception being Dr. Michael Gelfand mentioned above.

Always actively creative in pursuing the goal of obtaining legal recognition for their organizational efforts, some healers utilized the Bible in an attempt to show church leaders that their work was not counter to Christianity. As Chavunduka (1998) points out, the African Ngangas Association produced a newsletter in 1972 which read in part:

We fear God and we work with the Bible. Our work is blessed by God...We practice proper medicine as shown in Jeremiah 46:11...We admit that illness is natural, but we believe it can be healed up. So we try to give what we consider is the remedy, e.g. for boils, 2 Kings 20:7; fractures, Ezekiel 30:21; stomachache, Timothy 5:24; use of oil in curing ailments, Luke 10:34; James 5:14...We do not believe that there is anything wrong with our practice of medicine according to our traditional way of herbalism. We believe and maintain that we are just as good as any European doctors in as far as we are able to do according to our knowledge of herbalism.

By 1975, Zimbabwean n'anga had organized themselves into six associations.

While many urban n'anga were involved in any number of these six organizations, many

rural n'anga tended to be independent of associations owing to their relative isolation. Three of these associations could be found in Harare--the African N'anga and Herbalist Association, the Central African Chiremba's Association, and the N'anga Burial Society. In Matebeleland, there were two organizations--the Central African N'anga Association and the United N'anga Association. As Gelfand (1985) points out, the other and perhaps best organized association was the True African N'anga and Herbalist Association of Central Africa which had members in most of the larger cities and towns and had a wide following among Malawians employed on private farms; it was the only association that claimed membership in other countries--Malawi, Mozambique, and Botswana.

With independence in 1980 came an environment more conducive to the legal and governmental recognition of African-based and derived therapeutic traditions. The appointment of Dr. H. Ushewonkunze as the first Minister of Health in the new government signaled a paradigm shift of sorts--at least on the surface--with regard to healers and their relationship with the government. Ushewonkunze embodied both a belief in African vernacular medicine and practice and a belief in biomedicine: he studied traditional medicine and African culture before he went to the University of Natal, in South Africa, to study medicine.

So, in 1980, former Minister of Health, Dr. Herman Ushewonkunze, organized a meeting of the leaders of the various n'anga organizations with the prime purpose of assessing the validity of a single national association. It was agreed unanimously that such an organization would be viable and proper and an interim national executive committee was elected the following day. Dr. Gordon Chavunduka, then chairman of the Department of Sociology and Dean of Faculty of Social Studies at the University of

Zimbabwe, was elected the association's first president. From Dr. Ushewokunze's suggestion, the new association was named the Zimbabwe National Traditional Healers Association (Chavunduka 1998:1).

In September of 1980, ZINATHA held its first congress at Gwanzura Stadium in Highfield. It was a triumphant event with more than 3,000 healers from all over the country in attendance. African traditional music was played by a number of groups and a number of healers became possessed--in other words, it was a culturally rich and meaningful assembly in a way that previous ones were not. The congress was opened by Minister Ushewokunze and was closed by the Deputy Minister Mazorodze. Elections were held for the National Executive Committee and Gordon Chavunduka was re-elected President.³

Soon after the first congress, the new national Executive Committee began the process of establishing an organizational infrastructure throughout the country. This included the registration of new members and the establishment of district and branch executive committees of the Association. Offices were opened in Harare and Bulawayo and other urban centers. Chavunduka (1998) explains that large numbers of healers joined the organization at this time and that there was general excitement throughout the country regarding this new development. Healers were excited because they could see concrete evidence of official governmental recognition, a long fought for goal. It was the establishment of a medical council for African healers and the formal registration and licensing of them that was the fruition of all their previous efforts.

In the capacity of Minister of Health, Ushewonkunze wasted little time in influencing legislation for the legal recognition of healers. However, he quickly

encountered difficulties in enacting the Bill that would later become the Traditional Medical Practitioners Act. The Bill was opposed by many members of both the House of Assembly and the Senate. During debates in Parliament, Ushewonkunze was openly accused by some members of Parliament of encouraging the people of Zimbabwe to denounce progress and all scientific achievements and return to the Stone Age (Chavunduka 1998).

Government wasn't the only body opposed to such legislation. Opposition to the Bill was also voiced by Western-trained medical practitioners, leaders of some Christian churches and some Zimbabweans trained in Western countries. Eventually, however, Parliament passed the Bill, though with a small majority. Parts of the Act read as follows. Section 3(2) defines the function and purpose of the Council:

- (a) to supervise and control the practice of traditional medical practitioners;
- (b) to promote the practice of traditional medical practitioners and to foster research into, and develop knowledge of, such practice;
- (c) to hold inquiries for the purposes of this Act;
- (d) to make grants or loans to associations or persons where the Council considers this necessary or desirable for, or incidental to, the attainment of the purposes of the Council.

The Council constituted twelve members. Seven members of the Council including the chairman and vice-chairman were, and are, appointed by the Minister of Health and Child Welfare after consultation with ZINATHA. The other five members are elected by all the registered healers. Council members hold office for three years. Importantly, ordinarily all persons appointed or elected to Council are registered healers who have

practiced as healers for not less than five years. This last point is significant because it essentially granted healers complete agency in the governance of their own affairs through their own governmentally-sanctioned organization.

The passing of the Bill into law did little to quiet opposition. In 1982, the editor of the *Sunday Mail* wrote:

Dr. Herbert Ushewokunze's support of ngangas is a source of great surprise. Here is a man who took about seven consecutive years studying as a doctor, after six years in high school and eight years of primary education. But he accepts as fully-fledged doctors people who have no medical training whatsoever. Their training and qualifications is [sic] their say-so. They merely claim that they had a dream last night in which their dead great-grandfather told them to be a nganga and showed them some curative herbs. It means that I, Gono Goto, can go to bed tonight as plain Gono Goto, who is blind as a blind mouse, and wake up tomorrow morning as a fully-fledged nganga entitled to full membership of the so-called ZINATHA and enjoying the protection, praise and fatherly love of my president, Professor Chavunduka.

Much like Ushewokunze, Chavunduka embodied the world of African vernacular medicine--he was formally trained in it in South Africa--and the world of formal education and, in some ways, Westernization--he had already earned a PhD in Sociology. As such, he became an easy target for those wishing to condemn African vernacular medicine. In the same article quoted above, the editor wrote:

I pity his students. Since he is a professor of witchcraft they are students of witchcraft--students of retrogression, studying at the feet of a professor of retrogression. Indeed that is what the belief in witchcraft stand for. It stands for the Stone Age.

The tropes deployed by the above writer could have been those of the medical missionaries themselves. The undisguised contempt, the equation of African-derived

therapeutic practice and knowledge with witchcraft and retrogression--all of these ways of seeing, knowing, and talking about this system of knowledge and practice did not change immediately with independence. The ideological infrastructure of missionary and colonial understandings of n'anga was quite ingrained. And just as the colonial government could not legislate away a belief in witchcraft, neither could the postcolonial government--by giving healers legal recognition--legislate away a belief in African-derived therapeutic practices as something backward and retrogressive.

The opposition to the professionalization of African vernacular medicine--both legal and otherwise--was, of course, predictable notes Chavunduka (1998). Or, as Leslie (1983:314; cited in Chavunduka 1998) put it:

The irrational element in this situation derives from the fact that for more than a century the movement to professionalise modern scientific medicine has used the state to eliminate or drastically to curtail and subordinate other forms of practice. This movement has shaped the education of health professionals to an occupational perspective that distorts their comprehension of other systems.

In the absence of re-education programs and campaigns, missionary and colonial attitudes, perspectives, and worldviews were still deeply etched into the minds of many--African and non-African alike. Ayensu (1983:5; cited in Chavunduka 1998) notes:

The educated public in Africa and Latin America still have some ways to go in re-educating themselves. I am particularly disturbed by third World Western-trained doctors who show total disregard and disdain for the importance that herbal medicine plays in the world's health situation. Some of these doctors are even ashamed to admit that their parents relied on these ancient folk remedies to treat and save their lives during childhood. Many of the Western-trained doctors seem to have been

brainwashed into believing that only drugs originating in the developed countries have healing powers.

In the current disease climate, these attitudes are beginning to change, particularly as people look for more holistic approaches to managing chronic and deadly afflictions such as HIV/AIDS.

By-laws to the Act were approved by Parliament in 1997. The new code of conduct stipulates that healers will not, without good cause, cast any reflection on the probity, professional reputation or skills of another registered practitioner nor will they be allowed to divulge any confidential information concerning their patients, except when required to do so by law or with the consent of the patient. A traditional healer will not be allowed to advertise his or her services or canvas or tout for patients. The by-laws also forbid the selling of traditional medicine by the road side or in unhygienic premises (see Chapter Thirteen). Business partnership is only allowed with another registered healer.

For the benefit of the patient, the by-laws stipulate that it is an offense not to allow a patient to consult another registered practitioner from both “modern” and “traditional” medicine. It is illegal for a healer to conduct any experimental research on any patient (Traditional Medical Practitioners Professional Conduct By-laws: Statutory Instrument 245 of 1997).

The skills that healers utilized in their efforts at organizing themselves and gaining legal recognition are the same skills they continue to utilize in their ongoing political encounters with the government. The advent of increased levels of globalization, however, has meant that these same sets of skills must be used with often

new and novel sets of agents and institutions. This is particularly the case with international health development policy and practice directed at African healers.

¹ *Moto*, May 18, 1973.

² Quoted in Chavunduka 1998:32.

³ *ibid.*

CHAPTER TWELVE

The Policy Context for Involving Traditional Healers in Health Development

We believe that traditional healers have an important place, but we have yet to establish that they have a place in the treatment of all medical diseases, and they do need *discipline*.

-Dr. Timothy Stamps, Zimbabwean Minister of Health

If missionary discourses regarding n'anga had the effect of creating dangerous subjects--that is a group of indigenous medical practitioners who were thought, said, and known to be evil and backwards--these same discourses also found expression in colonial discourses surrounding n'anga. However, as we saw in Chapter Ten, colonial discourses on n'anga were more varied and primarily more concerned with issues of social control, especially where such control was thought necessary for maintaining standards of colonial production. Colonial officials were, for example, less likely than their missionary counterparts to see choices in therapy as choices in theology. Where both discourses often converged, nonetheless, was in their conflation of African indigenous practices with witchcraft, or a belief in witchcraft--something, in either case, that was not to be tolerated. Stamping out a belief in witchcraft--and a belief in the efficacy of the practices of n'anga who were thought to encourage such beliefs--became an ongoing spiritual and legal strategy for both missionaries and the colonial government. As was the case with the colonial venereal disease film analyzed earlier, this strategy relied on often essentialistic and stereotypical understandings and renderings of indigenous health practitioners to achieve its goals. Current health development messages and strategies directed at healers for various interventions also share characteristics with former

missionary and colonial discourses even as they purport to work in collaboration with, and on behalf of, indigenous healers.

Contemporary concern over how to best involve traditional healers in health development has been an ongoing formal policy debate since, at least, the 1970s.¹ It is likely this interest in involving healers in health care delivery came much sooner, however. Throughout much of Africa, for example, liberation movements were under way during much of the 1950s. In their confrontation with colonial regimes and in building local support, many African freedom fighters utilized discourses and images which referred back to pre-colonial cultural practices and histories. These ways of thinking about the past are what Malkki (1995:55) calls “mythico-histories,” that is a process of world-making that constructs categorical schemata and thematic configurations that are relevant to the pragmatics of everyday life. Such schemata were important in reclaiming past cultural practices and ways of life that had been debased, suppressed, and dismantled under colonialism. The arbiters of many of these “traditional” practices were usually, though not always, healers. In the case of Zimbabwe, as Lan’s (1985) work illustrates, healers (and more specifically, spirit mediums) were instrumental in efforts toward liberation, both early on in Zimbabwe’s colonial past (during the 1896 *Chimurenga*, for example), but also more recently in the 1970s. As mentioned in Chapter Eleven, the first Minister of Health of newly independent Zimbabwe, was a medical doctor as well as a healer. In such a context, the knowledge and practices of healers began to be formally appreciated in a way they had not been formerly.

At around the same time, a new generation of social scientists--and particularly anthropologists--began renewed work amongst healers. Influenced by the idealism of the 1960s and a developing interest in issues of economic and social development for Third World countries, many of these scholars began to look at healers as individuals whose knowledge might be used as a resource in the planning and implementation of various development projects (cf. Warren 1974, 1975, 1989; Brokensha, Warren, and Werner 1980). The work of these scholars built on earlier studies of medical pluralism in Africa (cf. Turner 1964; Pritchard 1937; Schapera 1940; Horton 1967) which focused almost exclusively on the symbolism and ritual of local medical practices. This applied aspect--which not only looked at ritual and belief surrounding curative practice, but how this knowledge could be utilized as a resource for development--began, in turn, to shape health development discourses (see below). Thus, whereas healers were seen as obstacles to health development under the missionaries and settler state, this image began to change with the advent of independence and changes in the scholarly foci of researchers which, in turn, began to influence international public policy.

Historically and contemporaneously, of course, the greatest opposition to seriously involving traditional healers in, for example, national health delivery programs has come from Western-trained doctors, who often contend that traditional practitioners lack basic knowledge of anatomy and physiology, of disease, and the accurate prescribing of medicine. It has also been said that traditional practitioners work in unhygienic environments and that their curative practices are shrouded in mystery and not falsifiable or reproducible by scientific measures.² These criticisms, as we have already seen in

previous chapters, have been around since the first arrival of medical missionaries in what is now called Zimbabwe.

Despite these criticisms, however, in places like Zimbabwe, over 80% of Zimbabweans still consult traditional healers, and many believe that the Western type of medical care fails to fully meet their needs, being inaccessible, expensive and without continuity. One of the most important factors in the sustained popularity of traditional healers is the often inaccessibility of Western medicine to much of the population, either because of excessive cost or because of the vast numbers of people living in rural areas where limited health services are located. In rural areas of the Third World, where the choice may be between traditional healers and, at best, a small dispensary with very limited resources, it would be difficult to cast aside the former: it is they who serve most of the people most of the time. In addition to accessibility, healers tend to be affordable--though this is debatable--and are culturally appropriate and acceptable, as Green (1994:38) argues, thereby fulfilling the major criteria for effective service delivery.

Given this reality, in 1976, the World Health Assembly formally acknowledged the potential value of traditional medicine in expanding health services by calling attention to the manpower reserve constituted by traditional health practitioners (resolution WHA29.72). In the following year, a Health Assembly resolution (WHA30.49) urged countries to utilize their traditional systems of medicine. Another resolution was passed in 1978, in which the WHO was called upon to develop a comprehensive approach to the subject of medicinal plants (WHA31.33). Nine years later, in 1987, the Fortieth World Health Assembly reaffirmed the main points of the

earlier resolutions, as well as related recommendations made at the International Conference on Primary Health Care, held in Alma-Ata, USSR, in 1978 (WHA40.33).

The Forty-First World Health Assembly drew attention to the Chiang Mai Declaration (1988): “Save Plants that Save Lives” and endorsed the call for international cooperation and coordination to establish a basis for the conservation of medicinal plants, in order to ensure that adequate quantities be available for the use of future generations (resolution WHA41.19).

In 1989, a resolution was passed (WHA42.43) that recalled earlier resolutions on traditional medicine, traditional health practitioners, and traditional remedies and affirmed that together they constitute a comprehensive approach to the utilization of medicinal plants in the health services.

Between African health professionals and traditional healers, there is currently a great diversity of interests and coalitions that has formed. Last (1986:1) notes, for example:

Governments (whether parties, bureaucracies, or military men) who need both to cut costs and maintain popular support; WHO (or a section within it) urging these governments on with ideas and international pressure; psychiatrists puzzled by solutions to patients’ problems in other cultures and pharmacologists on the look-out for new compounds; idealists seeking to develop truly national medicine and skeptics weary of the medical profession, its claims and its drug companies; radicals of varying persuasion, backing for example the countryside against the town or the “folk” against the bourgeoisie; or realists who simply remark that “primary health care” is already, de facto, the province of traditional medicine and therefore want local knowledge and skills recognized for what they are.

The inclusion of traditional medical practitioners in national health care delivery takes on greater importance in the context of national health emergencies such as HIV/AIDS. Given the paucity of human and material resources available to African governments and the extremely high number of AIDS cases in the region, there is an urgent need to devise new approaches that would contain the further spread of the dread disease. These new approaches should not only be developed within the framework of national strategies for delivering primary health care, but should also take into consideration the fact that in many countries, especially those in Africa, traditional medicine is a central part of the health practices of individuals and communities; a form of private practice, outside the formal health system. Governments, therefore, have a responsibility to assess the efficacy and viability of all forms of medical practice, ensuring none are harmful and to foster what is effective and beneficial, in keeping with the beliefs of the people. These positive practices can be crucial in meeting the challenge of the present crisis.

In responding to the gravity of the situation caused by AIDS, many African countries have developed national AIDS control plans and programs. For example, Botswana, Kenya, United Republic of Tanzania, Uganda, and Zimbabwe have identified program areas that they consider appropriate for involving traditional health practitioners in community health activities; these usually include community-based care, health education, counseling, and relief of certain symptomatic conditions. In addition to these areas, there is also the potential for involving traditional health practitioners in providing the community with culture-specific information on sexual behavior and in formulating and channeling specific health promotional messages. So far, these efforts have not been

coordinated, and therefore there is no basis for a comparison of their effectiveness.

However, there is no doubt that, properly motivated and involved, the traditional health practitioner can act as a valuable link to the majority of the population, who may be difficult if not impossible for modern health workers to reach.

Even in the urban centers, where the specialist and teaching hospitals tend to be located, notes one observer, “the health services are often in disarray, as these hospitals are often reduced to being mere consulting clinics without drugs, water, and essential equipment.”³ As we saw in Chapter Five, such disarray has been exacerbated by, among other things, many African countries’ adoption of economic structural adjustment programs. The stark economic and health realities of many countries have indeed made collaboration with traditional healers more attractive and necessary. This, in turn, has spurred much discussion on HIV/AIDS national policy and traditional healers in various African countries.

Zimbabwean National HIV/AIDS Policy and N’anga

Within Zimbabwe, there is currently no national HIV/AIDS policy. In 1996, a core steering committee--comprised of the Southern Africa AIDS Dissemination Service (SAfAIDS), researchers from the Medical School, University of Zimbabwe, a representative from the Attorney General’s Office, and the National AIDS Coordination Programme--held a consultative brainstorming meeting with experts from various fields. Key issues and potential players in the policy development process were identified. Seven expert groups were then established to consolidate key points for policy debate and to develop draft guiding principles and strategies. The draft papers produced by these

groups were used as the basis for the current draft document that was drawn up by the steering committee in November 1996. The second draft--the current working document--was subject to wide discussion, debate and refinement during 1997 and also reviewed on a smaller scale.⁴ The resulting recommendations encompass a wide range of concerns in the broad areas of health care, home care, counseling, research, information and legal and human rights in general.

The subject of traditional healers is discussed, albeit briefly, in this draft document. Unlike many other African countries, traditional healers in Zimbabwe, through the Zimbabwe National Traditional Healers Association (ZINATHA) have had a formal relationship with the Ministry of Health and Child Welfare since Independence.⁵ In theory, this has meant that there has been an official government policy regarding healers (see Chapter Eleven for a discussion of the Traditional Medical Practitioners Act and Council)--a World Health Organization recommendation for the training of healers in national health care delivery. In practice, however, government policy has been ambivalent at best with regard to traditional healers--perhaps a remnant of colonial times. Not so surprisingly, n'anga are cast in a disparaging light within the text of the draft document, even as the call is made for more collaboration between healers and other health professionals. What emerges from this draft document is an emphasis on a careful scrutiny and surveillance of traditional healers. Below is the full text:

Preamble

After a clinical diagnosis of HIV/AIDS is made and confirmed, many people seek alternative or traditional treatment. Some of the traditional remedies do indeed have biological-response modifying properties and relieve symptoms, which some traditional medical practitioners mistake for a cure for HIV/AIDS.

Guiding Principle 11: The general public have the right to choose the type of treatment they want, but they should have access to accurate information regarding orthodox, traditional treatment and faith healing.

Strategies

1. Subsections (2) and (3) of Section 31 of the Traditional Medical Practitioners Act [Chapter 27:14] of 1981 should be fully operationalised.
2. The requirement of traditional medical practitioners to register with and be accountable to a recognized statutory body should be better monitored and enforced.
3. Cooperation and collaboration between orthodox and traditional medical practitioners should be encouraged.
4. Individuals who make HIV/AIDS cure claims should be assisted by the Medical Research Council to substantiate their claims in an acceptable and scientific manner according to clearly laid down criteria, and claims should only be made by appropriate authorities after the necessary tests have been carried out.

In order to put these policy statements into some type of context, it might be best to take them point by point. Regarding the Preamble, if indeed it is true that individuals seek the care of “alternative” or traditional therapies after a diagnosis of HIV/AIDS has been made, we need to ask ourselves why this is the case. Is there something individuals feel they are getting from these other forms of curative practice that they are not getting in formal biomedical care? Or is it that, like most people who get sick, Zimbabweans are pragmatic in their care-seeking behavior, attempting to optimize their choices and perhaps in so doing, better the outcome? As we saw with Tichafa and Lynde in Chapter Eight, at least some people are “walking a tightrope” with regard to their care choices, moving between biomedicine on the one hand and African-derived medicine and therapeutics on the other. And while some traditional healers are aware that some of

their herbal remedies have biological-response modifying properties and relieve symptoms of HIV/AIDS, it seems a bit of a generalization to say that some “mistake this for a cure.” Of the more than 100 healers I interviewed over the course of four years, not one admitted to being able to cure HIV/AIDS. Granted, many admitted to being able to successfully treat symptoms--especially with regard to weight loss, anemia, and the like. But, none said they could cure the dread disease. Those healers who do claim to have a cure for AIDS are usually aware that they are committing fraud and that there is no cure for the disease.

Moving on to the Guiding Principle, that is that people have the right to choose whatever treatment they want, but they should also have access to accurate information regarding different methods of treatment. The assumption here is that accurate information regarding the curative practices of n’anga is obscured, that because such practices do not usually conform to the strictures of falsifiability and hypothesis-testing, they should be sought with care. But, shouldn’t such care also be exercised when seeking biomedical treatments? One of Zimbabwe’s major newspapers, *The Herald*, came to this conclusion in a 1996 article entitled, “Survey shows doctors unsure which Aids drugs to use.”⁶ The article quoted from a survey conducted by the advocacy group Gay Men’s Health Crisis. The survey found that doctors are confused about which AIDS drugs to prescribe for their patients and have to base their decisions on instinct rather than hard data. Only 25 percent use the highly-touted protease inhibitors as first-line treatment against the HIV virus. “As promising new antiviral combinations move from a controlled clinical research environment into the doctors office, we have to face basic questions like whether physicians have reached any consensus on how to use them,” Dr. David Barr,

GMHC's Director of Treatment Education is quoted as saying. Few clinical studies (as of 1996) had been done on the effectiveness of various combinations, and those that been done involved only a handful of patients. "Many physicians are having to make decisions long before we receive definitive results from trials," Dr. Gabriel Torres, director of the AIDS center at St. Vincent's Hospital in New York, is quoted as saying. "There has been controversy about what the initial therapy should be." Given the precarious nature of even biomedical treatment for HIV/AIDS, is it any wonder patients practice pragmatism and pluralism in their care options?

Also, there is still some suspicion of Western-based medicine. As we saw in Chapters Two and Six, Africans across the continent have become an important subject population for sometimes dubious clinical trials of AIDS-suppressing drugs, sometimes resulting in death. Moreover, in the minds of some Zimbabweans, hospitals signify a place into which you enter but do not exit. And the thought of dying in a place other than home is a terrible one.

With regard to the requirement that traditional medical practitioners register with and be accountable to a recognized statutory body and that this registration and accountability be better monitored and enforced, efforts have been made toward this end. ZINATHA, as the officially-recognized organization for healers, has worked toward this end. As Chavunduka (1998:39-40) writes:

Some people have asked: how does the Association exclude fake healers from its membership? Indeed it is possible for someone with very little knowledge of traditional medicine to complete the required application form to the satisfaction of the clerks of the Association and become a member. It is difficult to exclude completely all fake healers from

practicing medicine. However, a number of measures have been worked out in an attempt to deal with this problem.

He goes on to say:

One mechanism of control is the Register of Traditional Health practitioners which is published from time to time. Copies of the register are sent to officials of the Association and other community leaders all over the country. Some copies are sold to members of the public. The Association then relies very heavily on reports received from members of each community regarding the performance of resident healers shown in the Register. Reports from ZINATHA officials and other traditional healers practicing in the vicinity have proved [sic] to be useful. Many patients also phone or write to the Association regarding the performance of traditional healers in their area. Individuals who are believed to have doubtful qualifications are made to appear before the Association's registration committee which has power to cancel an individual's membership. Another useful method in preventing fake healers from joining the Association is to ask the chairman and other officials of the local branch of ZINATHA to comment on applications received from the area.

Part of the problem for ZINATHA is dealing with the sheer number of healers throughout the country. ZINATHA estimates there are some 50,000 healers within the country, many of whom do not belong to ZINATHA or any other healer organization. Keeping accurate records on such a large body of healers is almost impossible. Related to this point, is the fact that ZINATHA does not have the financial or human resources to be able to adequately police its own membership; and the Ministry of Health and Child Welfare is also not in a position to lend economic assistance to ZINATHA. Thus, many healers--good and bad alike--simply slip through the cracks of public policy.

Encouraging active collaboration between "orthodox and traditional medical practitioners," as outlined in point number three under the Strategies section of the draft

document, remains one of the greatest policy obstacles. There is much mistrust of Western-trained scientists and doctors on the part of n'anga, and this mistrust takes on new dimensions in the context of HIV/AIDS. The apprehension n'anga have in sharing their work with doctors and scientists revolves around two central concerns: first, is the question of who is best capable of treating existing and emerging diseases most effectively; and second, is the question of who stands to gain the most financially (or otherwise) as a result of these treatments.

In a recent meeting held at the University of Zimbabwe,⁷ Gordon Chavunduka warned that

there are thieves who are claiming to be Western-trained scientists, yet they want to steal our medicines. They steal a lot of our medicines. This is why we temporarily suspended the Research Project [with Blair Research--see Chapter Eight]. The bogus scientists exported our traditional medicines to different countries for their own benefit, leaving the traditional healer who was the owner of the medicine stranded.

Chavunduka ended by encouraging n'anga to be careful with anyone approaching them wanting the name of the herbs they are using for different diseases.⁸ Any business of research, he continued, should be done through the Research Department of ZINATHA, and when it reached the stage of presenting the herbs, n'anga should have entered an agreement with ZINATHA lawyers so that their interests could be adequately protected. In his concluding remarks, Chavunduka accused medical doctors and scientists of feeling threatened by n'anga and their own self-controlled research on medicinal plants, saying "Patients are now running away from the hospitals to find traditional healers. There are no hospitals in the rural areas and doctors do not want to work in the rural areas.

Scientists are ashamed to consult the traditional healers, but they know their medicines are worth using” (see again, e.g., Lynde’s discussion of clinical trials held by Blair Research Laboratories in Chapter Eight). Such feelings of distrust make it difficult for healers and doctors-scientists to work together, particularly with regard to any clinical trials of medicinal plants.

It is herbalists--though this category of n’anga is by no means discrete--in particular who tend to be involved in clinical trials of medicinal plants. This research interest in herbalists stems, in part, from the interests of the Biomedical Research Unit of the Global Programme on AIDS and the Traditional Medical Programme of the World Health Organization in the efficacy of natural products for antiretroviral screening. For example, part of their literature reads: “In this context, there is a need to evaluate those elements of traditional medicine, especially medicinal plants and other natural products, that might yield effective and affordable therapeutic agents.”⁹ The courting of herbalists by international doctors, researchers, and multinational pharmaceutical companies--as the above discussion by Chavunduka illustrates--carries its own set of problems which, in turn, intersect with local realities. For example, many of the people who hold leadership positions within ZINATHA tend to be herbalists--even though, numerically speaking, they are a minority. Chavunduka writes (1998:42):

One reason why herbalists are more active than members of other groups of practitioners is the desire to improve their status. They also tend to have more formal education than spirit mediums or prophets [both of whom tend to have more status than herbalists because of their connection to the ancestors and healing spirits]. There are other forces nowadays such as Christianity, Western education and attitudes of some politicians which have tended to favour *empirical* rather than *symbolic* medicine which have tended to strengthen the position of herbalists. The push

exerted by certain University [sic] departments in recent years such as pharmacy, chemistry and medicine and by pharmaceutical companies toward the study of plant remedies while ignoring spiritual medicine has also played a part; it has tended to strengthen the position of herbalists (emphasis added).

Assumptions that development practitioners, scientists, doctors, and international pharmaceutical companies make about herbalists--and, again, this is not a discrete category of healer--make them the ones to most likely be contacted by this diverse array of actors. As such, many of them become arbiters, cultural brokers, between these often translocal agents and local practices. Other healers may see them as more capable of dealing with outside institutions and agents and, thus, elect them to positions of leadership within local organizations. In this way, the policy and research interests of the international scientific and development communities come to impact and shape local political realities.

Apart from the potential for adversely affecting local political realities in healer organizations, such a focus tends to pry the local practices surrounding herbalism from their original context in which they find meaning and expression. As Reynolds (1986:165) warns:

There is an inherent danger that traditional medicine knowledge will be defined simply in terms of its technical herbal expertise, that this experience will in turn be recognized only for empirical pharmacology, without reference to the symbolic and ritual matrix within which it is used--still less to the social matrix in which those rituals and symbols have meaning at any particular time or place.

Declarations of the World Health Assembly such as "Save Plants that Save Lives," which call for international cooperation and coordination to establish a basis for the

conservation of medicinal plants, in order to ensure that adequate quantities be available for the use of future generations, continue to generate interests in those healers defined as herbalists. As Maclean (1985:49) notes:

It is much easier for medical scientists to countenance a study of herbs, which are visible, tangible and measurable, than to take account of the spiritual, psychotherapeutic and social dimensions of traditional medicine.

Even as scientists become more interested in studying the herbal practices of African vernacular medicine, however, such studies have been hindered by the complicated nature--a nature mediated and suffused by decidedly unscientific ritual and symbolic meaning--of these practices. Kargbo (1986), for example, illustrates that such herbal remedies are complex: several plants are often used in a remedy and these plants might be cooked with various portions of birds, fish, snakes, and insects. This is so because the healer sometimes recognizes and treats several symptoms rather than a single pathological entity. As such, he or she may combine various herbs and other materials whose respective pharmacological effects correspond with the various clinical complaints made by the patient. Related to this point, the mixtures used by healers are not always intended to eliminate symptoms alone. Some of the ingredients are intended to suppress the toxic effects of other medicines. This enables the body to withstand the aggressive nature of the other herbal remedies. Since such herbal remedies are often closely-guarded secrets, some healers may throw in an extra herb or two as a decoy so that bystanders will not know the active ingredient for the illness being treated.

Because many healers guard their herbal decoctions with great secrecy from even one another and their patients, scientists and researchers are viewed with particular

suspicion. As mentioned above, there is great reluctance on the parts of healers to being interviewed. Some of those who agree to be interviewed may lie or give wrong information as a way of protecting their knowledge; the fear, again, the such research might amount to a subtle way of robbing them of their knowledge. Some fear that any results of such research may be passed on to well-established international pharmaceutical companies. Others fear publication of their work without being acknowledged as the source of the information (Chavunduka 1998).

Another n'anga, Peter Sibanda, ZINATHA's AIDS coordinator, has complained that "I think scientists are collaborating with us in the areas they want, and not in the areas we should cover." He mentioned that the ethics of professional doctors will not allow them to refer patients to traditional healers.¹⁰ As mentioned in Chapter Ten, part of the reluctance by biomedical doctors to refer patients to healers is a remnant of colonial medical policy.

These differences of opinion have resulted in stalled legislation intended to bring--at least in theory--healers and doctors together. The proposed Health Professions Bill of 1995, for example, was intended to establish a Health Professions Council of all the health professions, including African vernacular health professions. The functions of the Council included:

- a) to formulate, develop and implement measures and policies designed to---
 - i) co-ordinate and integrate the functioning and operations of health professions;
 - ii) ensure the provision and promote the enhancement of professional and efficient services by health professions;
 - and

- b) to liaise and collaborate with all councils and, without in any way limiting the generality of this paragraph, to advise such councils on matters pertaining to--
 - i) practice control; and
 - ii) discipline; and
 - iii) education, training courses and examinations; and
 - iv) minimum standards required of any premises in or at which members of any health profession practice their profession or calling.

The Authority was to consist of---

- a) a president of the Authority, who shall be elected by the Chairmen of the councils from among their number; and
- b) the rest of the Chairmen of the Councils established in terms of this Act; and
- c) seven persons who are not health practitioners, appointed by the Minister; and
- d) the Secretary from the Ministry for which the Minister is responsible.

Section II (1) of the proposed Bill stated:

- (5) All acts, matters or things authorised or required to be done by the Authority may be decided by a majority vote at a meeting at which a quorum is present.
- (6) At all meetings of the Authority, each member present shall have one vote on each question before the Authority and, in the event of an equality of votes, the person presiding at the meeting have a casting vote in addition to a deliberate vote.
- (7) Any proposal circulated among all members and agreed to by a majority of them shall be of same effect as a resolution passed at a duly constituted meeting of the Authority.

ZINATHA summarily rejected the Bill. Chavunduka commented:

ZINATHA rejected the Health Professions Bill in its present form because an integration of traditional and modern medicine at the proposed council level will undermine the traditional health system because of the differences in approach and philosophy between the two systems of medicine.

The proposed Supreme Council if approved by Parliament will be dominated by modern medical practitioners. There are not many modern practitioners who want to see the traditional sector develop. They will destroy it.¹¹

The possibility of African healers becoming part of such an apparently illustrious and official health organization received a great deal of favorable publicity. Many people felt that the healers had a great deal to gain by becoming a part of the Health Professions Council--they saw it as a further means to attaining integration and equality between biomedical doctors and allied health professionals and African vernacular healers. The leadership of ZINATHA disagreed, however, and pressured the MOHCW to remove the Traditional Medical Practitioners Council from the Bill. Healers argued in favor of cooperation between what they viewed as two independent systems--modern and traditional--at all appropriate levels rather than the type of integration proposed by the Ministry of Health and Child Welfare. They argued forcefully that healers should continue to have, through ZINATHA and the Traditional Medical Practitioners Council, the main power in the selection and control of their activities with little input from other bodies in the health sector, especially given the long history of hostility between biomedical and vernacular practitioners and the biases introduced during the colonial era and differences in philosophy and approach.¹²

Rather than integration, healers argued that they represent a separate school of thought, a science, that needs both recognition and resources to develop itself on its own

terms. It was further argued that any attempts to integrate traditional medicine and modern medicine even at the level of the Health Professions Authority was likely to undermine the African vernacular health sector. The very structure of the proposed Authority (as briefly described above), the healers argued was biased toward biomedicine. For example, of the proposed sixteen members of the Authority, only one is from the African vernacular health sector--the other fifteen being biomedical practitioners and some non-medical professionals educated in Western-style education. Given this situation, healers opined that any healers on the Authority would be treated as second-class doctors. Furthermore, healers voiced the opinion that the degree of formal subordination likely to arise in such a context would be unacceptable to many healers.¹³

Moreover, the integration of healers as suggested in the Bill, some feared, might mean imposing significantly different standards and measures of healing traditions and so force healers to abandon those elements of their practice that did not easily conform to the strictures of biomedicine. As such, healers may be forced by circumstance to defect from their own holistic approaches and their unique integration into local cultural and social environments. Another integrative obstacle involved the feared imposition of a curatively-biased way of thinking and working of the biomedical health sector on the African vernacular one. ZINATHA leaders pointed to the development in Zimbabwe and other African countries of herbalistic hospitals and clinics¹⁴ as symptomatic of this influence, warning that such developments may not contribute significantly to the health of patients. Preventive activities and thinking were part and parcel of African vernacular medicine they argued--such practices being far more than an instrument of curative care.

Healers' rejection of the Health Professions Bill was important for a number of reasons. Their rebuff, and rationale for it, demonstrated a great deal of political astuteness. Healers were not seduced by the idea that belonging to an official biomedical and allied health organization would necessarily be in their best interest. Moreover, their rejection sent the message that healers are not passive agents with regard to health development. Indeed, the image of healers and African healing traditions as inert, static, and un-self-conscious was interrupted in favor of an image of healers as active and creative, altering received knowledge and practice, and on a quest for original understanding (cf. Feierman and Janzen 1992). This particular case illustrates the great creativity with which healers think and the great purpose with which they act. It also illustrates the potential for how health development efforts can dismantle different sociocultural realities even while taking them into account (Pigg 1995).

While healers' rejection of the Bill stands as an example of the great impasse between African vernacular medicine and biomedicine, and less we think this relationship is solely adversarial, there are instances of traditional healers and medical doctors working together. Mbuya Muramba of the high-density suburb of Mbare, for example, who has treated some AIDS patients for their symptoms, said some doctors were willing to refer to her patients they could not help. "The doctors used to look down upon us," she said in a recent interview, "but because of AIDS, we are now working together. We hold meetings with doctors and nurses and we teach each other things."¹⁵ Muramba was one of the healers involved in clinical trials with Blair Research Laboratories. To my knowledge those research findings have not yet been published and Muramba, whom I

interviewed in 1996 remains bitter about the experience because she was not given her promised remuneration.

But, there are more successful stories. In Zimbabwe's second largest city, Bulawayo, there is a "traditional medical" clinic which combines "modern" and "traditional" medicine. The clinic, founded by Barbara Sibanda in 1981 amid stiff opposition from the medical profession, gives patients a choice between different curative practices under one roof, and practitioners from either side can consult over the most likely successful form of remedy for an ailment. "Our success rate has been as good as any health delivery system. The choice for the patient is now wider, some kind of revolution in medical practice," said Sibanda in a 1996 interview.¹⁶ The clinic employs a full-time medical practitioner, a traditional healers, and midwives for its 25-bed maternity wing. Charging slightly less than other biomedical clinics for consultation and herbs, the clinic handles as much as 100 patients per day. At their July 1996 anniversary, Sibanda said, "The anniversary this week is to consolidate the contribution of traditional medicine to the health delivery system and demonstrate how the two can harmoniously be combined to produce good, even better results."¹⁷

The Zimbabwe National Traditional Healers Association and AIDS Control

ZINATHA's interest in combating AIDS began just three years after the first official case in Zimbabwe was announced in 1985. In collaboration with the Ministry of Health and Child Welfare, the Association organized two workshops in 1988. These workshops mainly targeted members of the ZINATHA national executive committee and members of the council. A few district officials also attended. In 1989, again in

collaboration with the MOHCW, the association held four workshops. These were mainly for ZINATHA district officials. In January 1990, ZINATHA embarked on a comprehensive community-based health education program for HIV/AIDS awareness, prevention, and care, with some financial assistance from donors (see Chapter Fifteen for an in-depth discussion).

The ongoing program has three main objectives. First, it seeks to educate traditional health practitioners on HIV/AIDS awareness, prevention, and care to encourage them to share their knowledge with the communities in which they work. Second, the program hopes to increase awareness regarding the medical practices of the health practitioners themselves, in terms of their capacity both to transmit the virus and to become infected with HIV. Third, it seeks to encourage greater communication and cooperation between traditional and modern forms of medicine.

ZINATHA AIDS coordinator, Peter Sibanda, has said, “We are teaching our people, particularly healers, AIDS awareness, prevention, some counseling skills and home-based care knowledge.” The impetus being that when HIV/AIDS was first discovered in the country, traditional healers were accused of undermining prevention efforts. Practices such as using understerilized razor blades for incisions on successive patients were attacked as potential HIV transmission routes. Not wishing to antagonize either their clients or the government, ZINATHA initiated workshops throughout the country as part of an education campaign. “We are trying to remove the cultural taboos and stigmas, and to deal with what we may call controversial cultural issues. We try and ease the taboos by encouraging discussion on AIDS within families,” said Sibanda.

From March 1990 to May 1990, a baseline survey was conducted of the program. The survey had three goals. First, to understand healers' knowledge, attitudes, and practices with regard to HIV/AIDS, in order to monitor the impact of the provision of new information through workshops. Second, to identify the most important information gaps, misconceptions, and requirements among participants and to advise on relevant workshop content. Third, to provide some indication of appropriate and effective means of providing this information.

Results from the survey (see Chapter Fifteen for a discussion) indicated low levels of education and literacy, which meant workshops would have to emphasize oral and pictorial methods of presenting information. A short pamphlet was designed in local languages, containing basic information on HIV/AIDS and illustrating how the disease related to healers. Topics for workshops included: What is AIDS? How is AIDS spread? How healers might be at risk of contracting or transmitting the virus. How healers can protect themselves from contracting the disease or spreading it. Signs and symptoms of HIV infection and AIDS. How it feels to be HIV-positive or have AIDS. Support that healers can give HIV/AIDS sufferers and their families. The role that healers can play in HIV/AIDS diagnosis, referral, treatment, care, and counseling. The role that healers can play in HIV/AIDS education and awareness.

As we shall see in later chapters, the categories utilized by health development practitioners--in this case, the leadership within the national organization, ZINATHA--were, and are, open to interpretation. The training manual for trainers, entitled *Methods in AIDS Education*, was developed by UNICEF in conjunction with the Zimbabwe Ministry of Education and Culture. As such, the idioms of disease and disease causation

discussed in the manual can be very different than those of healers themselves. At issue here is how to present medical information in a locally-appropriate way. The above lesson plan sets out a basic message on the biological “facts” of HIV/AIDS: What is, what it does to the body, how it is transmitted, how it is prevented, etc. While the trainers--some of whom are healers themselves--make every effort to adjust these messages to local circumstances, the very structure of the training plan itself only allows them to emphasize the medical message of the formal curriculum over local ideas, practices, and conditions (see Chapter Fifteen for discussion). In this way, such messages--part of much larger globalized notions of health development policy--have the potential to systematically dismantle the sociocultural reality of n’anga even in the course of taking them into account.

Local ideas and practices surrounding health, healing, and medicine--the subject of the next chapter--are, in turn, shaped by these broader forces. These globalizing forces are “historical artifacts that derive from Western domination; they reflect Western values of rationality, competition, and progress, in which context there is an implicit assumption that with modernization, local ‘traditional’ institutions and structures will be replaced by Western systems and patterns” (Manderson and Whiteford 2000). But, healers are not the passive recipients of globalised health development schemes or, more broadly, modernity, as we have seen. Just as healers think and act creatively and with purpose in their individual practices, so, too, is their handling of these broader forces. It is in their construction of particular healing gestures, reshaping of healing institutions, and finding of misfortune that such dynamism may be found--realms of activity that are often outside of, hidden from, or ignored by “official” development. However, it is in these realms that

healers fashion their own notions of practice and politics, medicine and modernity.

These are the subjects of the next chapter.

¹ As we have seen in previous chapters, however, the role--or more specifically the non-role--of healers in health care delivery had been an ongoing point of concern for early medical missionaries and allied health professionals.

² J. Chiwuzie, F. Ukoli, O. Okojie, E. Isah, and I. Eriator, 1987, "Traditional practitioners and here to stay." *World Health Forum*, vol. 8.

³ "Traditional practitioners are here to stay."

⁴ National HIV/AIDS Policy Document, July 1998. National AIDS Co-ordination Programme, Ministry of Health and Child Welfare.

⁵ This relationship, as we saw in the last chapter, is a complicated one.

⁶ *Herald*, July 13, 1996. Another article at the time, also from the *Herald*, ran the title "Scientists still fight to find Aids cure--expert." Such headlines can create doubt in the minds of readers as to the competence of doctors in treating the disease.

⁷ The Traditional Medicine Research Conference, January 7-8, 1992. Held at the Humanity Lecture Theatre Hall, the University of Zimbabwe.

⁸ What a difference from the spirit of openness and transparency healers displayed while attempting to get the recognition of doctors and scientists as illustrated in the last chapter.

⁹ Global Programme on AIDS and Traditional Medicine Programme: Report of a WHO Informal Consultation on Traditional Medicine and AIDS: In Vitro Screening for Anti-HIV Activity. Geneva, 6-8 February 1989.

¹⁰ "What role for traditional healers?" *WorldAIDS*. 1994; January, Edition 2.

¹¹ "The Role of ZINATHA in the Fight Against the Spread of AIDS." Paper delivered at the Population Council AIDS Seminar, Harare. July 10, 1995.

¹² The Professionalization of Traditional Medicine in Zimbabwe. Chavunduka, 1998.

¹³ *ibid*.

¹⁴ Ironically enough, some of ZINATHA's own leaders were involved in such endeavors.

¹⁵ "What role for traditional healers?" *WorldAIDS*. 1994; January, Edition 2.

¹⁶ "Traditional medical clinic concept spreads." *Herald*, July 25, 1996.

¹⁷ *ibid*.

PART III

Managing Misfortune: N'anga Responses to HIV/AIDS

Part III illustrates the diverse responses of n'anga to the HIV/AIDS. Building on the discussion from previous chapters, I show how n'anga contemporary responses to the epidemic have been deeply shaped by their encounter with 'modernity' in general and health development in particular. The subtext of modernity throughout Part III is how it is that a globalizing economy, novel flows of information and technology, new configurations of transnational power and control--rather than seize and transform n'anga in the act of conceptualizing, inscribing, and interacting with them on terms not of their choosing--have provided pathways and routes for them to transform themselves. At least part of this transformational process lies in their conceptions of disease. Such indigenous theories of disease contagion amongst n'anga speak in part to their understandings of afflictions as arising from the historical and contemporary basic organization of daily life as shaped by the entire framework of political and economic control. In other words, I will argue that n'anga interpretations of HIV/AIDS draw attention to a long-standing history of structural violence perpetrated on the average Zimbabwean, first under colonialism, and now under the postcolonial state.

The role of African medicines as symbolic and curative artifacts, and their articulation with processes of commoditization, is the focus of Chapter Thirteen. Indigenous medicine in Zimbabwe--as in other parts of Africa--at least in part, owes its commoditization to the forces of modern capitalism where access to health care, therapeutic practice, and curative substances has increasingly become a luxury rather than

a right; and where unscrupulous individuals sometimes enter the profession for the express purpose of making money, especially in the face of a devastating epidemic. However, the relationship between money and medicine is also the result of a self-initiated process of ‘professionalization’ on the parts of Zimbabwean n’anga; a process which has been, in turn, part and parcel of a larger historical struggle for legal recognition (e.g. as illustrated in Chapter Twelve). And while, for the most part, this battle for legal recognition has been won, it has come at a price. This chapter explores the often competing logics and internal contradictions of this process for the practice of n’anga and its implications for the future of African therapeutic systems in Zimbabwe.

Even as translocal actors--doctors, health professionals, and development practitioner--and n’anga line up on opposing sides of an ideological fence, this formation tends to conceal as much as it reveals. It raises questions about the hardness of the boundary separating the two camps and the nature of claims made on either side. But, too, it raises questions about the very nature of “traditional” medicine and healing. Where does traditional medicine end and biomedicine begin? And, what’s so “traditional” about traditional healing in Zimbabwe? Using a self-professed practitioner of natural medicine and ZINATHA-registered healer as a case study, I pay close attention to the blurring of “biomedical/modern” and “traditional” boundaries, particularly with regard to beliefs and practices surrounding HIV/AIDS. More specifically, the case of this healer illustrates the synergy and the opportunities that have resulted from the convergence of the local and translocal. This is the focus of Chapter Fourteen.

Since 1988, the Zimbabwe National Traditional Healers Association (ZINATHA) has been active in educating traditional healers about sexually transmitted diseases

(STDs) and HIV/AIDS. Working with the Ministry of Health (MOHCW) and various non-governmental organizations (NGOs), ZINATHA has implemented a comprehensive HIV/AIDS project which includes: training in HIV/AIDS prevention and care; home-based care and treatment; counseling and family planning services; community participation; information, education and communication; and participation in clinical trials. Such initiatives by the MOHCW, ZINATHA, and NGOs reflects the central role traditional healers play, or should play, in any kind of HIV/AIDS education and prevention programs. Chapter Fifteen offers an analysis of this project.

Chapter Sixteen offers findings from an AIDS survey conducted on healers. Findings reported here derive from interviews with Shona-speaking respondents in each of Harare's ten districts and Chikanga, a community in Mutare, the Eastern Highlands, as well as available literature.

In Chapter Seventeen, I offer a conceptual framework for looking at indigenous contagious diseases, primarily sexually-transmitted infections. Borrowing from Feierman and Janzen (1992:xvi), I analyze understandings of STIs as "sets of concepts concerning illness causation, anatomy, society, or self, as they relate to bodies of therapeutic practice, and also to the occupational roles within which healers work." Equally important, I view concepts surrounding STIs as articulating changing cultural definitions of the individual's place in society, the human body and its parts, and healing practices. Seen in this way, healing traditions regarding sexually transmitted infections not only emerge from (and respond to) systemic practices and processes of political and economic control, they provide interpretations of a rapidly changing reality. Local readings of AIDS are fashioned from mutually dependent understandings of the disease; that is, its genesis in

the severe socio-economic conditions initially wrought by colonialism and the subsequent erosion of decent behavior in its wake. Both these understandings of the disease share a common theme: the role of human and/or supernatural agency in either creating the conditions for HIV/AIDS or in using it to 'cull' African populations.

CHAPTER THIRTEEN

Of Markets and Medicine: The Commercialization of Muti

Making affordable drugs and treatment available rather than restricting them to patients in rich countries is a moral imperative.

-Salih Booker

The policy context for involving traditional healers in health services, as discussed in the previous chapter, occurs within an increasingly commercialized climate of therapeutic practice and access to health care (as the discussion in Chapter Five also illustrated) across the continent. Such commercialization is particularly evident in the (un)availability of affordable AIDS drugs to African countries--a commercial drug void some African healers are working to fill, for good and bad. Clearly more than three-quarters of those individuals suffering from HIV/AIDS worldwide live in sub-Saharan Africa and the vast majority of these people are incapable of paying the exorbitant price for AIDS drugs. How exactly to make affordable drugs available to African populations suffering from AIDS while at the same time protecting the investment interests and intellectual property rights of pharmaceutical companies has been an ongoing concern and has enjoyed spirited discussion at conferences, on the internet, and through various other media.¹ In May of 2000, five multinational pharmaceutical companies agreed to drastically reduce the prices they charge African nations for drugs to combat AIDS and the HIV virus. However, even at 90 percent discounts, a typical cocktail of AIDS-suppressing drugs might cost \$2000 a year for a single patient in Africa, more than four times the average per capita income in many of the worst-afflicted countries. While apparently a benevolent gesture, the reduction in drug prices was quickly labeled a

shrewd attempt to stave off local production of generic alternatives²--something already occurring in Brazil and India.³ Salih Booker, director of the Africa Policy Information Center in Washington and the Africa Fund in New York, put it succinctly: "The recent US proposal to lend Africa \$1 billion a year at commercial rates for the purchase of antiviral AIDS drugs is a cruel hoax at best and a vivid example of government-subsidized corporate greed at worst."⁴

And in July of 2000, the United States Import Bank--an independent government agency funded by Congress--announced the availability of \$1 billion in annual loans to finance the purchase of *American AIDS drugs and medical services* to sub-Saharan African nations. Loans would be provided at commercial interest rates, about 7 percent. As with the reduction of drug prices, the logic of this decision has to be seriously questioned. Why offer yet more loans at a time when Congress is being pressured to forgive past debt--to the tune of some \$100 billion in past development loans to the most indebted nations? These loans, along with a recent commitment by the World Bank to provide a minimum of \$500 million to help African nations set up anti-AIDS initiatives, provide added incentive to African nations to treat many of their AIDS and HIV-infected citizens with *Western medicines*. The cupidity of this gesture was quickly pointed out by a few African nations. In August 2000, South African and Namibia summarily rejected the offer of loans arguing that they needed affordable drugs not loans that would further burden their economies. Furthermore, members of the Southern African Development Community (SADC)--which represents 14 countries in the region--also expressed doubts about the offer. Dr. Thuthula Balfour, director of the health unit of SADC commented:

“Members are already burdened by debt. Making drugs affordable is the solution rather than offering loans that have interest.”⁵

A Zimbabwean editorial from the *Herald* in 1996 offered a biting commentary on the availability of AIDS-suppressing drugs being developed in the United States and Europe. Reporting on the International AIDS Conference which had just taken place in Vancouver, Canada, it stated:

The international Aids conference in Vancouver, Canada, has come and gone and many Zimbabweans may be forgiven for dismissing it as a non-event. These big meetings rarely address the needs of the common man, particularly the one in the impoverished Third World. Delegates to the conference from developed countries obviously returned home with their spirits quite lifted. But those from the Third World find nothing to cheer about in these medical advances. For most Zimbabweans the new, much more effective treatment will remain a meaningless pipe-dream for a long time to come. The cost of administering the drug combinations is quite simply just for the very rich.⁶

The above abbreviated discussion sheds light on the global context of medicines and their distribution. That medicines and their (un)availability are enmeshed in transnational webs of political economy--neoliberalism and global order--is clear.⁷

Translocal actors and processes also have an impact on local conceptions of medicine and the values attached to it. In fact, what African medicines mean as symbolic and curative artifacts, and their relationship to processes of commoditization, is slowly gaining the attention of anthropologists (see, e.g., the edited volume by van der Geest and Whyte 1988; van der Geest and Whyte 1989; Etkin, Ross, and Muzzamu 1990; Whyte 1992; Bierlich 1999; Whyte 2000). Indigenous medicine in Zimbabwe--as in other parts of Africa--at least in part, owes its commoditization to the forces of modern capitalism

where access to health care, therapeutic practice, and curative substances has increasingly become a luxury rather than a right; and where unscrupulous individuals sometimes enter the profession for the express purpose of making money, especially in the face of a devastating epidemic. However, the relationship between money and medicine is also the result of a self-initiated process of 'professionalization' on the parts of Zimbabwean n'anga; a process which has been, in turn, part and parcel of a larger historical struggle for legal recognition, as we saw in previous chapters. And while, for the most part, this battle for legal recognition has been won, it has come at a price. This chapter explores the often competing logics and internal contradictions of this process for the practice of n'anga and its implications for the future of African therapeutic systems in Zimbabwe.

Shona Medicines

In the context of Shona society, the term *medicine* assumes a much more elastic meaning as compared to Western understandings of the term. For Westerners the term signifies any preventive and/or curative substance, and this is certainly true in Shona society as well. Additionally, however, medicine also refers to metaphysical power that may be protective or, alternately, dangerous or punitive.

Medicines, or *muti*, in their curative and metaphysical embodiments figure prominently in the lives of Shona peoples. From life's nascent beginnings during conception to life's final passage into death--and a new life amongst the ancestors--muti is an important mediating presence. When a child is born, for example, there is great concern over the anterior fontanel of the infant as this is regarded as the weakest part of the body and where sickness or poison can enter. Any disturbance in the fontanel is

called *chipande* or *nhova*. Treatment typically requires a poultice of a tarry, thick mixture which is applied over the fontanel. Likewise, various roots soaked in water are used to bathe babies in as a way of fortifying their systems and of protecting them from illness (Chavunduka 1978; Gelfand 1964).

As a child matures into an adult, there are various afflictions which are visited upon him, all of which require recourse to muti in its metaphysical and curative manifestations. And because these afflictions may be caused by anti-social acts, upsetting or angering ancestral spirits (*vadzimu*) or a witch (*muroyi*), or failure to perform certain ritual practices or taboos (Gelfand 1985; Chavunduka 1980; Bourdillon 1998), muti assumes a very personal role and is associated with an individual's identity; muti signifies ideas of personal power and agency, the ability to protect oneself and others, to cure, or to harm and kill one's enemies if necessary (cf. Bierlich 1999; Comaroff and Comaroff 1997). Or as Crawford (1967:103) notes: 'Medicines are used to protect one against witchcraft; to pass examinations; to win the love of an unwilling woman; to see in the dark; to grow crops successfully; to dispel the *ngozi* and to raise it; to create or cure a witch; and for many other purposes.'

A review of these diverse uses helps underline the fact that the felt need for medicines in Zimbabwe is very great. Nationwide, 10 percent of children die before their fifth birthday--mostly from very treatable afflictions--malaria and diarrheal diseases; and, in certain locations, the Infant/Child Mortality Rate (I/CMR) appears to be rising (UNICEF 1994). In the context of extreme poverty and lack of access to even basic health care, the diarrhea, coughs, and fevers that families are medicating are potentially deadly. Parasites, anemia, diarrhea, tuberculosis, and HIV and other sexually transmitted

diseases are common. No doubt health problems could be better assuaged with improving economic conditions and public health measures, but barring such improvements people are sick and want curative care in the form of medicines. In such a context of high mortality and morbidity from infectious diseases, medicines are of crucial value for ordinary people as well as for health professionals.

From a curative standpoint, *muti* refers to various locally produced and commercially available herbs--usually available in the wild or at local markets where some are even carefully labeled and bottled for sale⁸--as well as Western pharmaceuticals, usually in the form of capsules and pills. And very often, this distinction may be blurred as some medicine sellers may package locally-produced/grown herbs in used, or recycled, translocally-produced medicine bottles. Additionally, some sellers give their herbal concoctions biomedical-sounding names such as "A.C.T.5," "Profferon," and "GK17,"⁹ perhaps with the hope that buyers will view these medicines as more effective than those which are called by their local, and more common, names.¹⁰

This, of course, raises the critical question: When does 'traditional' medicine become 'Western' medicine? I asked a ZINATHA administrator. His response:

Let me start by highlighting a point: more than 70 percent of drugs available today come from plants. That is, medicinal plants. And when we speak of medicinal plants, we are speaking of traditional medicine. But, these processes of extraction, processing, and production...these would lead us to calling them 'Western' medicine. Coming back to your question, when medicine has gone past the stage of being dispensed in a calabash (*gona*), of being dispensed in the form of bark, leaf, and root form, and so forth, and it is mixed with preservatives for insuring shelf life...surely, when you mix it with chemicals, like preservatives, etc., it ceases to be traditional medicine.

And yet, since 1988 at least, ZINATHA had been involved in training healers in just such practices--making medicines available in capsule form, bottled and clearly labeled for consumption. Such training was and is an attempt to 'professionalize'--read modernize--'traditional' medicine (see Last and Chavunduka 1992), the belief being that medicine stored in, and dispensed from, calabashes was unhygienic and more prone to healers not prescribing the correct dosage.¹¹ Herbal medicines are still usually dispensed wrapped in newspaper on which is written the dosage--instructions for dosage are also given orally. Of the 100 healers that I interviewed over the course of five years (1995-99), the vast majority continued to store their materia medica in calabashes, distributing medicine in this way. Also, since 1997 ZINATHA had been involved in its own private venture for the mass production and sale of medicines (see below).¹²

As discussed above, too, medicine within Zimbabwe is an inclusive term, signifying not only physical curative substances, but ritual curative substances and practices as well. Physical curative substances--medicinal plants encapsulated, bottled, and labeled for sale--are much more prone to being called 'Western' than their ritual counterparts. Divination through the throwing of bones or through spirit possession, for example, are less likely to be labeled 'Western.' As we shall see in the next chapter, however, this, too, is changing.

In its metaphysical dispensation, muti may refer to "protective" medicines, including substances and materials, usually in the form of talismen or charms, which either through ingestion (in the case of substances) or external application confer protective powers from diseases, evil spirits or bad luck (*mamhepo*), or enemies. It may

also refer to harmful or punitive medicines used, for example, to punish a spouse's alleged lovers,¹³ to hurt an enemy, or to gain someone else's property. Love potions also fall under the rubric of supernatural medicines. Other medicines, such as *mangoromera*, are used to instill such moral qualities as courage and strength (see Gelfand 1964). You would not find these medicines in capsule form, neatly bottled and labeled at ZINATHA headquarters.

The use of medicinal plants--and occasionally use in conjunction with animal and, sometimes human, parts--for curative purposes is quite common. Medicines are infused with their curative capabilities usually through sacrifice and/or the pouring of libations in conjunction with prayers. Thus, *muti*'s potency is not self-evident, that is, it comes from external sources--the ancestors or healing spirits, and is given agentive power through men's and women's intentions. The ability to give *muti* and to use it, to act as a curative agent, implies a moral relationship with the ancestors, healing spirits, and/or God, without whose support the *muti* remains inert.¹⁴ Curative practice, in this sense, is the site, *par excellence*, of mediation between the human and the divine.¹⁵ Moreover, this relationship underscores the fact that healing is a gift, bestowed by these various agents, and that malpractice can result in the gift being taken away.¹⁶ A corollary is that a medicine's efficacy, that is its ability to work, is contingent on the careful maintenance of these connections. And a healer whose *muti* gains a reputation for not working is suspect of not only being a charlatan, but of upsetting the careful balance of these relationships.

On occasion, the ancestral and/or healing spirits may work to ferret out such individuals, usually in public settings. During a ZINATHA-sponsored workshop in 1996,

for example, some spirit mediums became possessed during the playing of traditional music, led by the *mbira*, or thumb piano. One of the spirit-possessed mediums pointed out that several n'anga were 'fakes.' Ritually-brewed beer was poured on the back of a goat. When the goat shook the beer from its back, it meant that the meeting could continue with the blessing of the spirits. However, the goat didn't shake the beer from its back and the spirit asked a particular n'anga to step to the side. He stepped aside, and the goat shook the beer off. This confirmed the fact that he was indeed a "fake."

Such accusations have become increasingly common both amongst n'anga themselves as well as amongst n'anga and the wider society. In part, this stems from the perception that more individuals are entering the healing profession as a way to make money.¹⁷ This process may be further facilitated by the fact that the Traditional Medical Practitioner's Council and ZINATHA have not yet set a maximum and minimum scale of fees for registered n'anga--and really do not have the institutional or human resources to enforce it. Both parties recognize the slipperiness of this issue, particularly with regard to historical arrangements regarding fees. For example, in many rural areas healers do not charge very much--and sometimes anything--for their services, viewing their practice not as a business, but as a form of community service. Such healers and their families enjoy the reward of high status that comes from their practice and their favored access to the spirit world. In such cases, n'anga view fees as tributes to the spirits and not as material reward for themselves. In other cases, n'anga who do not receive any fees may expect a patient to give them gifts from time to time when s/he is fully recovered. This payment scenario can become quite expensive in certain cases.¹⁸

The lack of a fee structure, and adequate infrastructure to enforce it, has resulted in exceptional and widely publicized abuses. Perhaps one of the better known cases is that of Benjamin Burombo, a Kuwadzana-based herbalist-spirit medium who rose to national fame in 1993 for claiming to have a cure for AIDS. The dread-locked, self-proclaimed AIDS healer, was known to travel in lavish style--with well-dressed body guards and an ostentatious BMW, usually escorted by two Mercedes Benzes. His flamboyant and profligate lifestyle initially made him a media star as journalists at the time, intent on getting the scoop on healers who claimed they could cure the disease, regularly "hunted" such n'anga. Indeed, the media frenzy--and the marketing/clientele it helped generate--helps spur the incursion of unscrupulous healers into the profession.

As media coverage of Burombo escalated, AIDS patients began packing his Kuwadzana home. He boldly asked his clients to first produce a certificate verifying their HIV-positive status before he treated them. Following a treatment of herbs, and in some cases water,¹⁹ Burombo would advise his patients to go for another HIV test. He claimed that most of these patients returned having been clinically-proven to be HIV-negative. His patients were usually reluctant to talk about their conditions after undergoing his treatment. Those who did talk had mixed feelings, some saying they felt much healthier, others not being so sure.²⁰ He dismissed as foolish the idea that he submit his muti for clinical trials in Europe, arguing that such a scenario where his medicines were processed overseas would result in most patients failing to access the medicines because of costs--something the average Zimbabwean couldn't do already under his pricing scheme. He felt processing and manufacturing of drugs should remain local whereby they could be more adequately controlled.

At the height of his fame in 1993, Burombo charged \$Z5,000 for a single treatment, roughly the equivalent of what the average worker at the time would earn in one year. Today, he has lowered his treatment fee to Z\$2,000, arguing that most people could not afford the higher fees at the moment because of current economic hardships.²¹ How kind of him.



Sadly, of course, the price of such treatments is fueled by profound desperation as more and more people living with AIDS seek miracle cures. Aware that such abuses might occur, ZINATHA has regularly admonished healers for claiming to have a cure for the disease through various branch and regional meetings. Likewise, through workshops sponsored by the National AIDS Co-ordination Programme, healers were given a protocol whereby all drugs were to be subjected for clinical trials to evaluate their effectiveness. The Ministry of Health and Child Welfare (MOHCW), through locally-based Blair Research, would provide the project funds and employ a full-time researcher to collect data and compile the project report. The MOHCW would also provide patients who are confirmed HIV-positive, the patients being tested after 3 and 6 month intervals after commencing treatment. ZINATHA would provide a register of traditional healers

participating in the project. Unfortunately, the collection and testing of medicinal plants has been inconsistent, and the above project was suspended after just a short time; the reasons why are much debated. However, local AIDS activist and counselor, Lynde Francis, who participated in Blair Research's clinical trials with n'anga said:

They've never published them [the results]...because they proved that it [traditional medicine] works. I think they supported those trials because they thought it would prove once and for all that traditional healers were a bunch of charlatans and that it didn't have any effect. And when the trials clearly began to go the other way, I think they backed off because they ran out of funds and they couldn't complete...and they didn't analyze the data. They said the data was flawed. They did publish some preliminary data and it was good, it was really good. It really showed a difference that people were getting higher CD4 counts, better full blood counts, gaining weight. In the year that it ran, they had only, like, 4 deaths out of something like 150 people. It was very very few. And these were people who were coming from the main hospitals outpatients. They were really ill, people with CD4's of 14 and 13, you know. And yet, they were not dying. And that alone, I thought they would really want to trumpet from the rooftops, but, no, they have never really published it. They've never really made much of it at all.

Given the apparent antipathy between government and n'anga, I asked Lynde about the relationship. She explained:

I think it's very difficult to say...a lot of it has to do with the fact that most of the top people in the government were Catholic-educated. They're the product of mission schools. They were taught that traditional healing was witchcraft and to undervalue it. But, I still don't think that explains it enough. In this day, they should be aware of it. You know there's more to things than just Western practices. They should have a much more open mind to their own tradition and culture. So, I can't say that that's the whole answer, but it's obviously part of the answer.

With limited material and human resources, it seemed to me that the government would be more interested in at least exploring the role of n'anga in helping to combat the spread of HIV/AIDS. Lynde continued:

I don't know the answer to that question. It's something that frazzles and puzzles me tremendously. Why there's this resistance, why there's no real effort to investigate more. ZINATHA is doing stuff on its own, but it's not getting government support for it.

Government, of course, is comprised of people with multiple interests, voices, and opinions and, in all fairness, there are some in government who are supportive of traditional medicine. Dzivarasekwa Member of Parliament (MP), Edson Wadyehwata, for example, has championed local approaches to combating HIV/AIDS. In particular, he has argued that government should support research into AIDS by traditional healers and desist from "relying on foreigners otherwise we will be given wrong medication that may kill us faster than AIDS." Wadyehwata has argued that traditional healers have made considerable progress in their research into HIV/AIDS and that they could do more with government support and assistance. Sounding much like Gordon Chavunduka, president of ZINATHA, Wadyehwata has said, "We can't rely on foreign medicine, we need to pursue the traditional Zimbabwean way of researching on medicine otherwise we will be given the wrong medication...we hope government will see what further steps it can take."²² The question, of course, is: who in government is listening to MP Wadyehwata and what real power does he have in translating his concern into an actionable plan?

The above discussions shed light on some of the forces both motivating and constraining the efforts of n'anga to professionalize and to combat HIV/AIDS. First, there is the felt need to develop a set fee schedule for healers so that abuses of patients do

not occur, abuses which may be more likely in the desperation wrought by HIV/AIDS. Moreover, any apparent abuse on the parts of n'anga quickly finds its way into print, often perpetuating the public perception that n'anga are charlatans just trying to make a quick buck at the expense of their patients.²³ At the same time, ZINATHA does not have the human resources to enforce and monitor fee schedules even in the event that they could get their constituency to agree to them. And given the diverse economic fortunes of their clients, rural n'anga, for example, would find it difficult to charge the same fees as their urban counterparts.

Second, external pressures also contribute to the felt need of n'anga to professionalize. As medicine becomes increasingly commercialized and mass-produced, the clients of n'anga may begin to expect local muti to follow similar trends; that is, they may expect it to come in labeled bottles in capsule form. As one PLWHA, Tichafa, stated in Chapter Twelve:

I'd rather be with the Western people with regard to health. There's no checklist with traditional healers. You can even overdose. I've lost lots of money through these people [traditional healers]. They charge you lots of money for things not proven. The Western way is better -- good vitamins and good diet. I had TB once and went down to 47 kilograms. Vitamins and good diet saved me and constant visits to doctors. When you have diarrhea, you don't go to a faith healer for herbs! Right now I'm on a triple combination therapy of DDI, Crixovan, and Zerid.

N'anga respond to such criticisms, and one such response is to not only begin bottling and labeling medical concoctions, but to give them biomedical-sounding names as well. And while bottling and encapsulating medicines into pill form might seem like a positive move toward professionalization, there is still no testing mechanism in place which

would indicate to n'anga the level of concentration of active ingredients in these bottled and encapsulated medicines. Patients may have an idea of how much medicine they're getting in bulk form, but have no idea of how much they're getting in terms of levels of active ingredients.

Third, such production processes unsettle the apparent line between "traditional" and "western" medicine. This can pose challenges for both n'anga and their patients. For n'anga it could mean more time, energy, and money spent on "packaging" medicines that they previously made available in their crude form. Such a process could also mean closer scrutiny by the Zimbabwean Research Council which typically handles clinical trials of "western" medicines being introduced to the local market. For some n'anga, this could mean the loss of some autonomy in their healing practice. At the same time, n'anga are legally prohibited--in theory--from dispensing "western" medicines; this includes everything from antibiotics to aspirin. If n'anga begin processing their medicines in such a way that they are indistinguishable from their western counterparts, what will that mean in legal terms? For patients, apart from the challenge of toxicity mentioned above, there is the question of choice in care-giving options. If patients feel that the curative practices of n'anga are becoming more closely aligned with that of biomedical doctors, they may feel less inclined to visit n'anga, especially for *materia medica*.

Related to this effort at professionalization are the very real constraints placed on n'anga in their efforts to combat HIV/AIDS by government and the local medical establishment. Whereas historically the government has practiced a policy of benign neglect with regard to the curative practices of n'anga in relation to their patients, the

HIV/AIDS pandemic has meant increased scrutiny of n'anga by these agents. Before making public claims as to the efficacy of their medicines in treating HIV/AIDS, n'anga are required to submit their medicines to government-required clinical trials. Certainly such scrutiny is justified in a public health emergency, but given the inherent tension between government, health professionals, and n'anga, such scrutiny has the effect of pushing such claims and practices underground. It also reinforces the idea many n'anga have that both government and doctors are only interested in monitoring their curatives practices as a way of stealing this knowledge and enriching themselves.

These are just a few of the internal and external challenges ZINATHA faces in its efforts at professionalization. Such challenges, however, have done little to dampen the enthusiasm and zeal with which ZINATHA works. As an organization very much interested in professionalizing itself, ZINATHA has developed a number of programs. Some of these are discussed below.

ZINATHA Enterprises Private Limited

Visiting ZINATHA headquarters one day in 1999, I was surprised to see medicines in carefully-labeled bottles on the shelves above the receptionist's desk.

"What are these?" I inquired of one of the office administrators.

"We sell these here now," said G., handing me a sheet of paper. The paper, it turned out, was a share certificate for the company formed in 1997 which produced and sold the medicine, ZINATHA Enterprises Private Limited (ZEPL). Gordon Chavunduka, president of ZINATHA, writes (1999:44).

Because of the rising demand for traditional medicine in the society, ZINATHA established a pharmaceutical company in 1997 which was registered as ZINATHA Enterprises Private Limited. The company assists by producing in large quantities those medicines in great demand.

The mass production of such medicines by an organization designed to support the practices of n'anga greatly interested me. On the one hand, it seemed such production practices wiped out a very important aspect of the curative process, namely the face-to-face interaction between healer and patient.²⁴ On the other hand, I wondered if selling mass quantities of muti through ZINATHA headquarters would undermine the ability of individual n'anga to sell their own individually-harvested and processed medicines. G. mentioned that it was individual n'anga who indeed benefited from the sale of the medicines, 70 percent of the profit was returned to them (e.g. those responsible for harvesting/processing the medicine), while 30 percent was retained by ZEPL. N'anga were welcome to bring in medicinal plants they thought were particularly effective in treating certain afflictions. If they did indeed prove to be effective, ZEPL would then begin processing the medicines for mass consumption. Medicines I saw for sale were usually in powder form, encased in capsules. None of these, to my knowledge, contained artificial preservatives, which would have meant they were no longer 'traditional' according to the ZINATHA office administrator. None, to my knowledge, had undergone clinical trials to verify their safety and efficacy.

On a related point, in 1999 ZINATHA asked government to allocate five large commercial farms under the land redistribution exercise to enable its members to grow medicinal plants. Chavunduka expressed that unless action was taken to meet the

increasing demand for medicinal plant use in Zimbabwe, there would likely be a critical traditional medicine shortage in the next 20 to 30 years--a sentiment suspiciously similar to the one held by the Global Programme on AIDS and the Traditional Medicine Programme of WHO (see, e.g., *Report of a WHO Informal Consultation on Traditional Medicine and AIDS: In Vitro Screening for Anti-HIV Activity*, 1989).

As ZINATHA was currently in talks with an unnamed British “partner” over exporting Zimbabwean muti overseas, such a speculation may not have been far off. Allegedly, ZINATHA had been approached by the company especially for those medicines which assisted barren couples in conception. Among the particular medicines being considered were those of faith healer, Boniface Mponda, whose ‘holy water’ had allegedly already helped thousands of local couples to have children.²⁵ Local newspapers trumpeted the potential partnership, one holding forth in a triumphant tone: “If the partnership is successful, and the Zimbabwean traditional medicine is exported, this could turn out to be a breakthrough in the world of Zimbabwean traditional medicine.”²⁶ As this dissertation went to print, nothing had yet come of this partnership.

The School of African Medicine

Another ambitious facet of ZINATHA’s attempted professionalization of African therapeutic systems was an attempt to build the first school of African medicine in Zimbabwe. Part of the motivation for opening the school, according to Chavunduka, was that the traditional method of teaching apprentices in the field had been disrupted by the ‘new social order.’ “Traditional healers,” he explained in a local newspaper, “used to take about three years teaching an apprentice, but it’s no longer possible because most

people are now living apart and if it is in town, it's not possible to do an intensive course.”²⁷

After registering with the Ministry of Higher Education and Technology in December of 1998, and failing to secure funding from the Ministry of Health and Child Welfare, ZINATHA decided to fund the project on its own. The school was to be run like any other medical school, and a syllabus (as of July 1999) had already been drawn up. The program was to be divided into four mutually-reinforcing parts: culture and health, religion and health, medicines, and medical practice.

Alleging that some Western-educated leaders look down upon the idea of starting a school of African medicine in Zimbabwe, Chavunduka chided that “...such people were brainwashed by the type of Western education they received so they look down upon anything that is African.”²⁸ More likely, such alleged critics were casting doubts on the fruition of just such a school given ZINATHA's ambitious (and sometimes outrageous) projects, many of which have never completed.

The above illustrations help paint a picture of the economic and social forces which contribute to the both the professionalization of African indigenous medicine and the commoditization of muti. These very forces also encourage recourse to muti in its metaphysical capacity as well.

Occult Economies: Muti, Murder, and Witchcraft

In 1999, Zimbabwe's imploding economy and the resulting social tensions--protests, rising violence and crime, abuses of women and children--helped fan the flames

of witchcraft and witchcraft accusations. Sightings of *tokoloshis* and *chikwambas*, gremlin-like supernatural creatures, were commonplace.²⁹ The public perception that families were increasingly turning against one another with allegations of witchcraft had increased as well; for example, popular *chiremba* musician Thomas Mapfumo's trial for contravening the Zimbabwe Witchcraft Suppression Act for accusing his brother of bewitching and subsequently killing their father. A headline from the *Daily News* trumpeted, "Man jailed for killing father over witchcraft accusations."³⁰ Aspiring politicians were also taking advantage of the supernatural in an effort to gain office. War veterans leader Chenjerai Hunzi, for example, in an effort to run for president of Zimbabwe, consulted spirit mediums in Matebeleland, Mashonaland West and the Midlands to "ask for political guidance and for power to govern."³¹ Even ministers of religion were taking advantage of the supernatural in an attempt to better their material standing. A respected local pastor was caught sprinkling some "juju" in the nude around the premises of the company he worked for, presumably in an effort to not only ensure his promotion, but to guarantee his continued stay at the company following reports of an imminent retrenchment exercise.³²

This apparent burgeoning practice of the mystical arts into public life, far from signaling a retreat to an imagined 'tradition,' may be seen as a "mode of producing new forms of consciousness; of expressing discontent with modernity and dealing with its deformities. In short, of retooling culturally familiar technologies to new means and new ends" (Comaroff and Comaroff 1999:284). And rather than dismiss as rubbish such phenomena, why not ask, as does Farmer (1992:235): What might happen if we were to insist that such commentary is worthy of investigation? What might happen if we were

to proceed as if our informants were themselves experts in a moral reading of the ills that afflict them?

The following discussion of this 'occult economy' attempts to extend a 'hermeneutic of generosity' (Farmer 1992:235) to the very phenomena many dismiss as foolish superstition. Zimbabwean readings of these phenomena and social responses to them echo their readings of the wider world--a world where inequity and asymmetrical power relations abound. As Comaroff and Comaroff (1999:294) point out:

In point of fact, the processes involved in the rise of novel forms of planetary integration and compression--especially in the electronic economy, in mass communications, in flextime flows of labor and capital, in the instantaneous circulation of signs and images, in the translocal commodification of culture, in the diasporic politics of identity--challenge us by re-presenting the most fundamental question of our craft: how do human beings construct their intimate, everyday life worlds at the shifting intersections of here, there, and everywhere?

As the discussion below illustrates, recourse to the occult usually signals an attempt to make sense of and control a runaway world, sometimes with grisly consequences.

Ritual Murder and the Use of Human Body Parts for Muti

It is impossible to talk about Shona medicine without also bringing up the very controversial subject of human body parts in the preparation of certain kinds of muti. For example, perhaps as a result of the worsening economic and political environment in 1999, there were a rash of very public witchcraft accusations and cases of ritual murder. Though there has been no official inquiry into ritual murder in Zimbabwe, the practice

exists and in these days of economic instability, it appears to be more prevalent as reported in the media. The motives underlying such killings are usually some form of material success.³³ Though not usually involved directly in the killing of victims, some unconscionable traditional healers are involved in consultations on body parts and the preparation of those parts for ritual purposes.³⁴ “The traditional healers give advice on who to kill and which parts of the body to be used to prepare such medicines,” says Gordon Chavunduka, president of ZINATHA. Different body parts have different qualities ascribed to them. Genital organs and breasts are used for fertility purposes. The eyes of a victim grant the users farsightedness (in business), while the hands are used to attract many clients.

A perusal of police records for Harare indicates that 100 people were murdered in 1998 and most of the cases that went before the court were shown to be ritual murders.³⁵ In March of 1999, a policeman and his wife were detained on allegations that they ritually murdered their domestic worker to secure a minibus.³⁶ In April of 1999, a youthful-looking 38-year-old man from the Harare suburb of Epworth was released by his kidnappers after being declared “too old” to be killed for his body parts.³⁷ For every case that gets reported, however, one or more goes unreported. Add to this the rise in numbers of missing persons, and some investigators begin to speculate on a grisly pattern. Sadly enough, it is precisely those individuals who are most socially and economically vulnerable--children, homeless people, unskilled workers--who are usually the targets for ritual murders. Children in particular are singled out because it is believed by some people that their organs make powerful medicine.

This belief that children's body parts are particularly powerful has a number of grisly corollaries. For example, a man intent on having a bountiful crop may be advised by an unscrupulous n'anga to have sexual intercourse with his own daughter, the belief being that to ensure success, some opposite or anti-social act should be carried out by him (Gelfand 1967, 1985). It is rumored that many captains of industry and high-ranking government functionaries (all men) have participated in such practices. This most foul and incestuous act also finds expression in the belief in much of southern Africa that AIDS can be cured by having sexual intercourse with a female child virgin, resulting in the rape and infection of more than a few female infants.

Rape cases involving young girls had become so pervasive in 1996 that ZANU-PF and ZINATHA scheduled meetings in Mutare, the Eastern Highlands, to discuss strategies for subduing the practice. Importantly, n'anga were not only implicated in the instruction of such practices; they were also implicated in the rape of young girls themselves. Some researchers of indigenous medicine and practice approach such accusations with suspicion, arguing that male healers will sometimes, in an attempt to administer medicine to the vaginal cavity of a young girl, place the medicine on their penis (as it's longer than a finger usually) and insert it. Whether or not such explanations are credible is not really the point; in the midst of an AIDS epidemic, such practices clearly need to be stopped.

Harmful Medicine: A Short Case Study

Jealousy and its other face, greed, are often singled out as the prime motivators in the use of harmful medicines, and this is especially true within families.³⁸ The case of

Isaac Mtukudzi offers some insight into this phenomenon. At the time that I spoke with Isaac in 1999, he was working for an office supply store in downtown Harare. Originally from Rusape, he came from a large family (4 brothers and a sister as well as his mother) which he was helping to support since the death of his father. As the eldest son, he felt it was his responsibility, though with his remittances sent home he was barely able to afford living in the city himself. Given his financial straits and the economic precariousness of his life in the city, he often reflected that he was plagued by bad luck (*mamhepo*).

He remembered a conversation with his father not long before he died. His father said: “You see all of this [indicating their house and land in Rusape]? All of this belongs to you and never let anyone say otherwise. Everything [he picked up a brick being used as a door jam], even this, belongs to you.”

Isaac told me that his father’s father had allegedly killed, ritually murdered, a farm worker to ensure that his wealth would increase. Proper ritual action had not been taken to appease the murdered man’s spirit, and Isaac suspected that this was the root cause of much of his bad luck. I asked him if there was something he could do, for example visit a n’anga, and he said: “The problem, Diva, is that me and my uncle-- father’s brother--are not on good terms. He says he doesn’t consult n’anga because he’s a Christian. But, I know that he does. The two of us must go to the n’anga together.”

After his grandfather’s death, Isaac’s uncle made claim on half the cattle in the kraal, eight (8) in total. Isaac’s father supported this claim though, as the elder son, he was certainly not entitled to honor it. The uncle then said that he was going to slaughter his half of the cattle and eat the meat, an action considered extravagant and selfish, and he warned Isaac’s father to not go near the kraal.

One day, as Isaac and his father walked by the kraal, his father was struck with searing pain. He grabbed his arm, crying out in agony. Then, he grabbed his head, saying the pain was in both places. He sat down on the craggy terrain to compose himself. Later, as the family made its way back to Harare, a tire blew out on the family car and they stopped to fix it. After resuming their journey, this happened twice more, incredibly. Isaac's mother began to weep at this point, for surely the tires blowing out three times was not normal. She suspected witchcraft.

Back in Harare, Isaac's father went for medical treatment for the pain in his arm and head. His arm had begun to balloon out around the elbow. The attending physicians said they had never seen anything like it before and extracted fluid for testing.

Isaac's mother suggested that they consult a n'anga to get a second opinion. His father refused, saying "We are Christians...Anglicans." Unmoved, Isaac's mother went on her own to see a n'anga and was given some muti that would help. Unbeknownst to him, she gave him the medicine and he began to feel better.

Looking back now, Isaac wished he could have done more for his father. For him this meant being more aggressive in consulting n'anga and not giving in to his father's desire to treat his affliction solely as a medical/physiological one. With great clarity, Isaac remembered that day that his uncle came to pick him up from boarding school. He had had bad dreams the previous nights. He asked his uncle why he had come to pick him up while school was still in session. His uncle wouldn't answer.

"I know my father's dead," he told his uncle, who denied it. As they drove to Isaac's home, the dry winter veld of the Eastern Highlands rushing by, he saw many cars

lined up along the road leading up the family compound. And he knew. Yes, his father was dead.

He didn't cry.

Soon, he started developing some of the same symptoms as his father [especially the searing headaches]. His mother took him to a n'anga who made incisions in his scalp and on his wrists (which are still visible today) and "black" blood came out. As the black blood seeped out, he suddenly felt a cooling feeling surround his head. "You know when it is very hot outside and you walk into an air-conditioned room? That was the feeling."

Shaking his head finally, he said: "I've had a difficult life [and] the time when I needed my father most, I didn't have him."

Isaac's case helps shed light on the dynamics of harmful medicines on a number of different levels. First, his grandfather was responsible for ritually murdering an employee to ensure the continued success and growth of his agri-business. This material motive fuels many such actions, particularly in an unrelentingly harsh economic environment. Because no ritual action had been taken to appease the murdered man's spirit, it is likely that it returned as *ngozi*, an avenging spirit, to persecute his grandfather, his grandfather's relatives, and descendants. It is also possible that the *ngozi* was responsible for the tense relationship between Isaac's father and uncle. This strained relationship, in turn, may have resulted in the uncle placing a harmful charm in or near the family's cattle kraal (hence his uncle's admonishment to "not go near the kraal") which, subsequently, caused Isaac's father's illness. His father's stubborn refusal to consult n'anga (because of his Christianity) and his treatment-seeking on behalf of

biomedicine further contributed to his illness and, ultimately, to his death, according to Isaac. This was confirmed by the fact that, when exhibiting similar symptoms as his father's, Isaac was immediately taken to a n'anga for treatment and subsequently relieved of his symptoms.

Is it of course impossible to say how common such beliefs are as outlined above. However, there are many local people who do not believe in such phenomena as ngozi, viewing them as expressions of tremendous gullibility and ignorance. A letter to the editor in the *Daily News* (July 10, 1999), for example, blasted beliefs in such 'superstitions' stating:

When calamity hits us and we attribute it to ngozi we set in motion a chain of events which make it a self-fulfilling prophecy. We set about to try and sniff out who might have inflicted the ngozi on us. Maybe it's our jealous neighbor. No, it must be my business competitor, that's why my sales are low this month. Maybe it's my political opponent, he wants my parliamentary seat. The witch-hunting continues, suspicion and discord set in, the suspected or accused counteract with their hocus-pocus nonsense and indeed, ngozi has worked to ruin relations and people's sense of control over their lives.

I certainly do not reduce man to the physical material at the expense of the spiritual and the pursuit of higher ideals. On the contrary, my concern is that being stuck in the mud of superstition actually keeps us from the pursuit of these higher, spiritual ideals than we should be. We cannot tap into the latent but abundant spiritual potential within each of us when we are wallowing in the dirt of harmony- and potential-destroying indulgences like ngozi. Let us free our minds, bodies and spirits from superstitious nonsense so that we can achieve our full material as well as spiritual potential.

The truth claims of these occult narratives, that is whether or not they are verifiable (and the above author seems to think not), is not really the issue here. The

more relevant issue is what these narratives reveal about the nature of the world their speakers inhabit. In fact, by insisting that such commentary is worthy of investigation and by privileging the voices of informants in their readings of the ills that affect them, we move closer to an experience-near rendering of these phenomena. The underlying moral of the above narratives seems to be, in part, that crimes committed on others in an effort to gain material success are so serious as to not only be punishable to the person, but to that person's relatives and descendants as well. Such supernatural punishment may be read as an implicit critique of a ravaging, and increasingly pervasive, materialism that erodes familial and social bonds.

The above examples unsettle the presumed boundaries between 'traditional' and Western medicine. Certainly, the blurring of these boundaries has been facilitated by the commoditization of indigenous medicine, suspended as it is in a saturating capitalistic cultural context. As with other commodities, market forces shape the value attached to local muti. This is increasingly the case as translocal actors and organizations--scientists, researchers, and multinational pharmaceutical organizations--become more interested in local medicines. These processes of commoditization seem certainly to have accelerated with the continued spread of HIV/AIDS as local and translocal actors search for a 'magic bullet.' Certainly, too, the epidemic seems to fuel a growing body of unscrupulous healers (and non-healers) bent on turning a quick profit, for themselves or for their clients. This pertains to healers selling bogus concoctions as well as to those involved in cases of ritual murder, as discussed directly above.

Importantly, however, this process has also been facilitated by the self-conscious machinations of healers themselves as part of the struggle for legal and, perhaps more widely, societal, recognition in post-colonial Zimbabwe. For good or bad, “professionalization” is often viewed in terms of being “modern,” as in the production of capsules in neatly labeled bottles, keeping carefully-written notes on patients, and having the proper registration certificates from ZINATHA. Attempting to balance the demands of a market-driven economy with the demands of the ancestors and healing spirits, healers are placed at a critical crossroads. As we will see in the next chapter, “modernity” itself poses new sorts of possibilities and constraints to Zimbabwean n’anga.

¹ Currently, the most important policy tools for addressing this issue are compulsory licensing and parallel imports. Through compulsory licensing, any government can ask a patent holder to license the right to use its patent to a company, government agency, or other party. Under such an agreement, Zimbabwe could issue a license to a local company for an HIV/AIDS drug manufactured by, say, Merck. A Zimbabwean firm could then manufacture the drug for sale in Zimbabwe under a generic name, and it would pay a reasonable royalty to Merck on each sale. Compulsory licensing lowers prices to consumers by creating competition in the market for the patented good. Its impact is similar to the introduction of generic competition at the end of a drug’s patent term—prices lower considerably. Compulsory licensing can lower the price of medicines by as much as 95% or more. Parallel imports involve imports of a product from one country and resale, without the authorization of the original seller, in another, thereby allowing the buyer to search for the lowest world price. In this way, A Zimbabwean company or government agency, for example, might purchase HIV/AIDS drugs in India—assuming they are sold for a lower price in India—and then resell them in Zimbabwe. Since the price of medicines is sometimes lower in the United States and other industrialized countries, parallel imports can be a tool to enable developing countries to lower prices for consumers.

In Ghana, importation of generic, low cost AZT/3TC from India's Cipla, Inc. has been squelched by Glaxo Wellcome’s bogus claim of “patent infringement.” Recent reports indicate Glaxo Wellcome's patent claims to AZT/3TC in Ghana are nonexistent;

but their actions against Cipla and the Ghanaian drug distributor have halted drug distribution and are resulting in needless death (Health GAP Coalition position paper presented at UNAIDS meeting in Rio de Janeiro 13 December 2000).

² "On AIDS Drugs, a Mixed Blessing." *New York Times*, May 22, 2000.

³ In an unprecedented move, an Indian company offered in February 2001 to supply triple-therapy drug "cocktails" for \$350 a year per patient to a doctors' group working in Africa. *New York Times*, February 7, 2001.

⁴ "Use the Surplus to Fight AIDS." *Boston Globe*, August 28, 2000.

⁵ "Loans to Buy AIDS Drugs Are Rejected by Africans." *New York Times*, August 21, 2000.

⁶ "It's good news if you're rich." *Herald*, August 1, 1996.

⁷ Interestingly, both compulsory licensing and parallel imports are permitted under the international trade rules established by the General Agreement on Tariffs and Trade (GATT) and administered by the World Trade Organization (WTO). However, it is usually the powerful, industrialized countries--the United States, Japan, and the European Union--who benefit directly from this agreement. One of the GATT agreements, the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS), contains the international rules the WTO enforces on intellectual property with regard to patents, copyrights, and trademarks. Industry, especially the pharmaceutical sector, exercised heavy influence over the TRIPS agreement negotiations, and many public interest advocates generally believe the TRIPS agreement inappropriately favors corporations. In general, the TRIPS agreement requires countries to adopt U.S.-style patent systems, which apply both to products and processes, and last for 20 years. This has compelled many developing countries—which had followed the lead of virtually every industrialized country in enacting weak patent rules while they were still industrializing (many European countries did not recognize patents until the 1970s)—to refashion their patent rules dramatically (Weissman 2001).

But whatever the TRIPS agreement's biases, and despite the requirements it imposes on signatory countries, it permits compulsory licensing and parallel imports. Yet, despite the WTO-legality of these policy tools, multinational pharmaceutical companies object to the practices, which they perceive as curtailing corporate profits. Under pressure, the Clinton administration retreated from its long-standing, aggressive opposition to developing country efforts to undertake compulsory licensing and parallel importing. The Bush administration has signaled it will follow the revised Clinton policy (*ibid.*).

⁸ ZINATHA, since 1988, has encouraged n'anga to bottle their muti in an effort to make it more hygienic. It is important to point out that many of the medicine sellers at the markets are not n'anga, *per se*.

⁹ See, e.g., Chapter Fourteen.

¹⁰ In a related discussion of medicine use in Uganda, Whyte and Birungi (2000) note that foreign medicines--whether African or non-African--have always held a certain attraction.

¹¹ Deducing the correct dosage is usually the result of years of transmitted oral knowledge. One healer, an herbalist/spirit medium, told me that n'anga will usually dream of a particular herb/medicinal plant and even dream its correct use. These dreams, he said, are in part the result of observing animals--monkeys and baboons--in the bush utilizing medicinal plants.

¹² As a counter point, Whyte and Burungi (2000:145), in their work in Uganda, note "African medicines" are not mass produced and marketed on a large scale--local communities being self-sufficient in "traditional medicines."

¹³ This is usually the case if a man suspects his wife is committing adultery (I haven't come across an equivalent situation for a wife whose husband is committing adultery). The husband will consult a n'anga for the proper muti which he will place secretly in her bed or food. Thereafter, any man (other than the husband) that has sexual intercourse with her, will contract an affliction known locally as runyoka. Runyoka is also the name of the muti. As Gelfand (1985:37) points out, there are many types of runyoka, the most common being *runyoka rwemago*, *runyoka rwehamba*, and *runyoka rwemba*--all of these types of muti utilize different animal/insect parts (wasps, poisonous snakes, genitals of male and female dogs) which, through sympathetic application, are said to affect the wife's lovers in like manner.

¹⁴ See Bierlich 1999, Fortes 1987, Gelfand 1985.

¹⁵ Cf. Comaroff and Comaroff 1997:333.

¹⁶ Chavunduka (1999:44) points out, in the case of spirit mediums, it is strongly believed that ancestors and healing spirits can withdraw the healing skill bestowed upon the individual if offended.

¹⁷ See, for example, "Act Against AIDS Cure Charlatans-Nyazema." *Herald*, July 23 1996, "Bogus Healer Fined," *Daily News*, June 17, 1999, "False Prophets Swindle Thousands of Dollars," *Daily News*, May 12, 1999.

¹⁸ Chavunduka 1999.

¹⁹ See, e.g., the narrative of Lynde Francis and her husband in Chapter Eight.

²⁰ See, e.g., the narrative of Tichafa in Chapter Eight.

²¹ And this is still considered exorbitant where again, in 1999, the average worker made about \$Z1,500 per month.

²² "Measures urged to protect Aids orphans." *Daily News*, May 13, 1999.

²³ See, e.g., "Act against Aids cure charlatans--Nyazema." *Herald*, July 23, 1996; and "False prophets swindle thousands of dollars." *Daily News*, May 12, 1999; and "Mabvuku family escapes death after taking poisonous concoction." *Herald*, June 16, 1999.

²⁴ Face-to-face contact is not always necessary in the patient-healer relationship. And, as Gelfand (1985) points out, the patient need not always be present for a n'anga to diagnose his or her affliction.

²⁵ Popular faith healer Boniface Muponda had been only recently acquitted of 16 charges of sodomy and four of indecent assault. Muponda was, in 1999, beginning the long process of re-building his practice after the charges. Prior to the charges, he had begun ambitious plans for a hospital in the high-density suburb of Norton. After his criminal charges were made public, many of his donors had backed out of the deal.

²⁶ "Traditional Medicines to be Exported," *Standard*, June 13-19, 1999.

²⁷ "ZINATHA's Plans for School of Medicine near Fruition," *Herald*, June 15, 1999.

²⁸ *ibid.*

²⁹ "School closes amid witchcraft allegations." *Herald*, June 16, 1999. "Six teachers transfer over alleged witchcraft activity." *Herald*, June 17, 1999.

³⁰ May 14, 1999.

³¹ One of the spirit mediums visited by Hunzvi, based in at the Njere shrine in Matopos, allegedly gave him the "Tsvimbo yeuMambo," (the chief's stick), a walking stick which was said to possess powers to draw huge crowds to his meetings and which he was to

carry wherever he went. It was said to pacify opponents, command obedience, and grant a leader's heart the strength of a lion. The same kind of stick was given to former Vice-President Joshua Nkomo in the 1950s by the same spirit mediums.

³² "Pastor caught naked." *Sunday Mail*, July 11, 1999.

³³ See Gelfand (1985), for example, pp. 43-44.

³⁴ A Parliamentary commission from South Africa, for example, found that healers do play a part in medicine murder and witch killings, reporting: "From our investigations their role in these murders is indirect. They are consulted by people eager to further their own selfish interests, especially in the case of ritual murders or medicine containing body organs of innocent victims. This is usually regarded as the exploitation of superstitious beliefs. The victims are killed on instructions of traditional healers. They are murdered in secluded places by accomplices of the traditional healers' clients (Ralushai, et al. 1995).

³⁵ "Ritual Murders and Trade in Body Parts on the Increase," *The Sunday Mail*, April 18, 1999.

³⁶ "Couple in Alleged Ritual Killing Granted Bail," *The Daily News*, March 30, 1999.

³⁷ "Too Old to be Sacrificed," *The Standard*, April 18-24, 1999.

³⁸ See Gelfand 1985:33.

CHAPTER FOURTEEN

Not-So-Traditional Traditional Healers

African ethnography has for decades chronicled the local effects of usually externally-orchestrated change, and the plight of n'anga in Zimbabwe offers an illustrative example--as the previous discussion has illustrated. Since the days when missionaries Robert Moffat and David Livingstone first crossed the Limpopo, there has been an effort by translocal actors to intervene in the affairs of n'anga. And while the actors have changed over time -- whether they be missionaries, colonial administrators, doctors, social scientists, or development practitioners -- what remains the same is a close scrutiny, and very often suspicion of, African therapeutic traditions. One end result of this encounter between presumed "local" traditional healers and presumed "translocal" arbiters of "modernity" has been a profound ambivalence toward traditional healers.

This is, however, only one way of framing the discussion. While ambivalence may be the characteristic trope of the historical and contemporary encounter between the local and the translocal, broadly defined, I also suggest another trope: synergy. For while this encounter has meant an incursion of external forms and practices in the material and ideational spaces n'anga occupy, it has also been an uneven incursion, not fully saturating (drowning) local forms and practices. This confluence of forms and practices has been simultaneously syncretic and individuating in equal parts. As, for example, n'anga incorporated other practices -- involvement in a cash economy, new forms and modes of dress, new forms of communication and education, etc., -- their own historic practices were brought into sharp relief. Whether referred to as "re-localization" (Long 1996), or as the "convening of the local under the canopy of the global" (Hall 1999:15) this

coupling of the local and the translocal has resulted in a process whereby “local differentiation not only remains but actually intensifies” (ibid.).

From a theoretical perspective, this encounter provides the discursive building blocks by which local and translocal actors fashion facsimiles of one another, refracted images, suited for particular purposes. Major health crises such as AIDS (the 1918 influenza epidemic also comes to mind) create an environment where such distinctions intensify and proliferate. At the same time, however, it is important to remember that these distinctions are often consciously constructed and serve heuristic purposes for the actors involved and do not necessarily reflect an empirical reality. Moreover, an overly-narrow focus on these distinctions only conceals the very real linkages and areas of convergence and confluence between n’anga and translocal actors.

For example: John Maeresere, 43, is a spirit medium and herbalist who lives and works in a plain white-washed home in Chitungwiza, a short walk across a weed-strewn lot from the district’s main shopping center. His surgery, a separate small structure at the back of his home, is filled with an eclectic mix of neatly-stored *materia medica* in calabashes and plastic bottles with prim white labels. He specializes in treating HIV/AIDS, cancer, and STD-related complications. In fact, he will tell you, most of his patients are confirmed AIDS patients, having already been screened for HIV antibodies by a local clinic. He treats them with a self-produced ‘herbal cocktail’ which, he says, ‘triggers’ the immune system and inhibits the activity of the virus while also cleansing the blood. He says that AIDS existed before, in the distant past, but not as it does today. It was isolated, presumably lying dormant in some animal or plant host, springing forth at different times as punishment for transgressing some social/moral boundary. “You didn’t

get it if you were faithful,” he explains. When not treating patients, John manages micro-projects supported by the Danish Embassy (they also subsidize HIV antibodies tests for some of his patients). He is well equipped and qualified for such work.

He has a bachelor’s degree in economics from Yale.

John’s case is, by most stretches of the imagination, atypical: a “traditional” healer in an out-of-the-way place, ministering to out-of-the-way people, an African man with a degree from Yale. While atypical, though, John’s case shines a bright light on the deeply-ingrained assumptions we make about ‘local’ ‘traditional’ healers and their linkages with translocal institutions, agents, and ideas, in this global moment. Moreover, the depiction of healers as living embodiments of ‘tradition,’ (Chavunduka 1980; WHO 1990) as firmly rooted in specific locales since time immemorial (Ngwenya 1991), as strict practitioners of ‘indigenous knowledge,’ is increasingly called into question by even a cursory examination of Zimbabwean healers’ empirical reality: for example, an Epworth-based healer who conducts consultations on his late-model Nokia cellphone while throwing his *hakata*. From an analytical perspective the question, then, arises as to whose interests are served through such depictions? What do such depictions conceal and, simultaneously, reveal about the nature of the linkages between healers and the wider ‘modern’ world? How and why is it that even as the global becomes localized and the local becomes globalized, actors line up on either sides of a perceived ideological fence?

Turning to the first question, such depictions serve both traditional healers and the wider world. As other scholars have demonstrated (cf. Fry 1976; Lan 1985), the authority of healers with regard to managing misfortune (broadly conceived) is based

upon consensus rather than coercion. In other words, healers have a vested interest in maintaining the appearance of connection to the ancestors and the spirit world (from whence their powers derive) which, paradoxically, succumbs easily to self-imposed and externally-imposed interpretations of healers as arbiters of the 'traditional' and the 'local.' Through their own often very conscious efforts, healers become structurally opposed to say, biomedically-trained doctors, tied as they are with other often external oppressive institutions, and formerly linked with colonialism (e.g. the government, the World Bank, the IMF, etc.). This positioning takes on greater urgency in the age of AIDS where, as arbiters of 'tradition' and morality, healers can use their status to remonstrate their patients and doctors alike for forgetting their 'culture' and allowing this evil to infiltrate the nation (see, e.g. Chapter Sixteen).

Likewise, the international and national health development communities have a vested interest in depicting healers as a homogenous group with coherent and easily discernible cultural practices and existing in a timeless present -- attributes which mark healers as a population in need of modernization and intervention. But, too, such depictions serve as a powerful moral discourse as to biomedicine's efficacy in combating HIV/AIDS (a similar discourse was evidenced in the colonial film "Mr. Wise and Mr. Foolish" discussed in Chapter Ten). And despite rhetoric re-casting traditional healers as "noble witch doctors," (Rekdal 1999), or as collaborators with modern medicine (WHO 1990), they still find themselves subjected to processes of 'othering' (Seidel and Vidal 1997) which conflate individual behavior with "culture" and constructs healers as incapable of change and prisoners of immutable cultural traits which put themselves and their patients at risk, as we saw in Chapters Nine through Twelve.

In this way, healers and the wider world have vested interests in particular constructions of healers as traditional, local, and linked to a primal past peopled by ancestors and spirits. This viewpoint usually finds expression in the polarized tropes of “modernity” and “tradition,” of “local,” and “global” and of “culture.” As Comaroff and Comaroff (1999:294) remind us “...it is important not to forget that ‘the local’ and ‘the global’ do not describe received empirical realities. They are analytic constructs whose heuristic utility depends entirely on the way in which they are deployed to illuminate historically specific phenomena.” It is from these constructs that healers and, say, health development practitioners -- doctors, aid workers, health professionals -- fashion competing claims as to who is best capable, and under what circumstances, of combating HIV/AIDS.

Also, the very forces and forms that some healers seek to critique, control, and label as erosive of ‘local culture,’ are the very same forces that, for some healers, have opened up tremendous opportunities. For example, the Zimbabwe National Traditional Healers Association (ZINATHA) owes at least part of its very existence to the work of a Rhodesian (white) medical doctor, Dr. Michael Gelfand, who brought together many of the disparate healers’ associations in the name of forming a national organization (see Chapter Eleven). The case of Gelfand points to a little chronicled history of other similar types of linkages between translocal actors and local n’anga.

So, even as translocal actors and n’anga line up on opposing sides of an ideological fence, this formation tends to conceal as much as it reveals. It raises questions about the hardness of the boundary separating the two camps and the nature of claims made on either side. But, too, it raises questions about the very nature of

“traditional” medicine and healing. What are the constitutive elements of traditional medicine knowledge and practice? Is this completely separable from biomedical knowledge and practice? Where does traditional medicine end and biomedicine begin? And finally, what’s so “traditional” about traditional healing in Zimbabwe? Before systematically answering these questions (here and throughout the rest of the dissertation), I want to offer another case study of a self-professed practitioner of natural medicine and ZINATHA-registered healer. His case further illustrates the blurring of “biomedical/modern” and “traditional” boundaries, particularly with regard to beliefs and practices surrounding HIV/AIDS. More specifically, his case illustrates the synergy and the opportunities that have resulted from the convergence of the local and translocal--a synergy that is producing new kinds of identities among healers.

A Visit with “Dr.” Ngwenya

In many ways, “Dr.” Richard Ngwenya, a Harare-based practitioner of natural medicine who runs the James Mobb Immune Enhancement Clinic, epitomizes the new breed of traditional healers in Zimbabwe. Before discussing his particular beliefs with regard to wellness and illness, it might be useful to sketch a brief background of Dr. Ngwenya. It is common knowledge that Ngwenya is a retired high-ranking military officer. After his retirement from military service he became involved in the steel importing business, working closely with the Germans and the Chinese. During his work with the Chinese, he came across an herbal palliative called Mocrea (or Tai-Sheng) alleged to boost the immune system and used with Hepatitis and immune-suppressed patients in China. Ngwenya began importing Mocrea to Zimbabwe, at first approaching

Minister of Health and Child Welfare Dr. Timothy Stamps to okay the herbal palliative for clinical trials. When Dr. Stamps' okay was not forthcoming, Ngwenya approached then Deputy Minister Tsungirirayi Hungwe, asking her for a couple of AIDS patients on which to prove Mocrea's efficacy. She provided someone who worked at the Ministry and one of her cousins. After several weeks treatment both, allegedly, became much improved, gaining back lost weight and returning to their jobs full-time. After what appeared to be a miraculous recovery, Deputy Minister Hungwe appeared on a national television show in 1996 proclaiming that Mocrea appeared to treat (and reverse) many AIDS-related symptoms (e.g. weight loss, loss of appetite, chronic fatigue, etc.).¹ Her television appearance was a marketing coup for Mocrea as HIV/AIDS sufferers and their families and friends began asking about and aggressively seeking it.

Because Mocrea is an herbal palliative (in other words a medicinal plant) which in the case of Zimbabwe usually falls under the jurisdiction of n'anga (who frequently use medicinal plants), Ngwenya filled out an application of certification at the Zimbabwe National Traditional Healers Association (ZINATHA) and became registered as a "traditional healer" (an herbalist). As such, he had the legal right (in theory) to dispense medicinal plants, and herbal palliatives, which he did/does from his clinic. He also gave complimentary boxes to ZINATHA's downtown headquarters for sale--and he continues to do so--as a goodwill token of his certification and registration. In 1996, a 30-capsule bottle cost Z200 (at the time US \$1 equaled Z7), almost half the monthly income of the average worker at the time. The average bottle, with a recommended dosage of a capsule taken three times a day (more for full-blown AIDS sufferers), lasted ten days.

During my daily visits to ZINATHA headquarters in 1996, I usually encountered several people asking about and/or buying Mocrea, the administration manager and his assistant offering advice about dosage. I asked a prominent n'anga and ZINATHA executive board member from Epworth about Mocrea and whether or not he prescribed it to his patients. "I don't use it because it has not been tested," he responded. "Healing is a gift from God -- not for profit-making. I treat patients who cannot pay. There are negative side-effects to Mocrea, for example, getting fat," he continued. He went on to say that people should not go on television extolling the benefits of an untested herb.

The herbal palliative, Mocrea, was the centerpiece of Ngwenya's business efforts and his belief system surrounding illness/disease and, in particular, the 'so-called AIDS virus.' Ngwenya viewed the so-called AIDS virus as the end product of pathogens created in a laboratory for the express purpose of killing African peoples (see, e.g. Chapter Six). This, in conjunction, with the crippling economic, social, and political conditions African peoples were forced to live under--by Western nations and their puppet African leaders--was producing what appeared to be an AIDS pandemic. Interestingly, this particular understanding of HIV/AIDS is also reminiscent of South African president Thabo Mbeki's.

My first exposure to Ngwenya was at an AIDS Counselling Trust (ACT)² public forum in 1996, the theme being coalition building between traditional healers and biomedical doctors. This was one of many public fora at the time that sought to "bridge the gap" between "modern" medicine and "traditional healing." The meeting had not gone well, with traditional healers and doctors hurling accusations and counter-accusations about who was most beneficial or detrimental in efforts at combating

HIV/AIDS. Ngwenya and a doctor/professor from the University of Zimbabwe's medical school, in particular, were the most vociferous, yelling heatedly between themselves. The melee was brought to an abrupt halt by one of the presenters, an HIV-positive colored man who yelled, "Look at you fighting amongst yourselves like this. You should be working together...people are dying...I'm dying."³

Returning to Harare in 1999, I spoke with an official at the Canadian International Development Agency (CIDA) which had funded several HIV/AIDS and STD workshops for n'anga through ZINATHA. He suggested touching base with Ngwenya and visiting his clinic. "He's very slick, David. Very articulate. And I know he's injecting people with stuff he probably dug up in his backyard," he chuckled. "He's fond of quoting from a book [entitled *Something More Sinister* and written by Ben Geer] about biological and chemical warfare against the freedom fighters here." In fact, Ngwenya borrowed, and elaborated upon, much of Geer's thesis in developing the literature for his immune enhancement clinic (see Chapter Six). Importantly, rather than confining itself to 'conspiracy' and fringe medical literature, many of Ngwenya's materials drew on mainstream health literature, historical documents, newspaper articles, and even an interview with the current Minister of Health and Child Welfare, Dr. Timothy Stamps.

My friends at ZINATHA had also suggested visiting Ngwenya. "We'll go to his clinic, David," Marcus said, "and he'll have a look at you. The first thing he will ask you is if you want some tea or coffee. And he'll wait for you to ask for sugar," he explained. It was Ngwenya's premise to start lecturing visitors about the negative health consequences of consuming sugar. In fact, much of Ngwenya's focus was on nutrition and the negative health consequences of bad nutrition.

“You should see it -- it’s quite a place,” he continued speaking about Ngwenya’s clinic. Apparently Ngwenya had microscopes, drips (meaning IV apparatuses), and a staff. “He’ll take some of your blood or saliva and put it under the microscope and tell you about it,” he said, squinting his eyes and rubbing together his index finger and thumb as if he were looking through a microscope. He went on to say that Ngwenya is a proponent of people not eating sadza, a corn meal product and the staple food for the majority of Zimbabweans, or sugar. He said that both contain yeast and contribute to fungal growth.

“You know we African people, Diva, sometimes if our mouths get dry our lips turn white or red,” Giles began. “Ngwenya says that that is a fungus. He points to young people in the street and says, ‘Look at all these children! How can their parents allow their children to be dying like that?!’” he continued.

“Ah! You should see him, Diva!” Giles laughed, shaking his head. “He’ll have several people in his office and have several different conversations at the same time. He’ll talk on the phone like this [he grabbed the phone, holding the hearing end up to his ear and the talking end up at eye level]. ‘Ah, yes, Mr. General. I think we need to get together and discuss this issue more fully,’” he said pretending to be Ngwenya. “We saw him at a health expo [at the Harare showgrounds] the other day,” he continued. “I was with my friend -- you remember the one I told you about who got me the Eco-Net account [a young woman who had tested HIV-positive and had since moved to the United Kingdom]? I asked him [Ngwenya] if he had something that might help. He glanced at her and said [thinking my friend was asking about a simple vaginal infection] ‘Look! She’s having female problems...a discharge from her vagina and look at her lips. This

woman has a fungal infection...” At this point, the woman discreetly excused herself and quickly disappeared. “I searched all over the expo looking for her and finally found her at a beauty booth getting a...what do you call it?” he asked massaging his face with his fingers. “A facial?” I interjected. “Yeah, that’s it,” he responded. “I was concerned that she was embarrassed because Ngwenya said all of this in public with people walking around us!”

My other friend explained that Ngwenya gives some of his herbal concoctions biomedical names. “He will say to a sister [nurse], ‘Go get me some SS1 of GK5’” Marcus said. “You know that he doesn’t believe in AIDS,” Giles interjected rhetorically. “He says what people call AIDS is really a number of fungal [or other] infections that can be effectively treated with herbal medicines.” I asked Giles and Marcus where Ngwenya’s funding for his clinic came from. Marcus said that Ngwenya had gotten quite a package when he retired from the army, to the tune of Z1,000,000. He also suggested that Ngwenya also had a lot of contacts and networks through his having worked for the army. Additionally, Ngwenya actively courted sympathetic western donors, many of who he met/meets at various international conferences. Giles asked me if I had seen the clinic’s printed materials. “It’s quite nice,” he said, “like it was produced in the United States.”

With all of this information in mind, I was intrigued to say the least. I immediately called Ngwenya to set up a visit, explaining that I was a researcher from the United States and very interested in his approach to combating HIV/AIDS. As we spoke in the telephone, I heard a cacophony of noise behind him -- a busy staff asking for instructions, a television program blaring, patients -- and imagined him holding the phone

in the peculiar way Giles had shown me earlier as he orchestrated what sounded like organized chaos. We set a date and time to meet. After hanging up, I pulled out a copy of a city map to locate the clinic's exact location -- I had to rely on ETs to get around the city and wanted to make sure I knew where exactly to get off.

The James Mobb Immune Enhancement Clinic is a large, handsome, white building set off a tree-shaded street in the Avenues by an expansive, enclosed front-yard. I marveled at the beautifully carved wooden doors with their stained glass windows. Entering into a well-lit foyer with waiting bench and chairs for patients, I found the receptionist area off to the left where two attendants sat behind desks. Behind and above them were various medicines for sale with names like "A.C.T.5," "Profferon," "Extra-plus Vuka-Vuka" (a well-known aphrodisiac allegedly popular with foreigners), "Excelsia," "Messiana," "Mocrea," "G.K. Seventeen," and "Panaba Oil." One of the attendants rang Ngwenya.

He appeared in a flurry of movement, introducing himself while simultaneously escorting me back into his office, which was to the right of the foyer as you enter. A large, open room with vaulted white ceilings, the office contained a human anatomy chart of the endocrine system, a microscope, a color television, and VCR. I was immediately overwhelmed with the thick smell of eucalyptus saturating the air. There must have been an aroma-therapy vaporizer somewhere, though I could not locate it. My nose immediately began to run as I settled myself on the other side of Ngwenya's desk. I began to feel self-conscious -- would he conclude that I was being 'eaten up' by a fungus because my nose was running? I reached into my pocket for a tissue. Damn! Fresh out of tissues. Ngwenya noticed my distress and, without a word, got up in his very efficient

way and grabbed a box of facial tissues for me. He asked me if I would like tea or coffee, and I opted for tea, which his assistant promptly brought in. I remembered not to ask for sugar and peered over my cup at Ngwenya waiting for him to say something, which he didn't. Instead of milk or cream, we used some kind of soy powder which he liberally stirred into his steaming tea; mine, mysteriously, already contained it.

Ngwenya is probably between 40-45 years old with a medium build. His hair-cut struck me as very 1980s, short on the sides with a sharp peak at the top. He wore his pants pulled up very high on his waist in a way that looked uncomfortable, along with a button-down long-sleeved shirt and tie. He exuded an air of confidence and almost smug self-assuredness that was only augmented by his very precise, military comportment. He asked me what I was "chasing" [meaning what kind of information was I looking for]. I told him I was interested in looking at n'anga responses to HIV/AIDS. He laughed. "And what do you think of this so-called AIDS?" he asked with a sly grin, rubbing his chin. Unprepared to be on the other end of the questioning, and unsure of what kind of answer he was looking for, I began a tentative overview of my understanding of HIV/AIDS, its alleged origins (covering everything from Green monkeys to genetic engineering for purposes of biological warfare), and its disproportional impacts (relative to other parts of the world) on the peoples of sub-Saharan Africa.

Ngwenya continued smiling and said, "Very good. I can see that you're an intelligent young man." He pulled some multi-colored sheets of paper from his desk and started outlining his understandings of the 'so-called' AIDS virus. He spoke rapidly in a torrent of words -- many of them scientific and biomedical jargon -- and it occurred to me that he has probably presented this particular speech many times. It also occurred to me

how “official”-sounding his words were and how intimidating they might sound to patients. As he lectured, he pointed out various bits of information on the sheets, underlying parts and crossing out others. His hands were a brown blur moving across the paper.

He spoke at length about the Rhodesian biological and chemical warfare influence on Zimbabwe’s health sector (see Chapter Six) and the widespread “brain-damage” that has occurred as a result. “You’ve spoken with people here -- you’ve listened to our leaders. What is your assessment of their mental capacity? How do they compare to other people around the world? They begin a conversation and, in the middle of it, they forget what their point was...this is the result of brain-damage,” he emphatically concluded. As he spoke, the funeral of Brigadier General Gumbo played on the television in the background. One of Ngwenya’s employees, an older-looking man in suit and tie, came in and asked him why he wasn’t at the funeral as it was a State function [Gumbo was declared a national hero and being interred at the Hero’s Acre] and all present and retired military personnel were asked to attend. Ngwenya leaned forward on the desk and hissed, “I wasn’t invited! Look at that,” he said motioning at the television. “No one is there [meaning there were few attendees other than family and army personnel]. That is a village funeral,” he said, dismissing the event.

As we spoke, he called another one of his assistants in to go and get some medication he had just ordered over the phone. The assistant returned shortly with a different brand than Ngwenya ordered [because he didn’t have enough money for the brand Ngwenya had specified]. Ngwenya studied the box of vaginal suppositories and then recommended a dosage for the patient who was waiting in another of the clinic’s

rooms. “Tell her to insert one full pill the first day, which should completely coat the vaginal wall, then every day after 1/2 pill for a week,” he explained to the assistant. Another assistant entered the office and said, in a very soft deferential tone, that there were many patients waiting. We got up and Ngwenya showed me around the clinic, introducing me to staff and patient alike as a “medical student from the States” who was interested in looking at his therapies amongst the “natives” (he added with a mischievous chuckle).

We walked through the reception area to a treatment room which had about 15 large wooden chairs with attached IV suspension units lining the walls. The smell of sickness permeated the room as several people -- skeletally thin, weakened eyes, lethargic -- sat receiving ‘drips’ of some botanical infusion. Family members and/or friends of these patients sat quietly talking amongst themselves. This was the ‘public’ treatment room, no privacy, no screen to shield individual patients as they received their treatments. Down the hall and straight ahead from the foyer was the ‘private’ treatment room, intended for Members of Parliament (MPs) and other high-ranking governmental and non-governmental officials. Here they could receive treatment away from the questioning eyes of the public.

Ngwenya’s case is instructive for a number of different reasons. First, unlike most n’anga, Ngwenya underwent no formal training/apprenticeship for his healing practice--despite ZINATHA’s own guidelines and code of conduct which stipulate that new n’anga must be ‘presented’ by senior n’anga whom they trained under for proper registration and certification.⁴ Second, that he was awarded registration/certification without going through the proper channels, e.g. an apprenticeship with a senior n’anga,

not only raises serious questions about his own therapeutic credibility, but the credibility of ZINATHA itself in the registration and certification of n'anga. Third, and closely related to this second point, Ngwenya's efforts to register as a traditional healer may be read as an expedient way of marketing/selling his herbal palliative (Mocrea), without having it subjected to state-mandated clinical trials for new drugs. This loophole in the dispensation of trans-locally produced herbal palliatives further blurs the distinction between 'traditional' and 'Western' medicine, as discussed in Chapter Thirteen.

Related to all of these points is the role of circumstance and opportunism in creating healers who may not have existed otherwise--and this remains a cautionary tale for development practitioners. As AIDS continues its relentless march through Zimbabwe, there are many translocally donor-funded program and projects taking place which seek to educate and train healers with regard to HIV/AIDS. And while such translocal organizations usually work through ZINATHA--or work with governmental or non-governmental organizations that work with or through ZINATHA--this isn't always the case. And so, occasionally, individuals who do not have the proper credentials to be healers turn up at workshops or programs and, in some instances, can indeed make names for themselves as authentic healers and/or access funds intended for legitimate healers. Ngwenya has sometimes been accused of such behavior. In this way, health development surrounding HIV/AIDS and healers in Zimbabwe has the capability of creating new identities for individuals.

An official at ZINATHA once commented off-handedly that most people "do not refer to Ngwenya as a n'anga [but] as that 'Mocrea guy.'" In other words, local people do not recognize him as a ritual expert in the practice of indigenous medicine. And while

Ngwenya casting himself as a traditional healer might be interpreted solely as an expedient way for him to sell Mocrea, access translocal donors, and enrich himself, that would be an overly simplistic interpretation. As one local well-known HIV/AIDS activist and counselor told me:

His [Ngwenya's] heart is in the right place. He's actually had some success there [at his clinic]. His focus on diet and ridding the body of toxins--it's important. We don't prescribe Mocrea, but if a patient asks about it, we let them know that we do have it available. And it's actually quite effective at stimulating appetite and helping out with fatigue.

Fourth, Ngwenya's ideology and practice with regard to HIV/AIDS derives from a complex hodgepodge of information which draws upon local and translocal idioms of illness, disease, and misfortune. His belief that AIDS does not actually exist as such may seem spurious, but his efforts at explaining the impacts of macrostructural forces in the form of poverty and stress, etc., on the health of the individual is certainly plausible. Such a viewpoint evokes South African President Thabo Mbeki's controversial focus on poverty as the driving force behind the epidemic and his appointment of 'AIDS dissidents' as consultants to the South African government who argue that HIV does not cause AIDS.

The case of Ngwenya as a modern-day herbalist of sorts who blurs the distinction between traditional and western medicine is, however, not unique in Zimbabwe or other parts of Africa. Just as Ngwenya has responded to those forces we loosely label as "modernity"--a globalizing economy, novel flows of information and technology, new configurations of transnational power and control--so, too, have other types of healers within Zimbabwe and across the continent. Another example of not-so-traditional

traditional healers can be found mainly in the Ndaou communities on both sides of the Zimbabwean/Mozambican border, as pointed out by a local publication.⁵ Amongst spirit mediums, there is the new phenomenon of white (European) spirits being channeled through black mediums. Locally known as *zvivarungu*, these spirits have raised fears among traditionalists on both sides of the border as to the erosion of indigenous culture. Identifying themselves as the spirits of those soldiers from Europe who perished in past wars, some of the *zvivarungu* narrate how they entered Africa and were killed in combat. Many of the mediums complain that these spirits are the most expensive to satisfy, especially under the country's current harsh economic climate. At ceremonies *zvivarungu* demand Western lifestyles such as dressing 'smartly,' drinking soft beverages (like Coca Cola and the like) and clear alcoholic drinks (as opposed to the less expensive locally-produced opaque beers such as Chibuku), dining on sumptuous foods, playing records, smoking cigarettes, and sitting in well-furnished and hygienic huts. These practices run counter to historical, ancestrally-approved norms which stipulate that rituals should be conducted in a dignified manner which includes removing the shoes, sitting on mats, clapping hands, sniffing snuff, drinking opaque 'seven days' beer and dancing to traditional *mbira* music.

What are we to make of these not-so-traditional traditional healers? By what cultural calculus are we to make sense of these shifting practices? At its very core, I would argue, traditional medicine has never been very traditional. Rather, it has historically adapted itself to rapidly changing contexts--particularly with regard to initial missionary and European contact. At its very core, however, is the idea of a moral universe constituted, and constitutive of, the collective linkages and social relationships

of the individual with the natural and supernatural worlds. In the event that one or a number of these relationships ruptures, either through the individual's actions or the actions of a malevolent natural or supernatural agent, the end result will be illness, disease, or misfortune broadly defined. Such conceptions tend to view the individual as inextricably linked to the collectivity of natural and supernatural entities, relations, and processes, disequilibrium in which will produce negative outcomes. As a result, great ritual, symbolic, and social care is taken to maintain balance in the complex constellation of relationships in such a moral universe.⁶ Contact with translocal cultural practices, new and novel flows of information and technology, and ways of being in the world only enlarges this moral universe.

Added to this more dynamic definition of "traditional" medicine is the great popularity of this knowledge system with non-Blacks, especially as it becomes loosened from its original cultural context. It is, for example, possible to buy factory-produced Shona "*hakata* packages," marketed as "a fascinating parlour game based on the time-honoured principles of African divination" (van Binsbergen 1995:131-32). Or, alternately, seekers can visit a website where a virtual n'anga throws his *hakata* and divines their futures [include website here]. Visitors to many tourist jaunts throughout Zimbabwe are treated to the requisite "n'anga hut" where a vernacular doctor will take snuff, play *mbira*, enter into a possession state and prophesy for middle-American and European businessmen and housewives. In South Africa, healers have become a prominent fixture in popular culture, where newspapers and magazines advertise "Dial-a-Sangoma" and "Dial-a-Ngaka," phone-in divination services designed for both black and white clientele (Comaroff and Comaroff 1997:364). And while black healers and their

increasingly multi-ethnic and transnational clients have made headlines locally and abroad, more recently there has emerged the specter of the *white* healer (there are quite a few in Harare, covering the spectrum of specialties--herbalists, spirit mediums, faith healers, etc.). As Comaroff and Comaroff (1997:364) point out, for many white Africans, “‘traditional’ medicine--deracinated and culturally appropriated--has become one of the possibilities of their postcolonial modernity.” The same, it may be said, is true for black Africans as well.

¹ Her appearance on national television and her acceptance of Mocrea provided a great deal of grist for the media and further ammunition for discrediting Minister Stamps. Comment in the June 24, 1996 Herald proclaimed: “One day Stamps was publicly denouncing Mocrea and all other unconventional medicines whose inventors have claimed they can cure AIDS and the next day his deputy, Cde. Tsungirirayi Hungwe, was relaying on television personal experiences of a relative whose AIDS symptoms had been reversed by the intake of the Chinese concoction.”

² Founded in 1988, ACT is an AIDS service organization dedicated to :training counselors, volunteers, and professionals in awareness and prevention; condom distribution and STD control; and orphan support. It’s main sources of funding include HIVOS, Katholische Zentralstella, Misereor, SIDA and other international donor agencies. They also generate funds from the sale of materials and training courses, donations, and private/individual Zimbabwean donors. ACT collaborates with the NACP, Ministry of Education, Social Services, Child Survival of Zimbabwe, Harare Affected Society, SANASO, Save the Children (UK), UNICEF, ZCTU, district and provincial officers.

³ Interestingly, both this young man and his wife (who was also HIV-positive) had been on regimens of Mocrea and reported negative side-effects, namely paralysis, drowsiness, and diarrhea.

⁴ Ngwenya says that much of his medical training came as a ‘medic’ in the Zimbabwean army.

⁵ “Spirits with Expensive Tastes,” *Standard*, July 4-10, 1999.

⁶ See Janzen (1982), p. 14. See also Daneel (1971), p.180.

CHAPTER FIFTEEN

ZINATHA and HIV/AIDS Education

The case of not-so-traditional traditional healers, as discussed in the last chapter, are part and parcel of this quintessentially postmodern moment in Zimbabwe. Such practitioners continue to challenge conventional ways of seeing and understanding African healers from both the perspective of outsiders and healers alike. As an organization, ZINATHA has not as yet offered any commentary on these new types of healers that are emerging. If there is any connection between the emergence of these new forms of healers and the continued onslaught of HIV/AIDS, the connection remains to be seen. It is clear, however, that HIV/AIDS has drastically altered the social and economic landscape of the country and, as we have seen, healers respond to such changes in dynamic and sometimes novel ways.

One answer to the devastation wrought by the epidemic has been in healers' development of HIV/AIDS and STI educational interventions. Since 1988, the Zimbabwe National Traditional Healers Association (ZINATHA) has been active in educating traditional healers about sexually transmitted infections (STIs) and HIV/AIDS. Working with the Ministry of Health (MOHCW) and various non-governmental organizations (NGOs), ZINATHA has implemented a comprehensive HIV/AIDS project which includes: training in HIV/AIDS prevention and care; home-based care and treatment; counseling and family planning services; community participation; information, education and communication; and participation in clinical trials.¹ Such initiatives by the MOHCW, ZINATHA, and NGOs reflect the central role traditional healers play, or should play, in any kind of HIV/AIDS education and prevention

programs. The great challenge for ZINATHA is the fact that though its president is himself a traditional healer and thus sensitive to African-derived idioms of disease, the predominant messages in workshops are Western-derived biomedical ideas of disease and contagion. At issue here is the hidden process of cross-cultural translation embedded in these messages and how they come to subvert African-derived health practice and knowledge.

As there has been no real discussion of the ZINATHA HIV/AIDS project to date in the social science literature, the following analysis will attempt to give an overview of the project itself while also attempting to grapple with this idea of cross-cultural translation where relevant, particularly in the context of workshop messages. I pay particular attention to training in HIV/AIDS prevention and care, offering an analysis of the content of a particular workshop held in 1993. I offer brief descriptions of the other project areas as well.

In many respects, the ZINATHA HIV/AIDS project appears to be top-down oriented in that many of the initiatives appear to be generated and implemented through the auspices of the Ministry of Health and Child Welfare or other governmental ministries. For example, the trainer's manual entitled, "Methods in AIDS Education" was developed by UNICEF and the Ministry of Education and Culture. The lesson plan sets out a basic message on the biological "facts" of HIV/AIDS: What it is, what it does to the body, how it is transmitted, how it is prevented, etc. While the trainers--many of whom are healers themselves--make every effort to adjust these messages to local circumstances, the very structure of the training plan itself only allows them to emphasize only the medical message of the formal curriculum over local ideas, practices, and

conditions. In this way, such messages--part of much larger globalized notions of health development policy--have the potential to systematically raze the sociocultural reality of n'anga even in the course of taking them into account.

Obstacles to Analysis

There are a number of obstacles that immediately present themselves in any analysis of the ZINATHA HIV/AIDS project. The first obstacle is the sheer scope of the project itself. While the ZINATHA HIV/AIDS project is national in scope, we have no real concept of the infrastructure of the project, other than the fact that it is managed from ZINATHA headquarters in Harare. An assessment of the project, conducted by Dr. James Jijide for the Population Council, offers some insight:

The HIV/AIDS project is managed from ZINATHA headquarters in Harare with the assistance of eight support staff who complement the work of 15,000 non-salaried healers nationwide, all specializing in various aspects of STD/HIV/AIDS prevention and care. In addition, the HIV/AIDS project is served by 28 volunteers who are active at the community level. Volunteers organize presentations on HIV/AIDS as part of meetings of various clubs and organizations. Healers and volunteers receive allowances of Z\$20-50 (Apx. US\$3-8) each when they attend workshops. (7)

Jijide's assessment (actually labeled a "case study") of the project is based on work in ten suburban districts of Harare: Mufakosa, Glen-View, Glen Norah, Highfield, Mbare, Mabvuku, Tafara, Chitungwiza, Epworth, and Kuwadzana.

The general problems with Jijide's assessment are its lack of real data and the general conclusions it draws based on this lack of data. For example, while Jijide states

that this assessment is based on work in each of Harare's ten districts, he does not identify his sample population. Who did he get this information from? Who did he interview and in what number? Even if we assume that he wanted to keep his informants' identities anonymous to protect them from any sort of negative repercussions, he could have at least included what populations he spoke to and where, generally, they were located. This would be of enormous value to ZINATHA as they begin to identify and assess areas that need more support, training, etc.

Another weakness to Jijide's assessment is that he draws general conclusions without the data to support those conclusions. For example, he concludes:

ZINATHA's overall project activities are helping to bring about a change in high risk behavior such as unprotected sex, multiple partners and unsafe medical practices which could lead to HIV infection. They have also helped to create a more supportive environment for those living with HIV infection (8)

While this may indeed be true, on what is he basing these conclusions? Nowhere in his report does he cite quantitative or qualitative data that would support such conclusions. Despite these obvious weaknesses, however, Jijide's assessment does offer some general information that will be incorporated into the following analysis. Reliance on Jijide's assessment is indicative of the general lack of documentation on the project (and my inability to access other sources, such as licensed inspectors' progress reports of the project).

Historical and Cultural Context

As former chapters have demonstrated, traditional healers have historically played a crucial role in the health and wellness of various African populations. During colonialism and even after independence, however, many of these traditional healers found their work generally discredited, and this trend has continued under most contemporary African governments (Gelfand 1985; Green 1994). At least post-Independence, Zimbabwe may be the exception to this general trend, who through legislation passed in Parliament in 1981, brought the Zimbabwe National Traditional Healers Association (ZINATHA) under the auspices of the Ministry of Health.² In theory, such a relationship provides the context for mutual work and respect between the “Western-based” and “traditional” medical sectors. ZINATHA’s major objectives are designed to:

1. Unite all traditional healers into one organization;
2. Promote the practice of traditional medicine;
3. Promote research into the effectiveness of traditional medicine and methods of healing;
4. Promote training in the art of herbal and spiritual healing;
5. Supervise the practice of traditional medicine and prevent abuse and false practice;
6. Cooperate with the MOHCW and other institutions involved in public health; and,
7. Preserve and promote African culture (Chavunduka 1984:27).

Given the fact that some 80-90 percent of the population receives therapeutic services from traditional healers, it is easy to see why traditional healers should be central to efforts to contain and prevent HIV/AIDS. Also, despite the bio-medical services provided by the MoHCW, local governments, mission hospitals, employer-sponsored medical services, and private practice, the ratio of bio-medically trained doctors to patients is 1:7,286 (and most of these doctors are concentrated in such urban centers as Harare and Bulawayo). On the other hand, the ratio of registered traditional healers to patients is 1:226.³ If unregistered healers were included, this ratio would obviously be much smaller. These numbers underscore the centrality of traditional healers in matters of public health.

There are no governmentally-sanctioned requirements or qualifications for becoming a ZINATHA member, other than a primary education. Likewise, there are no governmentally-sanctioned requirements or qualifications for becoming a traditional healer. Historically and contemporaneously, the ability to heal is considered a gift, bestowed to individuals by ancestral spirits, particularly in the case of spirit mediums . With regard to herbalists, knowledge may be passed down from one generation to the next (Gelfand 1985). Though not reflected in much of the literature, the majority of traditional healers in Zimbabwe are women, with a ratio of about 5:2. The high percentage of women has important implications for any kind of planned intervention programs and projects.

Project Description

It is through the MoCHW's National AIDS Control Programme that ZINATHA developed the HIV/AIDS prevention project using traditional care systems. The ZINATHA HIV/AIDS project has four broad objectives:

1. To provide moral, psychological, social, economic, and cultural support to individuals, families and communities affected by HIV/AIDS.
2. To develop traditional methods aimed at reducing HIV/AIDS transmission, increase awareness of HIV/AIDS for prevention and care of people with AIDS, and create a supportive environment for those living with the disease;
3. To define priority areas, devise interventions and develop resources needed for effective management and implementation of HIV/AIDS prevention and control activities;
4. To increase collaboration between traditional healers in order for them to share experiences and skills among themselves and with other organizations involved in AIDS prevention.⁴

The above broad objectives reflect, almost to the word, WHO resolutions discussed in Chapter Twelve. Grouped under these broad objectives are a number of project areas: training in HIV/AIDS prevention and care; home-based care and treatment; HIV/AIDS counseling and family planning services; community participation; information, education and communication; participation in clinical trials. Below, I pay particular attention to training in HIV/AIDS prevention and care, offering an analysis of the content of a particular workshop held in 1993. I offer brief descriptions of the other project areas.

Training in HIV/AIDS Prevention and Care

Since 1989, ZINATHA has sporadically conducted Knowledge, Attitudes and Practices (KAP) surveys among traditional healers. One such baseline survey conducted in Gutu District⁵ in 1990 had three main objectives: (1) to understand the knowledge, attitudes, and practices of local healers in order to monitor the impact of the provision of new information through workshops; (2) to identify the most important information gaps, misconceptions and requirements among participants and to advise on relevant workshop content; (3) to provide some indication of appropriate and effective means of providing this information.⁶ The results revealed that most healers did not know much about HIV/AIDS.

The same year, ZINATHA intensified its training workshops for traditional healers. HIV/AIDS and STD workshops include training in: modes of HIV transmission, symptoms and diagnosis of AIDS, and counseling and care of people living with HIV/AIDS. Special instruction was provided on safe medical practices, such as avoiding contact with contaminated blood products and instruments, and maintaining aseptic conditions, including sterilization of traditional equipment and the use of gloves, when appropriate, during treatment. A particular emphasis of the workshops is to insure that sterile procedures are being used during invasive surgical procedures often used to administer traditional medicines and that used razor blades are disposed of properly. The workshops also attempt to encourage healers to use oral medication over those administered through incisions.⁷ Ten workshops on HIV/AIDS were held in various parts of the country in 1990. In 1993, 26 workshops, with approximately 90 participants each were held.

One such workshop, organized by ZINATHA and the AIDS Counselling Trust, was held at an upscale hotel in downtown Harare in 1993. Participants included members of ZINATHA's National Executive, the Traditional Medical Council, as well as regional representatives of ZINATHA--a total of 23 healers. The stated aim of the workshop was, "To equip participants with up to date information about HIV/AIDS and Sexually Transmitted Diseases (STDs) and the ensuing psychological, social and economic ramifications to enable them to facilitate programmes for HIV/AIDS and STD prevention in the community and within ZINATHA specifically." ⁸

Opened by the Minister of Health and Child Welfare, Dr. Timothy Stamps, the workshops other presenters were also all from the MOHCW. Likewise, all of the presentations--with the exception of one--used a strictly biomedical model of disease and disease transmission. Though not explicitly stated, the underlying goal of the workshop was to replace rather than enhance the existing knowledge and practices of n'anga. For example, the different signs and symptoms of various STDs were outlined with no reference to healers local understandings and classifications of these diseases--even though many STDs are locally thought to be best treated by healers. Another session emphasized local cultural practices--practices healers are assumed to uphold and encourage--that contribute to the spread of HIV, such as: widow inheritance, polygamous marriages, and the abuse of aphrodisiacs.

The focus for this workshop was on identifying "harmful" practices in n'anga therapeutic practice. One session emphasized, for example, "traditional curative practices contributing to the spread of HIV." After a day and a half of biomedical messages, healers were divided into groups and asked to identify procedures carried out

by other healers that may be responsible for transmitting HIV to the client as well as the practitioner. The reason for this documentation of n'anga curative practices was to isolate those harmful practices as precise points of intervention where significant health gains could be achieved: for example, insisting that sterile razor blades be utilized for "African injections" (where powders are worked into incisions). Elicited harmful practices included: scarification (*kutemera*), biting (*kuruma*), internal vaginal examination (*kuongorora chibereko*), delivery procedures (*kusunungutsa*), manual removal of the retained placenta (*kupindira chevakuru*), removal of piles (*kucheka sare*), and lifting of the sunken fontanel (*kuwidza nhova*).

Given this laundry list of "harmful" curative practices, healers were then told possible solutions. Healers were admonished to use one new razor blade per patient when applying herbs on the cut skin and that they should also use a spatula or leaves to administer the herbs to the wound. Likewise, they were told that medicines should be divided into single dose portions and that gloves should be worn when handling sores and abscesses. Gloves should also be worn when giving vaginal exams or removing the retained placenta. Biting (another common practice for either administering medicines or for sucking foreign objects out of the body, healers were told, should be terminated; unless the practitioner had managed to ask their healing spirit to transfer the power from their teeth to their hands.

Many healers find the above recommendations difficult to actualize in their practice; not because they do not want to comply, rather such recommendations are not practical given the limitations within which they practice. Some healers, for example, do not have ready access to new razors because of distance from stores or lack of

availability; likewise for rubber gloves. Other messages regarding hygienic use of medicines--for example, in storing and dispensation--were equally difficult to assimilate because of differing models of disease and contagion. I remember talking with a healer, an herbalist/medium who had attended a number of HIV/AIDS and STD workshops. She proudly showed her box of gloves and even began demonstrating on a patient how she no longer even used her hands to apply medicinal ashes to wounds, but rather a short stick. With her gloved hand holding the stick, she swabbed up some ashes--from a calabash she also used for other patients--and placed them in the patient's wound. The tip of the stick became wet from the blood in the patient's wound. The healer then put the stick back into the ashes and back into the patient's wound. She did this once more, not knowing that she was contaminating the very ashes she would be using with other patients. So, even as precise points of intervention are targeted, new points are born.

Interestingly, of course, healers were not asked to identify "harmless" and efficacious African-derived curative practices they may carry out. By holding up biomedical models and practices as the ideal, the curative practices and knowledge of n'anga are subordinated and illegitimized. African-derived curative practices, implicitly, are thus presented as something to be scrutinized and judged (even by the healers themselves), while the medical messages are presented as normative and correct. And while healers are divided into groups to interact and ponder presenters questions, there is really little room for real dialogue or mutual exchange of ideas. At least in this particular workshop, information moved from employees of the Ministry of Health and Child Welfare to healers, not from healers to government health educators. In this way the workshop reinforced an already inherent asymmetry between the ideas and practices of

the n'anga and medical knowledge, despite the fact that the workshop was co-organized by healers themselves.

Home-Based Care and Treatment

A component focusing on home-based care and treatment follows from the reality that, very often, when someone leaves the hospital and returns home, a traditional healer (along with immediate family members) becomes the caregiver. When an AIDS patient consults a healer, they typically receive a “cleansing treatment,” which usually consists of a series of herbal treatments, supervised by the healer. This cleansing treatment is followed by a series of other treatments, in conjunction with developing a nutritious diet and abstaining from sexual intercourse, designed to fortify the body. The focus on home-based care has a number of advantages: (1) it reduces the patient load in hospitals; (2) it reduces economic hardships faced by families in terms of hospital fees, transportation costs, etc.; and (3) it is assumed that many people prefer to spend their last days surrounded by loved ones in their home.⁹

The general objectives of home-based care training include: (1) to provide psycho-social support to the patient and the family; and (2) to educate the family and volunteer care-givers about how to care for the patient in the home, infection control and preparation of a nutritious diet. Assistance care-givers are expected to offer includes: (1) emotional support including supportive and bereavement counseling; (2) teaching families to care for ill patients; and (3) assistance to obtain medication for the patient.¹⁰

HIV/AIDS Counseling and Family Planning Services

Recognizing the central role that traditional healers play in local communities because of their knowledge of the spiritual and social worlds, the project seeks to utilize traditional healers in the modification of local peoples' behavior. In particular, this component supports the adoption of safe sex practices through condom use. Healers are encouraged not to be judgmental and to stress that condom use offers another way of attaining sexual pleasure. Herbalists, known for selling aphrodisiacs, are encouraged to emphasize to their clients that these substances are to be used for enhancing sexual relations with a wife or regular sexual partner.¹¹

In conjunction with the Zimbabwe National Family Planning Council (ZNFPC), ZINATHA is working at procuring and distributing condoms for the transmission of sexually transmitted diseases, including HIV/AIDS, and unwanted pregnancies. Targeted areas include: workplaces and commercial centers along highways (where much high-risk sexual activity takes place).¹²

Community Participation

ZINATHA attempts to work closely with chiefs and other opinion leaders in an attempt to get them to encourage the modification of traditional practices that may put people more at risk of contracting HIV/AIDS, such as certain initiation rites and the inheritance of widows by male relatives.¹³ In this way, ZINATHA works with local leaders in developing substitute rituals that will maintain tradition without putting people at risk.

ZINATHA also works with community-based peer counseling groups which represent various organizations (clubs, unions, religious organizations, etc.) to influence behavior change at the grassroots level. For example, traditionally in many Zimbabwean ethnic groups, the aunt or uncle is responsible for the sexual education of children. ZINATHA is attempting to utilize this traditional practice to set up AIDS prevention programs within schools, whereby a selected “aunt” or “uncle” regularly visits local schools to talk about various aspects of family life, including HIV/AIDS.¹⁴

Other aspects of the community participation component include: utilizing trained community health counselors, employed by the MOHCW, to disseminate information, education, and communication (IEC); making welfare services more available to people with AIDS by disseminating information about which services are available; uniting all community-based health providers to arrange for home visits to people with AIDS. Healers are encouraged to frame their interventions in the cultural idioms of the importance of care for extended family and that to do otherwise would provoke the displeasure of the ancestors.

Information, Education, and Communication

Drawing on the MoHCW’s comprehensive national AIDS education campaign (begun in 1987), ZINATHA has been able to disseminate information to both urban and rural populations. ZINATHA’s approach has been incorporated into the curriculum of some primary and secondary schools and ZINATHA representatives offer talks to University of Zimbabwe medical, social work, and other students at the university.

Through funds from the AIDS Council Trust (ACT), ZINATHA produced a book on traditional AIDS education in Shona, focusing on controversial issues, stigmatization, and misconceptions surrounding AIDS. As yet, the book has not been produced in Ndebele, the country's other major language.

Participation in Clinical Trials

Traditional medicines are being used empirically in many countries in the treatment of AIDS. Evaluating these treatments in HIV-infected individuals is a new challenge that confronts many African countries today (WHO 1989:1). Clinical trials of the efficacy of medicinal plants were being conducted at two wards of the Parirenyatwa Hospital, Zimbabwe's largest public hospital. There, HIV-infected patients had the option of being treated by traditional healers. Participating patients had to be between the ages of 18 and 45 and have restricted symptoms (e.g. be in reasonably good health). In the event they developed severe problems, they were withdrawn from the trial. The hospital handled the counseling of the patients, and all patients met regularly with representatives of the MOHCW and ZINATHA to review their progress.¹⁵

Given the alleged claims that some healers can cure HIV/AIDS, ZINATHA has been ambivalent about submitting medicinal plants and treatments for clinical trials (see Chapter Twelve). They encourage all healers who feel they have useful treatment strategies and remedies to submit them to clinical trials, but only under the auspices of the ZINATHA Research Department. For example, one healer, Grace Chihuri, felt her treatments had been successful in suppressing the symptoms of opportunistic infections related to HIV/AIDS. She treated 81 patients from 1990-91; five had since died, but 76

are still alive and their symptoms have been suppressed. Some of her herbal medicines have since been sent to the United States for further investigation.¹⁶

Old Wine in Old Bottles?

Based upon available documentation, the above project appears quite remarkable in that it was primarily developed and implemented by healers, with assistance from various governmental and non-governmental agencies. ZINATHA representatives appear to take on the role of co-collaborators in the planning and implementation of local education and prevention programs. This approach, in theory at least, appears to recognize what Long (1992:26), quoting Marilyn Strathern, refers to as “indigenous theories of agency.” Project planners (having intimate knowledge of the local community) appear to recognize healers’ positional status in their local communities and seek not to undermine that status.

Local planners and researchers are usually in the exceptional position to examine how notions of personhood and agency are locally constructed and how these constructions and relationships will affect the management of interpersonal relations between local people (Long 1992:26). Local researchers are thus well placed to analyze “...how differential conceptions of power, influence, knowledge and efficacy may shape the responses and strategies of the different actors” (ibid.).

Such an approach may be difficult to reproduce with outsider planners whose intimate knowledge of the local milieu would be significantly less. The situation underscores the need for any outsider planners (native or foreign) to collaborate with

local people in the planning, implementation, and evaluation of any type of research or interventions. Collaborative, participatory approaches make sense not only from a humanistic standpoint; Cernea (1991) reminds us that such approaches make good economic sense as well.

Collaborative, participatory approaches that place healers (and their clients) center-stage offer one of the most effective means for attempts at containing the AIDS epidemic in Zimbabwe--and other African countries as well. In theory, ZINATHA has attempted to do this through its HIV/AIDS project. Its general challenges are its extensive lack of financial resources and the insufficient number of trained staff. Such training efforts, as mentioned above, are further hampered by the low levels of literacy among many healers. ZINATHA must then develop ways to generate additional funds (there is talk of developing an African village as a tourist attraction) and also develop better ways of conveying information to illiterate healers.

Apart from these material challenges, there are also a number of discursive challenges ZINATHA faces, as hinted at above. Despite the fact that it is healers themselves planning and implementing the project (with help from various outsiders), they still rely on information not generated by themselves. Suffusing many of ZINATHA's project directives is the implicit message that African-derived therapeutic practice is harmful and something to be avoided or reformed. The workshop analyzed above--and many more like it--which work to improve the health practices of n'anga, also insist that n'anga accept that whole areas of their experience and practice are at best irrelevant, and at worst harmful, to the development process. N'anga are both portrayed

as and made into people whose knowledge has a limited, local importance--usually relegated to psycho-social support when medical practice can offer no more hope.

The messages inherent in health development targeting n'anga also articulates with institutional practices--practices long in the making as we have seen from previous chapters--which, together, delink n'anga from their social context. The effects of this delinking process are varied. As Pigg (1995) shows in her analysis of healers in Nepal, this process enables bureaucratic administration by narrowing its vision of complex realities. In other words, the complex realities on the ground do not lend themselves well to actualizable development schemes. At the same time, the simplification that facilitates administrative planning also generates problems of program implementation, particularly when pre-determined outcomes are desired (e.g. n'anga abandoning curative practices deemed harmful). Workshops based on decontextualized and sometimes distorted ideas of what healers do face great challenges in their ability to influence their actual practices. As is the case with the ZINATHA HIV/AIDS training program, sometimes even those programs and projects developed and implemented by healers themselves fail to bridge the gap between biomedicine and African-derived therapeutic knowledge and practice. Prying local forms of practice from their sociocultural context, the end result of processes of translation, hinders the effectiveness of programs even as it serves other bureaucratic functions. And despite many efforts to the contrary, it will be difficult for ZINATHA to really resolve these contradictions, relying as they do on pre-fabricated biomedical messages and information for their programs and projects.

Despite these challenges, the ZINATHA HIV/AIDS project is an important first step in developing projects to arrest the transmission of the virus. The impact of such a

project cannot be underestimated, especially given the central role of traditional healers in both the planning and implementation of the project and their role in the health and well-being of local communities..

¹ Other organizations working with ZINATHA include: the Zimbabwe AIDS Network; the Southern Africa Network of AIDS Service Organizations; the Zimbabwe Health Association; The World Health Organization; UNICEF; the Red Cross; Save The Children-UK; the Swedish International Development Authority; the Canadian International Development Agency; and the Zimbabwe National Family Planning Council.

² Organizationally, ZINATHA's policy-making body is its Medical Council. The National Executive Committee, which consists of 15 elected ZINATHA members, reports to the Medical Council. Implementation of programmes and policies is then carried out by District Executive Committees and branch Executive Committees which operate at the provincial, district and local levels. Within ZINATHA there are four departments -- Administration, Finance, Research and Education, and Legal Affairs -- that operate under the direction of the Secretary who executes ZINATHA's project activities.

³ From "A Case Study of the Zimbabwe National Traditional Healers Association (ZINATHA)," prepared by Dr. James Jijide.

⁴ *ibid.*

⁵ The survey points out that Gutu District was chosen because of the alarming number of AIDS cases and because it is a relatively well-developed growth point and also has a relatively less developed rural sector.

⁶ From the "Initial Report of a Knowledge, Attitudes & Practices Baseline Survey In Gutu District," prepared by Milton Wafawanaka and Celine Gilbert.

⁷ From the "report of the ZINATHA HIV/AIDS and STD Training Workshop, 30 August - 3 September 1993" compiled by E. Ndimande.

⁸ Report of the ZINATHA HIV/AIDS and STD Training Workshop, 30 August-3 September 1993.

⁹ *ibid.*

¹⁰ *ibid.*

¹¹ From "A Case Study of the Zimbabwe National Traditional Healers Association (ZINATHA)," prepared by Dr. James Jijide.

¹² *ibid.*

¹³ From the "Report of the ZINATHA HIV/AIDS and STD Training Workshop, 30 August - 3 September 1993"

¹⁴ From "A Case Study of the Zimbabwe National Traditional Healers Association (ZINATHA)."

¹⁵ *ibid.*

¹⁶ *ibid.*

CHAPTER SIXTEEN

Diagnosis and Treatment Strategies for AIDS

Efforts to educate healers about HIV/AIDS and STDs are ongoing, and calibrating messages with local realities and knowledge systems will continue to be a challenge. The following is a survey of healers' understandings of HIV/AIDS. Interviews were conducted with healers in ten designated districts in Harare which included: Chitungwiza, Dzvarasekwa, Glen Norah, Glen View, Highfield, Kuwadzana, Mabvuku, Mbare, Mufakose, and St. Mary's. A snowball-sampling method was utilized with researchers first interviewing district chairs of ZINATHA, then individual healers according to gender and area of specialization (e.g. spirit mediums, faith healers, traditional birth attendants, and herbalists). A questionnaire designed to provide a demographic profile (e.g., age, level of education, etc.) as well as a general picture of healers' knowledge and practices with regard to HIV/AIDS, was utilized.

A team of four researchers, comprising two American researchers and two Shona researchers, undertook the survey.¹ Both Shona researchers were affiliated with the Zimbabwe National Traditional Healers Association (ZINATHA) and underwent training in research techniques before beginning the survey. The questionnaire was tested and revised at ZINATHA headquarters in Harare by traditional healers before being administered in the field.

The research team conducted 100 interviews from June 17, 1996 to July 24, 1999.² Most of the interviews were conducted in Shona, though healers who were fluent in English were interviewed in English. Questionnaires were written in English,

translated into Shona, then translated back into English by a third party to insure their accuracy. Most often, interviews were conducted in healers' homes (e.g. in their *matare* - the place where they practice their curing/treatment), occasionally at ZINATHA headquarters, and occasionally at district meetings.

A Survey of Harare-Based N'anga and HIV/AIDS

Healers' general response to interviewers was that of openness. This might have been facilitated by the fact that most of the healers were familiar with the two Shona interviewers through their affiliation with ZINATHA. One healer expressed apprehension because of her experiences with a hospital's clinical trials of medicinal plants and traditional healing. Evidently, she had been told that she would be paid for her involvement and subsequently received no remuneration.

Some healers took great pride in showing their membership certificates from ZINATHA. Others showed similar membership cards from various healer organizations that pre-dated ZINATHA (formed in 1980) as a way of illustrating their long-standing affiliation with an officially-recognized organization (e.g. the Central African Chiremba Association). Other healers took great pride in showing their carefully stored and labeled materia medica (an initiative undertaken by ZINATHA in its healer workshops).

Regarding the HIV/AIDS knowledge scale, many healers did not initially confine their responses to "True," "False," or "Don't Know," and this signals a serious weakness in certain instruments designed to evaluate healers' knowledge. Rather, healers would qualify their responses with often elaborate explanations. For example, to the question "Is there a high chance that AIDS can be spread by sharing a glass of water with someone

who has AIDS?" many healers might answer "False," but then qualify it by saying that if both people had open wounds on their mouths, and the blood of the infected person entered the wound of the healthy person, there was a possibility of transmission. Another example included responses to the question, "Does using a condom during sexual intercourse lower your chance of getting AIDS?" Most healers answered affirmatively but, again, with qualifications. Some might say, for example, that condoms won't protect you if they have holes in them or if you exert too much pressure and they burst. So, while many healers might understand, in theory, that condoms can protect individuals from contracting HIV/AIDS, many also expressed doubt in the protectiveness of condoms in practice. This may signal some other underlying beliefs surrounding condom use in general. More generally, perhaps, such responses point to the depth of healers' biomedical knowledge of disease transmission.

Healers also qualified responses to the attitudes scale, sometimes not confining their responses to "Agree," "Undecided," and "Disagree." For example, to the question, "I feel that HIV/AIDS is a punishment for immoral behavior," one healer said that it was punishment for mischievous people (who were also immoral). Similar qualifications accompanied other questions and points to the need of the researcher to develop other ways of capturing more nuanced responses to survey questions.

General Challenges

One of the greatest challenges was locating healers. First, many healers hold other primary jobs and so the time they spend in their matare is often erratic. Some simply were not home when we visited. Second, many healers' homes do not have

numbered addresses and it is difficult to account for them in ZINATHA's official registry of healers, published semi-annually. Third, though it is not reflected in most of the literature regarding healers, many are very mobile and are constantly changing residences (either moving to new neighborhoods/districts/provinces/regions or changing residence within the same neighborhood). This makes it very difficult to locate them for purposes of interviewing. Thus, much time is spent inquiring with local people as to where a healer might currently reside.

Another general problem involved the nature of the interviewing process itself. As mentioned above, most of the interviews took place at the healers' residence. While such a location might have made the healer (hopefully) more comfortable, family and friends would often congregate during the interview, many times offering their own responses to elicited questions. Interviews thus, in some cases, became focus groups rather than one-on-one interviews.

The fact that both of the Shona interviewers were affiliated with ZINATHA was both advantageous and disadvantageous. The advantage included the fact that both Shona researchers were, for the most part, recognized by many of the healers. The interviewing could thus be construed as "official" business of the organization. A couple of healers remarked that it was good that we were conducting interviews through the official organization -- evidently some American or European interviewers had interviewed healers without working through ZINATHA. The healers expressed that those researchers had not gone through the "proper" channels and so the healers did not feel comfortable talking with them.

The disadvantage to working with ZINATHA affiliates was the potential for some negative repercussions for the healers themselves. Healers might not have felt comfortable answering questions in front of “official” representatives of the national organization for fear that they might answer incorrectly and/or be held accountable for not being more knowledgeable.

Although these challenges were present, the researchers do not feel that they significantly undermine the results. They do, however, point to serious considerations any researcher should keep in mind in planning and implementing any research program.

Demographic Characteristics of the Respondents

The major characteristics of the sample of 50 healers are characterized below.

Table 3

Gender	Frequency	Percentage
Female	22	44
Male	24	48
Missing Value	4	8
Total	50	100

Table 4

Marital Status	Frequency	Percentage
Single	1	2
Married	42	84
Separated	2	4
Divorced	2	2
Widowed	4	8
Total	50	100

Table 5

Highest Level of Schooling	Frequency	Percentage
None	10	20
Primary	28	56
Secondary	11	22
College	1	2
Total	50	100

Table 6

Country of Birth	Frequency	Percentage
Malawi	5	10
Mozambique	2	4
Zambia	1	2
Zimbabwe	42	84
Total	50	100

Table 7

Type of Traditional Healer	Frequency	Percentage
Herbalist	4	8
Spirit Medium	31	62
Spirit Medium/Herbalist	2	4
Bone Caster	1	2
Bone Caster/Herbalist	1	2
Faith Healer	8	16
Spirit Medium/T.B.A.	2	4
Seer	1	2
Total	50	100

Table 8

Specialization	Frequency	Percentage
Physical Illness	28	56
Physical/Supernatural Illness	22	44
Total	50	100

Physical illnesses most often mentioned (in no particular order) included: STDs, epilepsy, heart problems, depressed fontanel, infertility, epilepsy, high blood pressure, headaches, stomach problems, diarrhea, cancer.

Supernatural illnesses most frequently mentioned (in no particular order) included: evil castings (malevolent spells cast by a malevolent human agent), evil spirits, and assistance in promotion of mediumship.

Ninety percent of the healers said that they treat sexually transmitted diseases. Most commonly treated STDs included: drop (42%), syphilis (22%), gonorrhea (18%), and chancroid (18%). Interestingly, only 6 percent of the healers included HIV/AIDS in their list of frequently treated STDs. This may reflect the fact that, barring a blood test, there is no way for a healer to know whether a patient has HIV/AIDS. Healers are thus left treating the symptoms of the disease -- symptoms that may resemble other diseases, namely other STDs. General treatment strategies for STDs included:

Table 9

Treatment	Frequency	Percentage
Herbs--Drinking/powder in porridge	31	69
Herbs--Ointment	6	13
Herbs--drinking/ashes for Rubbing	2	4
Trees/roots	4	9
Prayer/holy water	1	2
Total	50	100

Knowledge of HIV/AIDS

Sources of knowledge of HIV/AIDS

Healers were asked if they had heard of HIV/AIDS and the vast majority, 48 (96%), had heard of it. While 15 (30%) had learned of the disease from the general media (e.g. radio, television, newspapers, billboards, etc.), more than half, 28 (56%) had heard of HIV/AIDS from ZINATHA or from other healers. Seven (14%) had heard about the disease from health workers, hospitals, clinics, or from the University of Zimbabwe. Forty (80%) healers had been to ZINATHA-sponsored HIV/AIDS and STD workshops. Of those who attended workshops, 20 (50%) had attended workshops at Mushandirapamwe Hotel in Highfield between 1995 and 1996.

Modes of transmission

Generally, healers were knowledgeable about the transmission of the virus. Men were slightly more likely to correctly answer questions on the knowledge scale, especially as it related to lower-level types of risk, than women. For example, when asked, "Do most experts say there's a high chance of getting AIDS by kissing someone on the mouth who has AIDS?," 65 percent of the healers answered "False." In terms of gender, more men answered correctly than women (50% for women versus 79% for men). Likewise, when asked, "There's a good chance you can get AIDS from a toilet seat?," men were more likely to answer "False" (75%) as compared to women at 55 percent.

With regard to major risk factors, men and women appeared equally knowledgeable. For example, when asked if “AIDS can be spread when a man has sex with a woman who has AIDS (and vice versa)?,” 100 percent of both male and female healers responded “True.” Likewise, when asked if “Having sex with more than one partner can raise your chance of getting AIDS?” 100 percent of both genders responded “True.” Healers were less sure if HIV/AIDS could be transmitted through man-to-man sexual intercourse, 86 percent of the women answering “True” and 79 percent of the men. When asked this question, many healers asked to have the question repeated again, some openly laughed, and others stated that they had never heard of such a thing.

When asked, “If a man or woman has sex with someone who shoots up drugs, do they raise their chance of getting AIDS?,” 100 percent of women healers and 96 percent of male healers answered “True.”

Interestingly, women (91%) were more likely to think that using a condom could reduce your chance of contracting HIV/AIDS than men (75%). This may reflect more openness on the parts of women to condom use (especially in protecting themselves from an infected man), a choice they seldom have control over as we saw in Chapter Seven.

Symptoms of HIV/AIDS

When asked if they could tell if a client has HIV/AIDS, 88 percent answered affirmatively. Eighty-one percent responded that they could tell through physical symptoms, which included: changes in hair (a “reddening” and “straightening” of the hair) and skin texture (an ashiness and dullness to it), weight loss, lack of appetite, deep cough, chronic diarrhea, unhealing sores, swelling of lymph nodes, and fatigue.

Fifteen percent responded that they were made aware that a client had AIDS through some form of divination -- either through bone casting, spiritual vision, or by using a looking glass (mirror).

Four percent said that they learned of a client's status through notification by a doctor or hospital.

What do the ancestors/spirits say about HIV/AIDS?

As noted elsewhere (see, e.g., Willms, Chingono, Wellington, et al., 1995), there is some debate as to whether or not HIV/AIDS is a new disease or the new name of an old disease. This sentiment was certainly reflected in healers' responses.

Of those healers who consult the spirits/ancestors, 15 (41%) attributed HIV/AIDS to a general breakdown in cultural norms, whether internally or externally caused. Internal, or indigenous, causes might be: having sexual intercourse with a woman who just gave birth, general immorality, or bestiality. There appeared to be recognition that people generally do not always behave in a way that would be considered culturally appropriate and that such transgressions would be labeled as a breakdown in cultural norms.

External causes of a breakdown in culture could be generally attributed to the forces of contemporary social, economic, and political changes in the status of Zimbabwe as a nation-state. Such explanations included that of: soldiers bringing the disease from the bush during the fight for independence, people from different nations and racial/ethnic groups "mixing" together, or the idea that AIDS comes from America and was purposely sent to Zimbabwe to destroy black people.

Twelve (32%) said that HIV/AIDS was a new disease, most likely brought about by the reasons mentioned above. Three (8%) healers viewed HIV/AIDS as an “old” disease, most likely associated with runyoka, rukombe,⁵ or, in one case, mukondombera (the same name given to the 1918 Spanish Influenza epidemic). In fact, one healer mentioned that HIV/AIDS and influenza were related.

Indigenous names for HIV/AIDS

There were a couple of indigenous names that healers used to describe HIV/AIDS, and these names typically reflect the effect of (or vector for) the disease. Mukondombera, mentioned above, literally means “a stubborn disease that won’t let go once it gets hold of you.”

Another name elicited was chiwere chepfambi, which means “disease of prostitutes.” The belief that prostitutes are responsible for the spread of the disease was, in part, echoed in healers’ responses to the question, “Do prostitutes have a higher chance of getting AIDS?,” in which 100 percent of both genders answered “True.” Some healers commented that “they are the ones spreading it,” “they spread AIDS -- no decent woman would approach a man,” or “they’re the carriers.”

The stigmatization of prostitutes as carriers of the virus, as opposed to their clients, may signal a general belief about women whose sexuality is not under the control of fathers or elders. Prostitutes, also referred to as commercial sex workers (CSWs), in theory, exercise control over their own sexuality by selling their bodies to clients. In practice, of course, it could be argued that CSWs are indeed not in control of their own sexuality -- that it is still controlled by the clients themselves. For example, some studies

indicate that female CSWs have little control over whether their clients use condoms during coitus, even when they request that clients utilize them.

Attitudes and Practices Regarding HIV/AIDS

General level of compassion for HIV/AIDS sufferers

Overall, healers appeared to be supportive of people living with HIV/AIDS. For example, 98 percent of the healers agreed that they would be supportive of an individual suffering from HIV/AIDS. When asked if they would feel very uncomfortable around someone with AIDS, 74 percent disagreed. Only 22 percent agreed, while 4 percent were undecided. Likewise, 62 percent disagreed with the statement that it would be dangerous to allow a child with HIV/AIDS to attend school.

While clearly expressing compassion for HIV/AIDS sufferers, healers were also very likely to view HIV/AIDS as a punishment for immoral behavior (90% agreed with this statement). This opinion is consistent with the belief that HIV/AIDS is generally caused by a breakdown in culture.

Willingness to talk about HIV/AIDS

Ninety-eight percent of the healers agreed that it was important to talk to a sex partner about HIV/AIDS prevention before having sex, while 100 percent agreed that they intend to talk about HIV/AIDS prevention with a partner before having sex. Seventy-six percent disagreed with the statement that they would be insulted if a partner insisted that they use a condom during coitus, while 88 percent disagreed when asked if they would dislike asking a possible sex partner to get the HIV antibody test.

Personal sexual practices and HIV/AIDS

With regard to personal practices and HIV/AIDS risk behavior, 90 percent of the healers disagreed with the statement that they would dislike the idea of limiting sex to just one partner to avoid HIV/AIDS infection. Ninety-six percent agreed that it was easy to use the prevention methods that reduce one's chances of getting HIV/AIDS. Ninety-four percent of the healers responded that they would use a condom when having sex if they were not sure if their partner had HIV/AIDS. Eighty percent disagreed with the statement that even if a sex partner insisted, they would not use a condom.

Summary and Implications of Data Findings

Demographic

Approximately half of the healers interviewed were either male or female (with four unspecified). Many of the respondents (67%) had, at least, a primary education, while 26 percent had a secondary education. There was an effort to interview a representative number of specialists, however, the majority of healers interviewed (62%) were spirit mediums. A majority (84%) were married, and this, no doubt, influenced their responses to the knowledge and attitudes scales.

While a majority of the healers (84%) were born in Zimbabwe, 16% were born in other countries: 10% were born in Malawi, 4% were born in Mozambique, and 2% were born in Zambia. Migration between countries, regions, provinces and districts, may emerge as an important variable to keep in mind when looking at healers' knowledge, attitudes, and practices regarding HIV/AIDS.

Knowledge of HIV/AIDS

Healers were generally knowledgeable about HIV/AIDS and the various modes of transmission. Perhaps this was to be expected of healers located in the capital city where access to information is presumably more readily available. Accessible sources of information include: television, radio, print media (e.g. newspapers, pamphlets, brochures), ZINATHA headquarters and various other governmental and non-governmental organizations, hospitals and clinics, and the University of Zimbabwe.

Slightly more than half of the healers (56%) had learned of HIV/AIDS through ZINATHA or from other healers. Eighty percent had been to ZINATHA-sponsored HIV/AIDS and STD workshops. Such results suggest the pervasiveness and perhaps, effectiveness, of healers' networks in disseminating information about HIV/AIDS. In this regard, every effort should be made to maintain and strengthen the networks healers utilize for information dissemination. Specifically, governmental and non-governmental financial and technical support should be given to ZINATHA.

Such a high level of knowledge amongst urban healers may also point to an urban bias (Chambers 1983) in favor of healers who live in urban centers. Because of poor roads and other infrastructural obstacles, the majority of ZINATHA's HIV/AIDS and STD workshops are held in the urban centers of major provinces, even though the vast majority of healers are located in rural settings.

It is significant that a majority of healers (81%) responded that they rely on physical symptoms (e.g. hair and skin texture, weight loss, lack of appetite, deep cough, chronic diarrhea, unhealing sores, swelling of lymph nodes, and fatigue) to discern a

patient's HIV/AIDS status. It would be assumed that spirit mediums, in particular, would rely on some form of contact with the spirit world to discern a patient's HIV/AIDS status. Surprisingly, only 15 percent responded that they were made aware that a client had HIV/AIDS through some form of divination -- either through bone casting, spiritual vision, or by using a looking glass (mirror).

These findings concur with other recent studies that suggest that healers do not solely subscribe to a social model of health (e.g. the belief that disease is caused solely by the purposeful acts of some supernatural agent or agents). Evidently, healers also subscribe to a more biomedical understanding of disease and use this understanding to assess the health of their patients by empirical means. The degree to which healers operate with such an understanding and how this impacts their ability to diagnose and treat HIV/AIDS requires further study.

¹ This was the case in 1996 where I worked with an undergraduate from Michigan State University. In 1995 and 1999, research was undertaken by myself and two ZINATHA-affiliated colleagues.

² Here, I share the data from the 1996 questionnaire. I utilize data from 1999 interviews, which were much more descriptive, in the next chapter.

CHAPTER SEVENTEEN

N'anga Theories of Contagious Diseases

These so-called n'angas are partly responsible for the deaths of thousands of people being buried weekly. They lie to them that they can cure this and that. There has been no concrete proof at all about the n'anga stories that have appeared in the past and those being written now.

Asum Nassali¹

As we have seen from the previous discussion, there are some individuals who question the credibility and sincerity of n'anga in effectively treating illness and disease. The belief that there has been an incursion of unscrupulous n'anga into the profession as a result of the desperation wrought by HIV/AIDS is quite common in Harare and not completely without merit. Public rhetoric such as this, however, distracts attention away from what n'anga actually know regarding disease, its genesis, transmission, and treatment. This is particularly true for what Green (1999) refers to as “indigenous theories of contagious disease.” In fact, there is a real lacuna in the social science and development literature on healers’ understandings of such afflictions as sexually-transmitted diseases. This chapter attempts to develop a conceptual framework for healers’ understandings of sexually transmitted diseases, including AIDS. Borrowing from Feierman and Janzen (1992:xvi), I analyze understandings of STIs and AIDS as “sets of concepts concerning illness causation, anatomy, society, or self, as they relate to bodies of therapeutic practice, and also to the occupational roles within which healers work.” Equally important, I view concepts surrounding STIs and AIDS as articulating changing cultural definitions of the individual’s place in society, the human body and its parts, and healing practices. Seen in this way, healing traditions regarding sexually

transmitted infections not only emerge from (and respond to) systemic practices and processes of political and economic control, they provide interpretations of a rapidly changing reality. Findings reported here derive from interviews with Shona-speaking respondents in each of Harare's ten districts (see Chapters Three and Sixteen) and Chikanga, a community in Mutare, the Eastern Highlands, as well as available literature.

N'anga Understandings of STIs in Zimbabwe

While there is a significant body of biomedical knowledge regarding STDs in Zimbabwe--epidemiology, transmission, and treatment (see, for example, Chapter Seven)--significantly less is known regarding n'anga indigenous theories and healing practices related to STDs. Thus, my own research was highly exploratory in nature, utilizing in-depth, key-informant interviews, supplemented by focus group discussions.

The base model for STIs amongst Zimbabwean n'anga is that of the accumulation of "dirt" in the stomach, the bladder, or the sex organs in the form of an "egg." The egg then "hatches" sprouting worms that invade the whole body via the blood. These worms kill the body and make the person vulnerable to all sorts of diseases. "Dirt" is usually not well defined. Sometimes it is described as dead sperm, menstrual blood, or "left-overs" of STDs. What is important is that the dirt is spread or transmitted during sexual intercourse and that it accumulates to produce an illness state (Wilmms, Chingono, and Wellington 1995). It is striking that this understanding of STIs is so similar to the way that biomedicine understands common STIs--that of an infectious agent transmitted during sexual intercourse. This seems to indicate a naturalist explanation perhaps

influenced by biomedical thinking, though such conclusions would be premature. More striking, perhaps, is the absence of supernatural elements such as witchcraft and sorcery in these findings.

Similar understandings of locally-recognized STIs have been noted by Green (1999:163) among healers in Zambia and Mozambique. A review of these understandings led him to speculate that *all* STIs are understood to some extent as being caused by pollution as well as by naturalistic infection. He explains that the causative agent of many of these illnesses is translated as ‘insect’ or ‘bacteria.’ This illness agent is believed to reside in sperm, vaginal fluid, and the blood of both men and women. Green notes that healers might refer to an STI sufferer having “contaminated blood,”² sometimes healers saying these illnesses are “found in either the penis or vagina,” without being more specific. Other healers in Green’s sample referred to “insects that are dirty and deadly”; “dirty water that is inside the private parts [and] changes into [an] insect”; and the idea that “each illness has an ‘egg of illness.’” Several healers referred to the pus of STIs as an element of dirt or as something the insect secretes or transmits that is contagious, accounting for transmission of an STI through causal contact.

Bodily Fluids and Contagion

Bodily fluids--blood, puss, genital secretions--are conceived to be invested with potent and dangerous properties in much of Africa. As Douglas (1992 [1966]:125) notes, those illnesses associated with these fluids and discharges are broadly believed to be

pollution illnesses. STDs/STIs fall within this broader understanding of diseases of pollution since they usually involve pus, boils, and various foul-smelling discharges. Blood is also a conduit for pollution, and the quality of one's blood can make a person susceptible to various illnesses and diseases. Blood can become "dirty" or "weak" from engaging in sexual intercourse with too many partners--especially partners who are too young or too old or from other racial/ethnic groups--or through exposure to death or other polluting influences or contacts (Schapera 1940: 194-195; Green et al 1995; Nzima 1995). Additionally, the blood of different groups of people--young and old, white and black, etc.,--are thought to be different temperatures. For example, young people are often thought to have "hot" blood, while older people are thought to have "cold" blood. If, then, a younger person has sexual intercourse with an older person, the mixture of hot and cold blood will result in illness and disease.

This view of blood that becomes bad or dirty through mixture or contact with strange blood is consistent with the ethnographic literature from other societies that neighbor Zimbabwe. In his work amongst the Tswana of Botswana, for example, Schapera (1940:196 cited in Green 1999) reported that: "A woman promiscuous in her sexual favors will likewise acquire 'bad hips,' through the accumulation in her body of 'bloods' of many different men. 'These bloods fight one another, they do not agree, and they poison the woman's body.' The condition is held to be contagious.'" In later research, Schapera (1978:174 cited in Green 1999), referring to pre-marital sexual intercourse noted that, "If a girl had many lovers her womb became spoiled, because the different 'bloods' ejaculated into her 'disagreed' with one another."

Likewise, Green (1999:170) notes that amongst Zambian healers that STIs are the result of having too many partners and a resulting excess of “mixing of blood” or mixture of semen.” This mixing spreads “dirt” or STI agents. He points out that while dirt may be conceived of as resulting from simple lack of hygiene, it may also have another meaning, that is a lack of moral behavior. One of his informants commenting on a locally-named syphilis-like STI explained that:

This is a disease that is caused by dirty blood. When a man meets a woman during sexual intercourse, there is a point where a man actually touches to reach his climax. This is the point where the sperms are ejected into the womb. At this point, blood is exchanged and if this blood is dirty, the man will come out with it and the same blood will stick on the skin of the man. Once it is kept there for sometime, it will cause pimples and later cause a sore.

This focus on bodily fluids is also important from the perspective of lay people. Some of my informants mentioned that sexual intercourse is achieved only when the bodily fluids--that is semen and vaginal fluids--mix together. In other words, it is only through the co-mingling of both partners’ bodily juices that both partners can say they actually had sex. In this way, sexual intercourse with a condom is not really considered sex as it prevents this mixing of fluids; part of the reason, perhaps, so many men enjoying “eating their sweets with the wrapper off.”

Review of Clinical Symptoms

By way of comparison, I offer clinical symptoms for major STDs found in Africa as summarized by Green (1999:138):³

- **Gonorrhea:** Initial symptoms are painful urination usually followed by thick, yellow, purulent discharge from the urethra. In females, the urethra is short and urethritis is often not noticed.
- **Chlamydia:** Symptoms are similar to those of gonorrhea, but infections tend to be less acute and milder. Women are usually infected at the endocervix, urethra or both. Infection of the endocervix may produce symptoms but inflammation of the cervix is often present and there may be a discharge. The most common symptom among women is a burning sensation while urinating. With men, symptoms are usually present seven-ten days after infection and consist of burning sensation during urination and discharge.
- **Syphilis:** Primary syphilis is characterized by a hard chancre, a single, painless ulcer on the genitals or elsewhere (lips, tongue, breasts); even when not treated it will heal spontaneously in a few weeks. The lymph glands are bilaterally enlarged but not painful. Secondary syphilis appears four-six weeks after the primary infection as a generalized secondary eruption (symmetrical rashes that do not itch), often accompanied by mild constitutional symptoms.
- **Chancroid:** An ulcer develops on the skin of the penis three-five days after sexual contact. The ulcer can enlarge in every direction. New ulcers often develop from the initial one. They are painful and soft on palpation. In most cases only one side is affected. The chancroid sore is painful and soft, as distinct from the syphilis sore, which is painless and hard.
- **Papillomaviruses:** A genital papillomavirus infection may result in (i) no obvious lesions, (ii) a small papule or bump (flat *Condylomata*), (iii) an exophytic genital

wart with spike-like projections (*Condylomata acuminata*), or (iv) eventually a cancer (most often cervical). most persons with genital or perianal warts have no symptoms and are mainly concerned about the appearance of the warts. In men they are usually located on the penis, scrotum, or urethra, while in women they are located on the labia, introitus, vagina, and cervix. They are found in the perianal area in both sexes (Jones and Wasserheit 1991:25). Genital warts may also be due to *Condylomata acuminata*.

Locally-Recognized STIs: Their Symptoms and Treatment

In Harare, it was not uncommon for n'anga to give English names for some STIs (for example, “drop”) and, in some cases, the same indigenous and/or English names are used for different diseases. As Green (1999) notes, this does not mean that these STIs exactly correspond symptomatically to the STDs of biomedicine. Rather, this may signal disagreement and/or confusion over STI symptoms as well as overlap between the biomedically recognized symptoms of these illnesses.

For each STI elicited, a composite profile of causes, symptoms, and other characteristics has been constructed from reviewing answers to survey questions and generalizing from the majority of answers.

Gonorrhea (*yemaronda, isick, drop, njovera*). This STI is usually characterized by abdominal pains, painful urination, loss of appetite, constipation, and sores, as well as hair loss in the genital area. Men and women are affected in roughly equal numbers. It's cause was said to be sexual activities with prostitutes or with multiple partners--especially those with loose morals. Treatment strategies differed amongst n'anga. For

example, an herbalist utilized “African injection”--an incision made through a razor blade--on the area near the respective vein which, he said, assured that the medicine went directly to the site of infection. He pointed out that eating or drinking the medicine would result in its “loss” through digestion. He also prescribed a topical ointment for sores.

Syphilis (*songeya*, *drop*, *yematariyana*). Symptoms included frequent urination followed by a whitish discharge, swelling of the penis, sores in the genital area, abdominal pain, and difficulty walking. Men and women are affected equally. Causes were said to be having multiple sexual partners--particularly from places like bars and beerhalls, older women engaging in sex with younger men, having sex with a menstruating woman or a woman who just miscarried, erratic menstruation cycle (causing dirt to collect in the vagina). In the case of the indigenously named *yematariyana*, it is thought that the disease was brought by the Italians who worked on roads and bridges in the 1950s. One bone caster/herbalist commented that “God created a black man for a black woman, and therefore it is not good for a white man to sleep with a black woman or vice versa. Our blood is different and that difference created the problem.” The most common forms of treatment were African injections--incisions made on the affected areas and medicine administered to the wounds. In the event that a man “had lost his manhood”--meaning he had become impotent--an additional treatment was carried out where a cock would be cooked with special herbs, then consumed, for manhood restoration.

Chancroid (*mvarapo*, *yemabhora*, *yemajuru*, *mazvimbiawa*). Symptoms included swelling of genital area--the development of hard boils--below the ribcage, foul-smelling

whitish discharge from the genitals, and the sensation of “ants marching from the stomach to the genital area.” Causes were said to be “having sex with a dirty woman,” multiple sexual partners, having sex with a woman who is menstruating or recently miscarried. Like syphilis and gonorrhea, treatment is in the form of a burnt medicine applied into incisions near the boils themselves. Boils are said to subside within a couple of days.

Drop. Symptoms included abdominal pains with genital discharge, foul odor, as well as sores. Sexual intercourse with multiple partners, sex with woman who is menstruating or recently miscarried, or having sex with a woman of “loose morals” were the most commonly mentioned causes for drop.

Treatment strategies are consistent with others observed in the surrounding region. Green (1999:166), for example, notes that in Zambia: “The main objective of treatment is to kill an infective micro-organism (insect, dirt, bacteria, virus), or expel it from the body or blood. As is characteristic of healers in the broader region, they use herbal decoctions (teas, or, less often, herbs mixed in porridge) made from boiled roots. These might have the effect of purgatives or emetics, especially if they are supposed to expel dirt. Some medicine is said to make the illness insect leave the body through frequent urination. Other treatment objectives include cleaning the blood, healing wounds, or making specific symptoms disappear such as warts, ulcers, sores, or other visible skin symptoms. STIs featuring sores or ulcers may be treated topically with poultices made with powdered roots. For STIs with warts or growths, these might be cut out and/or the patient may be asked to sit in a container of water with crushed medicinal roots.”

What is AIDS, Where Does it Come from, and Why is it Here?

As suggested above, the base model for AIDS is that of STIs for healers in Zimbabwe. These understandings of the disease share a naturalistic conception of the disease. HIV/AIDS is also conceived of in symbolic terms as well. In this sense, local readings of AIDS are fashioned from mutually dependent understandings of the disease; that is, its genesis in the severe socio-economic conditions initially wrought by colonialism and the subsequent erosion of decent behavior in its wake. Both these understandings of the disease share a common theme: the role of human and/or supernatural agency in either creating the conditions for HIV/AIDS or in using it to 'cull' African populations. This section attempts to unravel some of the symbolic understandings of the disease.

While the term HIV/AIDS is used almost universally in Zimbabwe by health professionals and lay people alike, there are also a great diversity of indigenous names for the disease which either reflect the vector of its transmission or its effect. As pointed out by Willms, Chingono, Wellington, et al (1995), some of these names include: *mkondombera* "a stubborn disease that once it gets hold will never let go"; *chiwere* *chepfambi* "disease of prostitutes"; *gukurahundi* "a heavy rain that washes away everything"; *bumbiro rezvirwere* "a basket full of seeds of different variety all germinating at one time"; and *shuramatongo* "a ghost homestead" meaning that an infected man will infect his wife and the wife will infect any children she's pregnant with thus destroying the home. Implicit in these local names for AIDS is the idea that it is a variety of illnesses--weight loss, chronic diarrhea, genital sores--that occur concurrently

and, as such , are difficult to treat with one medicine; that AIDS is spread by prostitution or promiscuous behavior; and that AIDS is devastating homes, families, and communities.

Even so many years into the epidemic, there is still debate whether or not AIDS is a new disease or a new name for old diseases such as *runyoka* and *rukombe*. Both these diseases are the result of people engaging in locally-inappropriate sexual behavior-- meaning sexual behavior that violates cultural taboos and proscriptions (taboos around extra-marital sex in the case of *runyoka* and around pre-marital sex with *rukombe*). In formal interviews, many n'anga note the similarity in symptoms between *runyoka* and *rukombe* and AIDS, acknowledging that AIDS is indeed a new disease. However, there is reason to suspect that privately some n'anga believe AIDS to be *runyoka/rukombe*, or at least that there is some kind of relationship between AIDS and locally-known diseases. There are, of course, considerable differences in these diseases: *runyoka* is sex-specific-- it only affects men, while both sexes can acquire AIDS; *runyoka* and *rukombe* are curable with the intervention of a n'anga, AIDS is not; infants and young children can get AIDS, but not *runyoka* or *rukombe*; AIDS is international in its effect, *runyoka* and *rukombe* are illnesses that can only be found in certain African countries; and people die from *runyoka* and *rukombe* much more quickly. Indigenous etiology highlights the role of transgressing locally-appropriate practices in the role of contracting *runyoka* and *rukombe*--that is, people guilty of violating cultural taboos or proscriptions surrounding sexual behavior. AIDS, on the other hand, can affect less guilty people (spouses) and the innocent (children).

Amongst n'anga who suspect that AIDS is really a new name for an old disease, there is consensus that it has always been present. In the past, it was less pervasive because there is the impression that people were more "decent"--meaning they were respectful of their culture and did not engage in "promiscuous" behavior. "Promiscuity" here refers to sexual behavior that violates a cultural taboo or proscription. This is an important point because, unlike in its Western understanding, the term does not refer solely to having many sexual partners. Historically, culturally-inappropriate behavior included pre-marital sex, extra-marital sex, extra-racial/tribal sex, sex with someone outside one's own age set, and sex with a woman who has recently aborted or given birth or who is menstruating. Those who engage in such acts are generally considered "guilty" or "unclean."

The theme of a imagined past free of immoral behavior is common among many n'anga. There are at least a couple different ways of interpreting this theme: First, is the idea that colonialism--that is contact with, and subjugation to, an invading group of "strangers"--had a polluting effect on local peoples in terms of "mixture," or sexual unions between different peoples with different blood constitutions (see previous chapter). Second, this theme can be interpreted in terms of local peoples adopting the cultural practices of this group of strangers.

AIDS Genesis and Operation in the Body

N'anga offer a variety of explanations for how AIDS is generated in the body:

- AIDS begins when young (hot) blood mixes with old (cold) blood through sexual intercourse.
- AIDS starts when white (European or American) blood mixes with black (Zimbabwean) blood through sexual intercourse.
- AIDS starts when the blood of one tribe mixes with the blood of another.
- AIDS begins when “dirty” blood mixes with clean “blood” (where dirty blood is that of a woman who is “dirty”--meaning a woman who is menstruating or has recently given birth or aborted).
- AIDS starts when many kinds of blood mix together.
- Local diseases mixing with foreign diseases starts AIDS.
- Various STDs mix together to start AIDS.

This focus on “mixture” points to the genesis of the disease being different blood constitutions mixing or meeting during sexual intercourse. While it might be assumed that the mixing would be two-way--the disease starting in both partners--instead, it is the guilty partner whose blood is weakened or diluted during the mixing. Thus weakened, their bodies become vulnerable to the multitude of illnesses that together constitute AIDS--weight loss, diarrhea, deep cough, etc. Given the physiological, social, and economic vulnerability of women to contracting HIV/AIDS from males, this way of thinking about the disease, unfortunately, can mean that many women are considered the “guilty” ones in the relationship. This can have devastating consequences for women--particularly poor women--and their children, as we have seen in Chapter Seven.

AIDS as a Punishment from the Ancestors and/or God

The idea amongst some n'anga that HIV/AIDS is a punishment from the ancestors and/or God is consistent with the ethnographic literature on Bantu therapeutic systems regarding misfortune and its management (Janzen 1982). As a socially experienced and lived phenomenon, HIV/AIDS is a signifier of things gone wrong at many different levels of being -- individual and collective, empirical and symbolical, the "modern" and the "traditional," and of borders -- national, cultural, individual -- flagrantly transgressed. In this symbolic capacity, HIV/AIDS serves as punishment for breaching social custom and, in this sense, n'anga interpretations of HIV/AIDS and its root causes may be seen as a conservative force, upholding historically local forms of morality in the face of translocal forms of incursion. In this way, n'anga understandings seem to fit within a framework of malcontented modernity (Comaroff and Comaroff 1993), HIV/AIDS being the end result of cultural erosion at the hands of modernizing social forces and material forms. Some n'anga link the polluting moral depravity which causes HIV/AIDS directly to another country, very often the United States. A female herbalist from Highfield, for example, explained that, "AIDS came from America. I also believe that this came as a curse from God. The nations of today, especially in America, they have lost their way and forgot the commandments of the Lord, for example homosexuality and cloning."

A male bone caster from Highfield echoed similar concerns: "AIDS is a punishment from God and the ancestors. Nations have lost their morals. The only remedy should be for people to adhere to their cultural values. And it is also my conviction that once that is in place a cure is going to emerge from Africa. This is so

because the disease emanated from the Western countries and, therefore, Africa will bring the answer.”

A male herbalist from Kuwadzana echoed this moralist discourse: “AIDS is a punishment from the Almighty for wrong-doing. Incest is now very common. Even cows develop a disease if you breed with one bull for too long...what more if fathers are having babies with their daughters?” The very idea of incest, abhorrent to most, has a close historical relationship with n’anga. There is, for example, the belief that a man can increase his powers -- in business, love-making, etc., -- if he has sexual intercourse with his own biological daughter. And far from being a practice that is spoken about in private places, it is openly discussed even in the national media. A story entitled, “Witchcraft on the rise as hunt for riches hots [sic] up,”⁴ explains that “...some men even go to the extent of sleeping with their own daughters for ritual purposes. The president of the Zimbabwe National Traditional Healers Association, professor Gordon Chavunduka, confirmed that such incidents were increasing in Zimbabwe. ‘We don’t permit our healers to do that but we are aware that some of them are doing it privately. We regard the practice as a criminal offense which calls for a sever penalty.’”

In Warren Park, a female bone caster spoke of the root causes of AIDS in similar terms while also linking the disease to poverty: “As far as the origins of the disease are concerned, I am strongly convinced that this is God’s punishment for the adulterous lives being led by so many people. The problem is not only an African problem, *but everyone poor is suffering* (emphasis added).”

Directly linked, perhaps inextricably so, to the moralist theme of punishment is the theme that AIDS is end result of a loss of “culture,” and the mixing of different

peoples and bloods. Many of these explanations share a great deal in common with those involving punishment with the exception that AIDS in these latter explanations is seen as the outcome of the purposeful actions of highly mobile human agents--soldiers, prostitutes, long-distance truck drivers--who often come into contact, and have sexual intercourse, with "strangers." Prostitutes are often singled out as receptacles of pollution and infection, for the sperm of many different men--of different blood constitutions and temperatures--collects in their loins and mixes together. As subsequent men have sexual intercourse with these prostitutes, they become exposed to the polluting sperm-mixture, "sucking" it up through their urethras into their bodies where disease begins. A male herbalist in Dziverasekwa, for example, noted that, "AIDS is a mixture of all the sexual transmission infections. This disease was bred by mixing of soldiers from different countries, for example, peace-keeping missions to Mozambique and the current Democratic Republic of the Congo. Soldiers from different countries share the same prostitutes and the sperm from different men collect in her and mix together and she spreads it to other men."

An elderly male bone caster from Dziverasekwa explained: "AIDS is a white man's disease which is being brought by our sons and daughters who are now marrying the whites. If we stick to our culture, we will not have these problems."

The above narratives concerning indigenous theories of disease contagion amongst n'anga speak in part to their understandings of afflictions as arising from the historical and contemporary basic organization of daily life as shaped by the entire framework of political and economic control. Such interpretations of HIV/AIDS speak to

a long-standing history of structural violence perpetrated on the average Zimbabwean, first under colonialism, and now under the postcolonial state.

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As this dissertation has attempted to illustrate, the story of HIV/AIDS, health development, and traditional healers in Zimbabwe is a long and complicated one. HIV/AIDS does indeed emerge from and constitute a particular discursive field which finds changing meanings in changing contexts. Likewise, responses to the disease, and the interpretations of these responses, find expression in, and derive meaning from, historical relations between African healers, medical missionaries, colonial officials, contemporary doctors and health professionals, as well as development practitioners. It has been my attempt to chart these changing meanings over time, utilizing a broadly historical framework, moving from a political economy of repression under missionary and colonial regimes of knowledge to its contemporary manifestations in post-colonial Zimbabwe. At the same time, I have endeavored to show that healers have been active agents in their encounter with these historical actors and with this new disease. The subtext of modernity throughout the dissertation demonstrates that a globalizing economy, novel flows of information and technology, new configurations of transnational power and control--rather than seize and transform n'anga in the act of conceptualizing, inscribing, and interacting with them on terms not of their choosing--have provided pathways and routes for them to transform themselves. Throughout their historical encounters with these broader forces, n'anga have acted as key intermediaries, soothsayers, and master interpreters (and occasionally charlatans) in managing the

misfortunes of their individual clients and, indeed, the collective Zimbabwean body itself in often rapidly changing contexts. They will continue to do so for a long time.

¹ Letter to the Editor, *Herald*, July 6, 1999.

² Words to this effect were used by faith healers in Chapter Eight to refer to Tichafa's blood.

³ Summarized from a standard handbook for Tanzanian health workers, *Communicable Diseases*, African Medical and Research Council, Nairobi, 1978, and from Jones and Wasserheit 1991.

⁴ *Herald*, June 5, 1999

CONCLUSION

In this ethnographic and historical study of n'anga, or traditional healers, in Zimbabwe, I have endeavored to demonstrate how healers' sense-making of HIV/AIDS is complex and shifting, finding different meanings in different social contexts. My principal interest has been to demonstrate that their sense-making of the disease, and responses to it, is inextricably tied to broader social forces which, in turn, are integral in the constitution and construction of local practices and processes.

To understand these complex relationships, I have utilized a political economy of health perspective, conjoined with epidemiology, demography, and an interpretive anthropology. In particular, I suggest that the multiple meanings given to AIDS by healers serve not only as a critique of "modernity" and the many real and imagined ills attached to it (moral, material, and the like); such meanings also suggest the ways in which healers reject, refashion, or accommodate modernity to meet their own needs and the needs of their patients. It is through such often invisible action on the world that healers demonstrate their creativity and agency in the face of a runaway disease.

Though my findings regarding urban-based healers in Harare reflect a particular group of people, place, and time, such findings demonstrate the overall importance of a historically-informed political economy of health analysis that clearly illustrates how international and national conceptions of health development come to impact practices and processes at the local level. In Harare, efforts at involving healers in the formal health care delivery system have been shaped by historical practices, both legal and social, that have implications for the degree to which healers involve themselves (or are involved) in formal health development.

In this sense, this ethnography raises three key points. First, healers are very much subjects of their own histories, active agents, with complex linkages to translocal institutions, actors, and ideas. Second, structural violence has been an historically given reality of Zimbabwe at least since colonial times, and healers draw upon this history as part of their sense-making of HIV/AIDS. Third, even as individuals and institutions find ways of resisting or refashioning oppressive social forces, there are certain groups that find this task difficult, if not impossible. This is particularly the case for women, and this has implications for their level of risk for HIV infection. Healing as a profession and healers as a group are implicated in the subordinate status of women and, thus, analysis of both healing and healers may offer insight into ways of ameliorating this situation. Finally, attention to these three intersecting points may help inform strategies for more realistically and equitably involving healers in health development.

In the following discussion, I elaborate on these three points.

The Global in the Local: Agency and Healers

Healers' readings of AIDS as arising from the conditions of modern life where misfortunes take on new and novel meanings is consistent with their role as repositories of local forms of morality in the face of apparent cultural erosion. In turn, their responses to the disease, while certainly not predictable, do take on a certain kind of intelligibility when viewed through an historical lens. Legal, economic, political, and social structures developed and deployed by missionaries, the settler state, the post-colonial state, and even healers themselves have shaped these responses without necessarily determining them. This relationship—that is between the actions of healers, both individually and collectively, and the social context in which these actions find expression—illustrates in

very concrete detail the relationship between structure and agency. Moreover, this relationship reveals that broader social forces are integral in the constitution and construction of the “local” (cf. Marcus and Fischer 1986).

Healers’ actions, while certainly circumscribed by various structures--legal, ritual, medical, economic--are also “inherently social, in which dominant and emergent trends in global systems of political economy are complexly registered” (Marcus and Fischer 1986:78) in practice. The Yale-trained traditional healer, John Maeresere, offers a cautionary tale for those of us who would too quickly label healers as not having complex ties to wider social, economic, and political realities. Likewise, the *zvivarunga* found in the Ndau communities on both sides of the Zimbabwean-Mozambican border who represent white European spirits, though channeled through black mediums, also represent the implication of the global in the local. This suggests, then, that the “local” and the “global” are not necessarily socioculturally discrete systems violently brought into relationship (though violence has indeed been a characteristic of their confluence), but rather they are systems already constituted relationally, entering new relations through historical processes. In this sense, healers’ practices reflect, to quote Comaroff and Comaroff (1999:294) how it is that “human beings construct their intimate, everyday life worlds at the shifting intersections of here, there, and everywhere.”

Part II of the dissertation provides insight into the agentive qualities of individual healers and one of their institutions, the Zimbabwe National Traditional Healers Association (ZINATHA). Despite the very real structural violence perpetrated on healers by early missionaries, colonial administrators, and their post-colonial counterparts, healers have managed to carve out a very important space for themselves with regard to health service delivery, being recognized both locally and translocally for this role. This

role has, however, been one fraught with ambiguity. Missionary and colonial discourses surrounding n'anga sought to depict them as detrimental to health care delivery, as obstacles to health development, and as dangerous subjects. Healers, in turn, responded to these discourses, organizing themselves into professional associations and availing themselves of many of the same structures used to oppress them in the first place. And while such organization might be generally viewed as the appropriate response to assaults on their craft, it has not been without its own sets of problems.

Such problems are evident in Part III of the dissertation. For example, as ZINATHA continues its efforts at professionalization—in developing a medical school, in bottling and labeling materia medica, etc.—it begins to delink African vernacular medicine from its original social context, much as a Western-derived health development process has, as well. So, even as healers respond to ‘modernity’—and HIV/AIDS is certainly implicated in this—in creative and constructive ways, this, too, causes its own sets of problems with which they have to constantly contend. When does ‘traditional’ medicine become ‘Western’ medicine? Are such distinctions, such dichotomies, even supportable or relevant anymore in this postmodern moment? And finally, what role should healers have in managing this misfortune known as AIDS?

“Modernity” and “tradition” as the archetypal opposite poles of the global and the local, of present day and past history, of progress and backwardness are often consciously constructed and serve heuristic purposes for the actors involved in their construction.¹ These constructs seldom reflect an empirical reality. Attention to history demonstrates that local Zimbabwean realities have always been implicated in larger global forces and processes. Since the times of contact with Europeans, healers have availed themselves of

dynamically changing understandings of disease and illness as well as changing sociocultural practices. These understandings, in turn, inform their management of misfortune, broadly defined. This points to the inherent negotiability of African vernacular medicine as a pervasive feature of social, medical, and ritual processes. In thinking about African vernacular medicine, and healers' roles in combating a deadly epidemic, we need to begin with historical and anthropological literature which represents both as social process, healing and disease as subject to multiple meanings, and diagnosis and treatment as open-ended and multidimensional rather than single-stranded and definitive. Such open-endedness and ambiguity allow healers room to negotiate the multiple meanings of HIV/AIDS as well as treatment strategies for the disease.

The tension throughout this study has been that of illustrating how the contemporary responses of n'anga to HIV/AIDS are the products of a historical legacy of resistance and accommodation to missionary and colonial forms of control as well as health development. The evidence presented in the dissertation suggests that, contrary to much popular thinking, healers and their practices are not decipherable through self-contained, ahistorical frameworks. Rather, their responses to the disease are only made intelligible through the realization that these practices and responses to misfortune have always been in *flux*, a dialectic of accommodation and resistance to broader forces that are implicated in both local and non-local contexts, in the construction of "modernity" and "tradition."

Structural Violence

Such creativity and agency is important from a theoretical perspective as well, especially with regard to structural violence. As Part I of the dissertation demonstrated, structural violence has been an historically given reality of Zimbabwe at least since colonial times,² where black Africans were often denied the fruits of scientific and social progress. The poor diets, squalid living conditions, and often taxing working environments directly impacted the health of African workers while, at the same time, health services were denied them. As long as there was an ample pool of labor, there was no real incentive for European settlers to reduce diseases among this population. Such trends, of course, continue today as the ruling government becomes more embattled, more corrupt, and more predatory in the face of a viable opposition movement. In this way, structural violence directs our attention to how, in a very literal sense, these wretched living and working conditions come to be embodied as biological events and increase people's risk for HIV infection.

Chapters Four through Eight of the dissertation, in part, illustrated how HIV/AIDS may be viewed as a metaphor, a microcosm, of the exceptional suffering of the collective Zimbabwean body, a body being consumed by virulent strains of economic, political, and social insecurity. Structural adjustment policies, introduced in 1990/91, and governmental corruption and mismanagement have done much to erode the living and health standards of many Zimbabweans: skyrocketing inflation and interest rates, astronomical increases in the prices of basic goods as well as translocally-produced medicines, have done much harm to the average Zimbabwean. The health care delivery system has been particularly hard-hit. This situation has, in turn, shaped the trajectory of HIV/AIDS. As I argued earlier, the disease is particularly devastating under conditions

of poverty, gender discrimination, and economic insecurity. The disease's impact on Zimbabweans is made worse because health systems cannot meet health needs, because household resources are depleted or non-existent. Government mismanagement and corruption as well as economic structural adjustment have become conjoined in undermining the standard and quality of life for many Zimbabweans, in many cases placing them at increased risk of infection for HIV. For those already infected, the public health system can offer little comfort.

With the already over-taxed formal medical system on the verge of collapse, there are very few other options available to the average Zimbabwean as he or she confronts a deadly disease—that is, other than seeking n'anga for treatment. Such treatment-seeking behavior, the pragmatics of choice, has been an historical feature of medical pluralism in Zimbabwe and, indeed, much of Africa. The ability to seek multiple, and sometimes overlapping, health care options speaks to the great flexibility and agency with which Zimbabwean patients act. From a theoretical perspective, of course, an overly narrow use of structural violence to account for the abysmal state of affairs in Zimbabwe (particularly regarding HIV/AIDS) does not account for the tremendous agency with which people either respond to, and in some cases, contract, HIV/AIDS. Thus, I have stopped short of completely embracing a framework that privileges structural violence over the agency of individuals and institutions.

Even in the face of structural violence, people are often more than passive victims. Sense-making of structural violence and misfortune may also be seen as a form of agency, a form of acting upon those forces that may often seem beyond being acted upon. Local moral demographics, for example, which attribute the creation or

dissemination of HIV/AIDS to powerful outsiders is a rhetorical attempt to refashion discourses that often place the sole responsibility of the disease on its very victims. At the same time, as a review of southern African history reveals, such explanations may also have some legitimate basis in truth. As I have illustrated throughout the dissertation, HIV/AIDS constitutes multiple and changing realities, both biological and symbolic. While the war against the biological manifestations is largely being lost, the rhetorical battle over its meaning and origins still hangs in the balance. Such struggles over meaning, of blame and accusation, provide one of the few arenas for individuals to perform their agency.

Silenced Agents: Women and the Structure of Risk

Where agency is less visible, however, is in the plight of Zimbabwean women, and particularly poor women. This has particular implications for their level of risk for HIV and how, once infected, women are treated by the wider society. Because of the subordinate and vulnerable socioeconomic status of women and girls, they may find it difficult to resist sexual overtures of men. Resistance to such advances, or efforts to redress non-consensual sexual intercourse on the parts of women, is usually met with violence by the male perpetrators and occasionally by the woman's (or her partner's) family. Indeed, I have attempted to illustrate in concrete detail the tremendous violence directed at women that suffuses Zimbabwean society. The domestic violence some women are subjected to is made worse by the possibility of HIV infection at the hands of an abusive husband or partner. Often, women find themselves involved in a cruel calculus: faced with divorce or dire poverty on the one hand and the risk of HIV infection

on the other, the choice is one of “social death” or biological death. Such physical and social violence is part of a larger matrix of systemic societal violence directed at women and enshrined in such practices as the male interpretation of customary law (cf. Chanock 1998).

Women are victimized in other, less explicit, ways as well. From a research standpoint, particularly from epidemiological and public health perspectives, women have often been cast as “core transmitters” or as a “core risk” in the spread of HIV/AIDS. Sentinel surveillance on pregnant women, utilized to chart the course and impact of the epidemic, means that they may often be the first identified as HIV-positive. Likewise, a sick child (whose sickness is later determined to be HIV) often signals a sick mother, though she herself may be asymptomatic. This reinscribes the notion that women are responsible for the poor health status of their children. Moreover, such public health discourses become coupled with folk discourses, often feeding into and intensifying ongoing extant power asymmetries.

Healers are certainly implicated in this process. As arbiters of social custom, and the repositories of local histories, healers are charged with upholding historically buttressed readings of personal conduct and morality, particularly in the advent of translocal forms of incursion: a globalizing economy, new configurations of transnational power and control, and promethean flows of information and technology. The moral dimensions of healers’ readings of HIV/AIDS hold special significance for women. Those understandings that see the disease as the end result of having breached social custom often cast women as the guilty parties. Women, as we saw in Chapter Seven, are often held to a higher moral standard than men--they are the guardians of morality and, in

a sense, culture.³ Disease, particularly STDs and HIV/AIDS, signals disordered structure, a breakdown in the natural and supernatural ordering of reality. For clinical and public health reasons, as discussed above, HIV/AIDS is usually first detected in women. Thus, the public health and medical understanding of the disease becomes coupled with folk understandings and women are blamed as the primary vectors of the disease.

Though the above discussion would seem to point to the notion that healers as a group enjoy a level of agency not afforded to women as group, this would be an oversimplification of the reality on the ground. In fact, the majority of healers in Zimbabwe *are* women. The irony of this reality is not lost on me. If the majority of women in Zimbabwe lack agency and, yet, the majority of healers are women, that is a class of people who seem to enjoy a level of agency, how can we make sense of this situation? First, I would argue that the vast majority of women in Zimbabwe are *not* healers. Of a country with a population of about 13 million, there are some 50,000 healers, almost two-thirds of whom are women. This represents a small overall sample of women. Second, healers, as a specialized group of ritual and medical experts, enjoy a level of status and protection not afforded to the majority of the population. They enjoy a level of agency not available to most women. Finally, this underlines the fact that healers' identities are multiple. As a ritual-medical expert, a healer may be a spirit medium as well as an herbalist or a traditional birth attendant as well as a bone caster. In these different capacities, they may draw on different sets of skills, with different sets of outcomes. Thus, the flexibility of identity healers enjoy may also allow for increased agency. Though perhaps impossible to prove, women may indeed be drawn to healing as

a way of actualizing and performing agency.⁴ Healing is, after all, one of the few professions in which women enjoy an increased ability to act on the world.

In this study, I have attempted to develop a conceptualization of Zimbabwean healers and their responses to a deadly disease using a historically-informed analysis. This inductive approach, while methodologically cumbersome, is necessary given the very real need to examine critically the degree to which assumptions underlying standard health development paradigms accurately reflect Zimbabwean historical and social realities. For example, health development training workshops on STDs and HIV/AIDS implicitly insist that healers accept that whole areas of their experiences and practices are at best irrelevant, and at worst, harmful, to the development process. This is not only a disservice to those healers who are making great strides in treating some of the symptoms of HIV/AIDS, it also further alienates healers as potential collaborators in fighting the epidemic. Workshops based on distorted ideas of what healers do face great challenges in their ability to influence their actual practices. One of the ways ideas about who healers are and what they actually do can be ascertained is through an interpretive anthropology that is accountable to history and political economy.

AIDS, as we have seen, is much more than a medical condition—it is a barometer, as well as sign, of the great historical and symbolic suffering afflicting Zimbabwe and its people. Attributing meaning to the disease in such a context, attempting to answer for their patients the “why me?” question, lifting the burden of blame from patients’ shoulders and resting it, at least in part, on history and on structures of violence—all of these efforts speak to the great care with which healers manage this misfortune known as AIDS. In the absence of affordably-priced AIDS and accessible

drugs and care, the efforts of healers are all that desperate and afflicted patients have to hold on to. Granted, there are some individuals who engage in charlatanism, posing as healers to take advantage of desperately ill people. This, however, I would argue is the exception rather than the rule.

In the above sense, then, healers have a central role to play in efforts to combat HIV/AIDS in Zimbabwe. While the terms of their engagement with health development strategies are still being developed and debated⁵, healers nonetheless represent key collaborators in the fight against AIDS, particularly in the absence of other forms of intervention. And we ignore them at our own peril.

¹ Some particular purposes are discussed in Chapter Fourteen.

² This may have been the case in pre-colonial times as well, particularly with regard to the status of women and children.

³ Interestingly enough, as pointed out in Chapter Fifteen, the majority of healers in Zimbabwe are women. If healers, then, are the guardians of “tradition,” this means that a majority of these guardians are indeed women.

⁴ Theoretically, of course, few healers “choose” their professions; rather, they are “chosen” by the spirit world for the healing profession.

⁵ For an overview of the role of healers in health service delivery, please refer to Chapter Twelve.

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