

**Navigating Indigenous Resources that can be Utilized in Constructing a Karanga
Theology of Health and Well-Being (*Utano*): An Exploration of Health Agency in
Contemporary Zimbabwe**

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Abstract

Health and well-being are the central concerns for most African people. If health and well-being (*utano*) is the top priority for most Africans, the general and almost complete breakdown of the Zimbabwean public health care system in the past decade (2000-2010) has had far-reaching repercussions on the whole populace. Whereas African theology and religious studies have expended considerable energy in addressing the theme of health and well-being, there have been limited attempts at developing indigenous theologies. This study plugs the gap in the available scholarly literature by proposing a Karanga theology of health and well-being paying particular attention to a specific community's responses to the health delivery systems in Zimbabwe. Through an examination of indigenous responses to health and well-being and critiquing the collapse of the health delivery systems in the period 2000-2010, the study argues that understanding health agency in contemporary Zimbabwe enables appreciating the centrality of *utano* (health and well-being). This study also seeks to establish the agency of the community in responding to the national health care crisis, focusing specially on the Karanga community in Murinye district. It explores the Karanga healthworlds and documents the agency of the Karanga health-seekers and health-care providers in responding to the health-care crisis. The major focus of the study is to establish how the Karanga navigate the existing religious and medical facilities (Modern scientific bio-medicine; Traditional healing and Faith-healing) in their search for healing by conducting fieldwork research which entailed the use of interviews and participant observation. The study was also influenced by oral theology based on the community's underlying faith experiences. It also relied upon the life history approach and narrative theology to establish trends and patterns in the Karanga medical system. The study concludes by exploring some useful and life-giving Karanga indigenous resources that can be utilized in constructing a Karanga theology of health and well-being in contemporary Zimbabwe. A Karanga theology of *utano* places emphasis on a liberative motif which is life-giving and life-enhancing. This includes acknowledging the agency of health-seekers who are actively involved in their own welfare. It argues that *utano* is achieved when, on the basis of indigenous beliefs and Christian beliefs regarding health, individuals and families invest in refusing to accept ill-health. Information drawn from study participants demonstrated how they sought the opinions of traditional healers, prophet healers and modern health practitioners whenever they felt that their condition was compromised. The study foregrounds the fact that for the Karanga people, issues of health and well-being cannot be separated from their religious perspectives. There are diverse religious traditions among the Karanga people and these inform their understanding of *utano*. As such, the three health delivery systems should not be viewed as competitors for clients but more importantly, they should be viewed as complementing each other.

DECLARATION - PLAGIARISM

I, Sophia Chirongoma declare that:

1. The research reported in this thesis, except where otherwise indicated, is my original research.
2. This thesis has not been submitted for any degree or examination at any other university.
3. This thesis does not contain other persons' data, pictures, graphs or other information, unless specifically acknowledged as being sourced from other persons.
4. This thesis does not contain other persons' writing, unless specifically acknowledged as being sourced from other researchers. Where other written sources have been quoted, then:
 - a. Their words have been re-written but the general information attributed to them has been referenced
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Name of Student: Sophia Chirongoma

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Date:

Acknowledgements

There is no doubt that this work would not have been possible without the support and participation of a number of key players.

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I am thankful to the Almighty God for the privilege and blessing of belonging to an amazing family filled with abundant love, support, tenacity, perseverance and placing such a high value on academia. Without my family I would not even have dreamt of getting this accomplishment. I do not have adequate words to express my gratitude and appreciation for the support rendered by my entire family and their spurring me on to see this work to completion.

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Dedication

This work is fondly dedicated to the blessed memory of my parents Ethiel and Constance Chitando and to my mentor Steve de Gruchy. My heartfelt wish is that you were all here to finally see the fruits of your labours and I sincerely hope that I have done you proud.

Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ARHAP	African Religious Health Assets Programme
ARV	Antiretroviral
BSAC	British South Africa Company
CFU	Commercial Farmers' Union
DRC	Democratic Republic of Congo
DRC	Dutch Reformed Church
ESAP	Economic Structural Adjustment Programme
FOSENET	Food Security Network
GNU	Government of National Unity
HBC	Home-Based Care
HDI	Human Development Index
HIV	Human Immunodeficiency Virus
IMF	International Monetary Fund
LMS	London Missionary Society
MDC	Movement for Democratic Change
MOH	Ministry of Health
NDP	National Democratic Party
NGO	Non-Governmental Organisation
PHC	Primary Health Care
PHR	Physicians for Human Rights
PLHIV	People Living with HIV
RHAs	Religious Health Assets
SDA	Seventh Day Adventist
SRANC	Southern Rhodesia African National Congress
STIs	Sexually Transmitted Infections
TB	Tuberculosis
UDI	Unilateral Declaration of Independence
UNICEF	United Nations Children's Fund
VHW	Village Health Worker
ZADHR	Zimbabwe Association of Doctors for Human Rights
ZANUPF	Zimbabwe African National Union Patriotic Front
ZAPU	Zimbabwe African People's Union
ZCC	Zimbabwe Council of Churches
ZCTU	Zimbabwe Congress Trade Union
ZINATHA	Zimbabwe National Traditional Healers' Association
ZLHR	Zimbabwe Lawyers for Human Rights
ZNNP+	Zimbabwe National Network for People Living with HIV/AIDS

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Chapter One

Introducing the Study

1.1 Introduction

Whereas African theology and religious studies have expended considerable energy in addressing the theme of health and well-being, there are limited studies which attempt to develop indigenous theologies based on a particular community's perspective of health and well-being. This study attempts to fill the gap in the available scholarly literature by proposing a Karanga theology of health and well-being and paying particular attention to a specific community's responses to the health delivery systems in Zimbabwe. Through an examination of Karanga indigenous responses to health and well-being and critiquing the collapse of the health delivery systems in the period 2000-2010, the study argues that in order to understand health agency¹ in contemporary Zimbabwe, the notion of *utano* (health and well-being) is central. In doing so, a shift towards African traditions in the study of religion as propounded by Adogame, Chitando and Bateye² is encouraged. The study offers fresh insights into interpretations of health and well-being through examining the actions of individuals and communities in a challenging socio-economic environment such as the current situation in Zimbabwe. In addition, it contributes to the discourse within African theology and religious studies by presenting useful resources that can be utilized in constructing a Karanga theology of health and well-being (*utano*).

¹ In this study, the meaning of the term 'agency' is derived from the African Religious Health Assets Programme (ARHAP) vocabulary and it is therefore used to denote "the capacity to 'do', to move into action, to utilize the assets one has, to seek and achieve desired goals, as affected by social and environmental conditions. In the context of dramatic health challenges such as HIV and AIDS (and conditions of poverty), human communities have assets and the capacity to exert agency. Agency rests within individuals, but even more so in communities, organizations. The common assumption that "poor people are 'not able to do' is untenable. Poor people are always engaged in strategies and struggles for survival, adaptation and freedom." BETTER WORDS: IRHAP WORKING GLOSSARY "How do we find a common framework with which to pursue research, policy, and interventions between religious and public health leaders?" http://www.arhap.uct.ac.za/words_words.php [Accessed 25 October 2013]. Throughout the study, the term agency is therefore used to emphasize that the Karanga people are active participants in searching for and provision of health and well-being.

²Adogame, Chitando and Bateye (2012) *African Traditions in the Study of Religion in Africa: Emerging Trends, Indigenous Spirituality and the Interface with other World Religions* (Ashgate: Ashgate Publishing Limited).

1.2 African *Healthworlds*³ as an Indigenous Resource for Health and Well-Being

Health and well-being are the central concerns for most African people. To the traditional African, no illness or misfortune happens through sheer coincidence. Everything happens for a reason and requires an explanation that can only be adequately provided by the traditional diviner.⁴ This attitude is embedded in the African understanding of human existence which is viewed as a communal form of existence. This perspective is also influenced by the African understanding of life. "Life is regarded as a sacred gift from God; hence, the affirmation of life is central in African societies and all forms of life must be promoted and preserved."⁵ According to Jean Marc Ela, "an analysis of the socio-economic indicators of health in Africa reveals the mechanisms that enclose humanity in a circle of misery and sickness."⁶ For Ela, Africans are more and more preoccupied by social problems, the challenge of daily life crowd in on believers and research has established that health is their priority (75%) even before family (48%) or job security (33%).⁷ Writing particularly about the Karanga people, Tabona Shoko concurs with Ela, in the following words; "The Karanga enjoy peace of mind when their state of health is in good condition. Health involves physical and spiritual states. Absence of illness and disease bring relief and joy..."⁸

³ The use of the term healthworld is derived from ARHAP research and it refers to "people's conceptions of health and their health-seeking behaviour as framed by the background store of inherited or socialised knowledge that defines their being in the world. It is shaped by the health policies of governments, the variety of health practices available to them, and the interaction between health and religious practices, as well as questions of social development and environmental realities" BETTER WORDS: IRHAP WORKING GLOSSARY "How do we find a common framework with which to pursue research, policy, and interventions between religious and public health leaders?" http://www.arhap.uct.ac.za/words_words.php [Accessed 25 October 2013]. See also Paul Germond and James R. Cochrane, "Healthworlds: Ontological, Anthropological and Epistemological Challenges on the Interface of Religion and Health," in *Reasons of Faith: Religion in Modern Public Life* (University of Witwatersrand: Wits Institute for Social and Economic Research (WISER), 2005); James R Cochrane "On Healthworlds". WHO Seminar, Washington DC. 8 Feb 2007. Based on a paper presented at the Annual Meeting of the American Academy of Religion, *Panel on Religion, Health and Social Justice: African Perspectives on a Global Issue*, 18-21 Nov 2006, Washington D.C.; ARHAP. 2006.

"Appreciating assets: The contribution of religion to universal access in Africa." Cape Town: Report for the World Health Organization, African Religious Health Assets Programme; Thomas, L., B. Schmid, M. Gwele, R. Ngubo, and J.R. Cochrane. 2006. "Let us embrace: The role and significance of an integrated faith-based initiative for HIV and AIDS." Cape Town: (ARHAP) African Religious Health Assets Programme.

⁴The traditional diviner is known as *n'anga* among the Karanga-Shona in Zimbabwe.

⁵ For more information on this, See Manda (2006) *South African women's health with specific reference to HIV/AIDS. An ethical enquiry into the importance of the African ethic of Ubuntu and traditional African healing systems in a search for psychosocial and spiritual well-being*, Pietermaritzburg: University of KwaZulu-Natal, (Unpublished PhD Thesis).

⁶ Ela J. M. (1989) *African Cry* (New York: Orbis Books), 67.

⁷ Ela J. M. (1989) *African Cry*, 67.

⁸ Shoko T. (2007) *Karanga Indigenous Religion in Zimbabwe: Health and Well-Being* (Ashgate: Ashgate Publishing Limited), 35.

Shoko proceeds to explicate that “...the Karanga are preoccupied with the desire to preserve health and well-being...and to restore it when a breakdown in general fortune occurs in a world that is potentially dangerous and populated by forces of evil.”⁹

If health and well-being (*utano*) is a priority for most Africans, the almost complete breakdown of the Zimbabwean public health care system in the past decade has had far-reaching repercussions on the whole populace. The field work of this study, therefore, sought to establish the agency of the community in responding to the national health care crisis, focusing specially on the Karanga community in Masvingo province, particularly Murinye district of Zimbabwe.

This study contributes to wider discussions around health agency and health assets stimulated by the African Religious Health Assets Programme (ARHAP).¹⁰ With African researchers and practitioners at the centre, ARHAP seeks to “develop a systematic knowledge base of religious health assets (RHAs) in sub-Saharan Africa.”¹¹ ARHAP also endeavours to assist in “aligning and enhancing the work of both religious health leaders and public policy makers in their collaborative effort to meet the challenge of disease, e.g. HIV and AIDS; and hence to promote sustainable health, especially for those who live in poverty or under marginal conditions.”¹² It reiterates that this interface and complexity should be embodied in policies and practices that generate an alignment of best practices between health systems and religious bodies, initiatives or institutions. ARHAP sees this approach as “both a strategic and a development imperative for public health systems if health interventions are to be *sustainably* and *deeply embedded* in local communities.”¹³

⁹ Shoko T. (2007) *Karanga Indigenous Religion in Zimbabwe*, 139.

¹⁰ It is significant to note that the author is aware that in 2012, ARHAP subsequently changed its name to IRHAP (International Religious Assets Programme) in order to more properly reflect the expansion of its interests and partners. However, throughout this study, reference will be made to the term ARHAP because the study commenced during the time when it was still ARHAP.

¹¹ See ARHAP (2006) *Appreciating Assets: The Contribution of Religion to Universal Access in Africa*; de Gruchy S (2003) *Of agency, assets and appreciation: Theological themes for social development*; Gunderson GR (1998) *Aligning assets for community health improvement: Building on enduring strengths of faith groups and health sciences*; Kretzmann J and McKnight J.L. (1993); *Building communities from the inside out: a path toward finding and mobilizing a community's assets*; Kretzmann J and McKnight JL (2002) *Assets-based strategies for faith communities*.

¹² ARHAP (2006) *Appreciating Assets: The Contribution of Religion to Universal Access in Africa* available on www.arhap.uct.ac.za [Accessed 20 April 2009].

¹³ Thomas L., Schmid B., Gwele M., Ngubo R. and Cochrane J.R. (2006) “Let us embrace: The role and significance of an integrated faith-based initiative for HIV and AIDS.” Cape Town: (ARHAP) African Religious Health Assets Programme. [Emphasis, Mine]

Building on the research undertaken by ARHAP, this study endeavours to highlight the need for policy makers in Zimbabwe's public health care system to adopt the same approach and incorporate local communities' perceptions of health and well-being and their responses to ill-health. With a particular focus on Karanga healthworlds (*utano*), this study affirms the following assertions made by ARHAP:

Health-seekers in an African context more often than not work with and live out of a conception of the body that is not limited to the physical individual entity... This has a direct impact, then, on how people seek health, what they will regard as "more healthy" (it may be that their individual body takes second place to what they perceive as the health of the family or community, for example), and how they respond to interventions by others.¹⁴

This study thus endeavours to foreground the agency of the Karanga community in accessing and facilitating health care in Murinye district. It seeks to assert that the Karanga people are not just passive recipients of medical care but they are also active participants in seeking health care, especially their utilizing multiple health care providers as well as providing health care through indigenous remedies such as traditional medicine and faith-healing.

1.3 Research Questions and Objectives

The study thus seeks to answer the following research questions:

1. What is the Karanga view of health and well-being?
2. What are the health options available in the rural areas of Masvingo province, Zimbabwe?¹⁵
3. To what extent are the three health care systems [Modern scientific bio-medicine; Traditional healing and Faith-healing] integrated in providing holistic health-care? Do they co-operate in their care-giving endeavours? Or is the work of the different areas of health care in conflict [Complementary/Confrontational]? If so, how and why? Are the three health-care systems strange bedfellows with attitudes of antagonism towards each other or there is mutual cooperation?
4. What key socio-economic and political factors influence Karanga people's health negatively and positively?

¹⁴ Thomas L., Schmid B., Gwele M. Ngubo R. and Cochrane J.R. (editors) (2006) "Let us embrace..

¹⁵ The case studies were conducted in Murinye district which is located in Masvingo province.

5. How are health-seekers responding to the health-care crisis, i.e. how do individuals, families and communities harness their agency to negotiate the different health delivery systems?
6. What are their views regarding the use of multiple health-care systems?
7. In times of crisis, people turn to religion for solutions; for the Karanga when it comes to the crunch, they often resort to their indigenous healing systems. In view of such a scenario; what would an indigenous Karanga theology of health and well-being (*utano*) look like?
8. What are the available resources within the Karanga context [e.g. the agency of the health-seekers and health care providers] that can be utilized to develop a system of health care that would cater effectively and holistically to the Karanga people's healthworlds (*utano*) in view of the current health-care crisis?

These research questions are foundational to the following objectives of the study:

1. To explore Karanga healthworlds i.e. to understand contexts and worldviews which influence their healthworlds.
2. To establish and document the agency of the Karanga health-seekers in responding to the health-care crisis i.e. how do the Karanga navigate the existing religious and medical facilities [Modern scientific bio-medicine; Traditional healing and Faith-healing] in their search for healing?
3. To draw out some useful and life-giving Karanga indigenous resources that can be utilized in constructing a Karanga theology of health and well-being in contemporary Zimbabwe.

1.4 Research Methodology

In the first instance, this study undertook a literature review in order to establish the African understanding of health and well-being (healthworlds) generally, and more specifically the Karanga understanding of well-being. This included the use of secondary sources such as published books, journal articles, government documents, monographs and newspaper articles. Second, the study drew insights from oral theology. Oral theology is primarily theology done from below. It “refers to the varied religious expressions of an oral community

based on their underlying faith experiences.”¹⁶ “Oral theology is first developed from an emic perspective while systematic theology is done from an etic perspective. Oral theology is applied; context based, and answers the most important questions about life in that culture.”¹⁷ This study was conducted utilising the emic perspective; the research participants were the key sources of information regarding their understanding of health and well-being. An exploration of the Karanga health-seeking strategies and health-care provision was based on the expositions provided by the participants’ lived realities gathered through interviews and participant observation.

Third, extensive field work was carried out and the use of primary sources such as semi-structured interviews and participant observation was carried out. Fieldwork in Murinye district was conducted to ascertain the Karanga conception of *utano* (health and well-being) and also to establish ways in which people responded to the health care crisis (agency), particularly their utilization of multiple health care providers as well as providing health care in terms of indigenous remedies such as traditional medicine and faith-healing. Semi-structured interviews were conducted among health seekers and health care providers. The participants were selected through the use of the snowballing sampling technique. The study participant sample was as follows: The health care providers were divided into three categories: Bio-medical practitioners (represented by nurses from the two local clinics, Mashenjere and Shonganiso clinic); Faith/Prophet healers (represented by healing prophets within the Zionist fold who rely on the healing power of the Holy Spirit) and Traditional healers (represented by indigenous healers who make use of traditional medicine or herbs and rely on ancestral resources). There were five respondents from each group, i.e. interviews were conducted with five bio-medical practitioners; five nurses and five prophet healers based in Murinye District in Masvingo, highlighting how health-seekers are navigating these three systems. Information was drawn through semi-structured interviews with key informants as well as participant observation during healing rituals. During the healing rituals, information was gathered from both health seekers and health-care providers. The profile of the fifteen health-care providers is as follows; eight were females and seven were males. Within their categories the numbers are as follows:

¹⁶ Naudé P. (1996) "Theology with a New Voice? The Case for an Oral Theology in the South African Context," *Journal of Theology For Southern Africa* 94: 23

¹⁷ Casey A "The use and limitations of oral tradition in the New Testament and the implications for theology in oral contexts today" <http://culturnicity.files.wordpress.com/2011/04/sufficiency-of-oral-theology-post.pdf> [Accessed 20 August 2012]

- Prophet-Healers (4 male and 1 female) - these are healers who rely on the healing power of the Holy Spirit, although in their diagnosis they seem to dwell more on socio-cultural and spiritual causes of ill-health.
- Traditional-Healers (2 male and 3 female) - they are indigenous healers who make use of traditional medicine and herbs, and draw from the ancestral resources - their diagnosis hinges around socio-cultural and spiritual causes.
- Nurses (1 male and 4 female) - they rely on western bio-medicine and their focus is more on the environmental and physical causes of ill-health.

For the health-seekers, semi-structured interviews were conducted among three groups of people, Zionist Christians (ten participants), Seventh Day Adventist Christians (ten participants) and those who sought healing from traditional healers (ten participants). The profile of the health-seekers was as follows:

- Patients at the Prophet-Healers (4 male and 6 female) - all the ten participants were Zionist Christians. The deliberate choice of Zionist Christians was made particularly because some conservative Zionist churches only accept the use of faith-healing from their prophet healers. Utilizing any form of western bio-medicine or traditional medicine is regarded as anathema within such Zionist Christian circles. In some instances, women are forbidden from using contraceptives or accessing maternal health-care and their children do not receive immunization. This study was therefore trying to establish how the Zionist Christians in Murinye navigate the three health delivery systems in light of their religious background.
- Patients at the two local clinics (4 male and 6 female) - all the ten participants were Seventh Day Adventist Christians. This particular choice was made because the Seventh Day Adventist doctrine only accepts western bio-medicine and members of the church are encouraged to follow a healthy life-style through observing a nutritious diet. Consulting traditional healers or prophet-healers in search of *utano* is strictly forbidden by the church. This study endeavoured to investigate whether or not the Seventh Day Adventist Christians in Murinye are conforming to their church doctrine in making decisions about utilising the three health delivery systems.
- Patients at the Traditional-Healers (4 male and 6 female), these were selected by virtue of the fact that they utilize traditional medicine in their quest for *utano*. However, it is interesting to note that because Zimbabwe is a predominantly Christian

country,¹⁸ most of these participants were members of some Christian denomination. The focus on this particular group was to establish whether they rely on traditional medicine only or they also make use of the other two health delivery systems.

Both health-seekers and health-care providers were asked questions regarding their personal and also their communities' health-seeking behaviour, i.e. did they rely on only one health-care provider or did they sometimes utilize two or three health-care systems simultaneously and why was that the case? The case studies conducted in this study reveal that most health-seekers utilise multiple health care providers and all the health-care providers interviewed expressed openness to the interchangeable use of the three health-care systems.¹⁹ The fieldwork research also explored the Karanga indigenous notions of well-being, showing that for the Karanga, religion and health are closely related as illustrated by the case studies whereby prophet healers are blending indigenous traditions and Christian concepts in their healing ministry.

A life history approach was employed to establish trends and patterns in the Karanga peoples' utilisation of the three medical systems. Dhunpath and Samuel explain this approach as follows, "life history research captures 'lives as experienced.' It provides the qualitative interpretation individuals make of their lived circumstances and events. It shows how individuals make meaning of their lives. Its interpretivist and phenomenological roots are evident".²⁰ In particular, the life history approach places emphasis on in-depth analyses of the life histories of research participants in order to appreciate the challenges and opportunities available to individuals and families.²¹ As Kakuru and Paradza highlight, this is a very helpful approach as it enables the research to have a qualitative understanding of a participants' life.²² This was particularly important as issues of health require confidentiality

¹⁸ According to an online source in 2012, statistics reveal that approximately 85% of Zimbabweans confess to be Christian. For more information see "Religion in Zimbabwe" <http://relzim.org/major-religions-zimbabwe/> [19 November 2013].

¹⁹ Depending on the nature of the illness or at times the availability of health facilities/providers, some patients utilize all the three facilities concurrently e.g. one can first seek health care at the clinic and from there they visit either the faith-healers or traditional healers and in other cases they consult both.

²⁰ Dhunpath R and Samuel M. (2009) 'Introduction' in Dhunpath R and Samuel M (eds) *Epistemology Methodology and Representation* (Rotterdam: Sense Publishers), x.

²¹ Samuel M. (2009) 'On becoming a teacher: Life history research and force-field model in teacher development' in Dhunpath R and Samuel M (eds) *Epistemology Methodology and Representation* (Rotterdam: Sense Publishers), 4.

²² Kakuru D. M & Paradza G. (2007) Reflection on the use of life history method in researching rural African women: Field experiences from Uganda and Zimbabwe *Gender and development* 15(2), 287-297.

and sensitivity. As a result, I sought to establish close relationships with the study participants in order to access valuable information relating to their understanding of health, as well as the choices that they have made in their quest for well-being.

From the knowledge gathered through both the field work and the literature study, key themes were drawn out, explored and presented as useful resources for constructing a relevant and contextual life-giving and life-enhancing Karanga theology of *utano* (health and well-being) in contemporary Zimbabwe. The common themes emerging from the case studies of health-care providers and health-seekers offer insights for constructing a Karanga indigenous theology of health and well-being.

1.5 Conceptual Framework of the Study

The theoretical framework adopted in this study is the African Healthworlds approach, which focuses on understanding health and well-being in particular African contexts. The study draws from tools developed by the African Religious Health Assets Programme (ARHAP). ARHAP focuses on the assets African communities bring to resolving the challenges they face around ill-health.²³ It also notes the key role of religious values and organisations in shaping the capacity of communities to respond to challenges or to seize opportunities to advance health. ARHAP's emphasis on "assets" points to "what people already do that can be built upon and better leveraged."²⁴ In the same vein, this study endeavours to foreground the agency of the Karanga community in accessing and facilitating health care in Murinye district so as to try and find ways of building upon such assets and making them more accessible to the wider community.

Most of the available literature on Shona traditional healing systems such as the work of Bourdillon²⁵, Aschwanden²⁶ and Gelfand²⁷ present a general overview on Shona healing systems without analysing how particular Shona ethnic groups understand health and well-being. Furthermore, these works do not proceed to suggest ways in which an indigenous

²³Summary of ARHAP'S research outcomes , July 2009, available on <www.arhap.uct.ac.za> .

²⁴ Cochrane J.R. Schmid, B. Cutts, T. (editors) (2011) *When Religion and Health Assets Align: Mobilising Religious Health Assets for Transformation* (Pietermaritzburg: Cluster Publications).

²⁵Bourdillon M.F.C. (1976) *The Shona peoples: An ethnography of the contemporary Shona, with special reference to their religion* (Gweru: Mambo Press).

²⁶ Aschwanden H. (1987) *Symbols of Death* (Gweru: Mambo Press).

²⁷ Gelfand, M (1973) *The Genuine Shona: Survival Values of an African Culture* (Gweru: Mambo Press). See also Gelfand M, Mavi S, Drummond RB, Ndemera B. (1985) *The Traditional Medical Practitioner in Zimbabwe: His Principles of Practice and Pharmacopoeia* (Gweru: Mambo Press).

theology of health and well-being can be developed based on the views and healthworld of a particular indigenous community among the Shona. However, these works are significant resources for this study because they provide a broad background to the Shona worldview in general as well as presenting important insights on the traditional healing systems among the Shona. Whilst focusing on a particular community of the Shona (the Karanga of Murinye district in Masvingo province), this study also proceeds to offer insights for formulating a Karanga theology of *utano*. Olov Dahlin²⁸, Hansson Gurli²⁹ and Tabona Shoko³⁰ through their fieldwork amongst the Karanga of Mberengwa also provide very useful and relevant insights to this study, particularly their exploration of the Karanga concept of *utano* (health and well-being). However, their work focuses more on describing the factors that diminish *utano* and also discusses the role of the three health-care systems among the Karanga of Mberengwa but they do not venture to explore issues around the theology of *utano*. This is the gap that the study endeavours to fill since there is no available literature presenting resources that can be drawn upon to develop a Karanga theology of *utano*. As such, this study engages the conceptual frame used by Dahlin and Shoko in order to articulate the healthworlds and understandings of *utano* among the Karanga of Murinye district in Masvingo province and proceeds to offer insights that can be utilized to constructing a Karanga theology of *utano*.

In order to deal with the concept of indigenous theology, insights are drawn from the work on inculturation theology by Stuart C. Bate.³¹ Bate focuses on churches which centre themselves on “healing ministry” and suggests that they are “coping-healing churches” in order to denote that they have found ways of ‘coping’ with the African reality of constantly seeking for healing, well-being and wholeness.³² Bate contends that there is a pertinent need to develop a clear theology of healing,

Faced with the upsurge of healing churches, theologians have been attempting to come to grips with the whole gamut of experience, controversy and concern which has arisen

²⁸ Dahlin O., (2000) *Zvinorwadza: Being a Patient in the Religious and Medical Plurality of the Mberengwa District, Zimbabwe* (Universitetryckeriet: Uppsala).

²⁹ Hansson, G. (1996) *Mwana Ndi Mai: Toward an Understanding of Preparation for Motherhood and Child Care in the Transitional Mberengwa District, Zimbabwe* (Studia Missionalia Upsaliansia, no.LXV. Uppsala: Swedish Institute of Missionary Research).

³⁰ Shoko, T. (2007) *Karanga Indigenous Religion in Zimbabwe: Health and Well-Being* (Ashgate: Ashgate Publishing Limited).

³¹ Bate S.C. (1995) *Inculturation and Healing: Coping-Healing in South African Christianity* (Pietermaritzburg: Cluster Publications).

³² Bate S.C. (1995) *Inculturation and Healing*, 15-19.

around the Coping-healing phenomenon of late. It is an incipient attempt to develop a theology which responds to the *sensus fidelium*...³³

M. L. Daneel has researched and written extensively on a theology of healing in African Independent Churches (AICs) in Africa, with a special focus on the Shona in Zimbabwe.³⁴

Regarding healing, Daneel suggests that,

...the appropriation of the role of the traditional healer by the prophet healer in the AIC's indicates the emergence of a Christology, based on Christ the healer, which may be a major contribution of African theology to the Church as a whole.³⁵

Daneel points out how the affirmation of the power of the Christian God through Christ the healer presents an effective means of conquering the spirits which trouble people. This role was traditionally that of the healer/diviner (*n'anga*) in Shona society.³⁶ To indicate a theological framework around which the theological notion of Christ the healer may be developed, Daneel draws from the work of a fellow African theologian Buana Kibongi.

Buana Kibongi shows that the Congolese *nganga* was never a mediator between *Muntu* (man) [sic] and *Nzambi* (God) but only between man [sic] and the departed spirits. The *nganga's* activities drew out the concepts of liberation and redemption... It was after all the *nganga* who established the "theological framework" on which the missionaries could build. Even more important, the *nganga* is the predecessor of Christ in Africa: He, as the new *nganga*, is the fulfilment of the past traditions...The prophetic Independent Churches, which can also be described as "healing institutions," have placed the paradigm of Christ as the "healing *nganga*" in sharper relief than any other church in Africa.³⁷

Mbonyinkebe Sebahire also highlights the emerging theological emphasis of Jesus as healer and doctor in the African context; he also concurs that healing involves the whole community,

Indeed, it is the support of the believing community which makes health and salvation available. The faith which founds and which structures the new community is the very source of healing.³⁸

³³ Bate S.C. (1995) *Inculturation and Healing*, 161.

³⁴ See Daneel M.L (1971) *Old and New in Southern Shona Independent Churches*. Vol. 1, *Background and the Rise of the Major Movements* (The Hague: Mouton); (1974) *Old and New in Southern Shona Independent Churches: Church Growth-Causative Factors and Recruitment Techniques Volume 4 of Change and Continuity in Africa Series* (Mouton De Gruyter); (1987) *Quest for Belonging – Introduction to a Study of African Independent Churches* (Gweru: Mambo Press); (1988a) *Old and New in Southern Shona Independent Churches*. Vol. 3, *Leadership and Fission Dynamics* (Gweru: Mambo Press); (2001) Ed. *African Christian Outreach*. Vol. 1, *African Initiated Churches* (Pretoria: South African Missiological Society).

³⁵ Daneel M.L. (1983a) "Communication and liberation in African Independent Churches." *Missionalia* 11:2, 86

³⁶ Daneel M.L. (1983a) "Communication and liberation...", 87.

³⁷ Daneel M.L. (1983a) "Communication and liberation...", 86-87.

³⁸ Sebahire M (1987) "Healing through faith? The Afro-Christian Churches." *Pro Mundi Vita Dossiers* 42, 14

Sebahire concludes that healing is part of the ongoing process of liberation to which the Church should be committed. This study draws from the above-mentioned resources and takes up the challenge put forward to African theologians by Bate which he sums up in the following words:

Given the widespread nature of the Coping-healing phenomenon among Christian groups and movements in Africa, *the development of a coherent and widely disseminated theology of healing by African theologians is clearly of paramount importance.*³⁹ [Emphasis, Mine]

Building on the work of the above authors, this study seeks to add a contribution towards the construction of a Karanga theology of healing and well-being (*utano*).

1.6 Outline of the Study

Chapter Two traces the history of health care in Zimbabwe, outlining the context of the study. In an endeavour to present a clearer picture of the country's health-care crisis, the chapter explores the socio-political and economic changes that the people of Zimbabwe have gone through and how these developments have had a direct impact on the country's health-care system. To this end, the chapter gives a brief background of the several historical stages that the country has experienced, from the pre-colonial era up to 2010. The inaccessibility of health care to the majority of Zimbabweans caused by the near collapse of the public health care system is foregrounded. It lays bare how such a situation leaves health seekers in a dilemma whereby they can only but rely on alternative health providers such as faith healers⁴⁰ and traditional healers,⁴¹ a move regarded as retrogressive by the modernization development paradigm.⁴²

Chapter Three explores Karanga healthworlds, showing how the Karanga understanding of health and well-being shares some similarities with other African contexts. It seeks to understand the inherent rich resources within the Karanga indigenous knowledge systems and how this influences the Karanga understanding of ill-health, healing and fullness of life.

³⁹ Bate S.C. (1995) *Inculturation and Healing*, 173.

⁴⁰ As noted in the extensive writings on Zionist Churches by Marthinus L Daneel (1971, 1974, 1983, 1987, 1988, 1989b, 1995), faith healing has been one of the most powerful and persuasive expressions of the gospel of good news. The term faith healing refers to a system whereby patients go to the 'healing prophets' or 'faith healers' who will pray for their healing, sometimes these healers administer holy water or holy oil and at times they 'extract' some objects from the patients' bodies.

⁴¹ 'Traditional health care systems' refers to the use of herbal or traditional cures either self-administered or administered by traditional healers.

⁴² Depending on the nature of the illness or at times the availability of health facilities/providers, some patients utilize all the three facilities concurrently e.g. one can first seek health care at the clinic and from there they visit either the faith-healers or traditional healers and in other cases they consult both.

Chapter Four is an exploration of religion as a health asset. It draws insights from the ARHAP framework on religious health assets and attempts to integrate this theory with the Karanga indigenous notions on health and well-being. An exploration of the crumbling public health care system presented in chapter two provides fertile ground for exploring the Karanga understanding of religion as a health asset through field work. It seeks to fathom the key religious and socio-cultural factors influencing Karanga people's health-seeking behaviour, i.e. it aims to establish how health-seekers navigate the religious and medical plurality presented by the three health care systems [Modern scientific bio-medicine; Traditional healing and Faith- healing].

Chapter Five outlines Karanga people's agency in securing health and well-being with a special focus on three different types of health-care providers [Modern scientific bio-medicine; Traditional healing and Faith-healing]. It endeavours to explore the key religious and socio-cultural factors influencing Karanga people's health-seeking behaviour within the plural context of health-care provision.

Chapter Six seeks to answer one of the key objectives of this study, namely, to contribute towards the emergence of an indigenous theology of health and healing. The chapter proposes some of the central features of a Karanga theology of utano. It reiterates how the need to pursue a Karanga theology of utano emerges from the global preoccupation with the theme of health and healing. Drawing insights from the preceding chapters, this chapter addresses the tension brought about by the three types of health care provision. In order to mitigate this tension and to further the development of African Christian theology, the chapter identifies some of the major tenets of a Karanga theology of utano.

Chapter Two

The History of Health Care in Zimbabwe: An Overview

2.1 Introduction

In order to understand who we are, there is a need for us to know where we are coming from. As such, this chapter seeks to trace the history of health care in Zimbabwe⁴³ so as to set the background for a clearer picture of the country's health crisis. In order to present a clearer picture of the country's socio-political and economic status, the chapter gives a brief background of the several historical stages that the country has experienced, from the pre-colonial era up to the year 2010,⁴⁴ showing how these developments had a direct impact on the country's health-care system. The reason for this historical background is to identify "crucial moments when political-economic contradictions became insurmountable under the prevailing logic of uneven development".⁴⁵ The chapter reiterates that the years of colonial development and underdevelopment in Zimbabwe were regularly "interrupted by capitalist crises and intensified uneven development, around which debt bubbles rose and burst, and political change often ensued".⁴⁶ Politically, the historical periods under discussion were often characterised by social upheavals, fundamental shifts in development strategies, and even new ruling political parties. It is thus impossible to discuss the state of Zimbabwe's health system without linking it to the socio-political and economic situation because these three are inseparable and they have a strong bearing on the country's health system.⁴⁷

This chapter also endeavours to analyse the role of the government in facilitating health care. It foregrounds the dilemma presented by the inaccessibility of health care to the majority of Zimbabweans due to the near collapse of the public health care system. It also sets the background for chapters three to six which lay bare the dilemma that confronts health seekers

⁴³ According to Kriger N. J. (1992) *Zimbabwe's Guerrilla War : Peasant Voices* (Cambridge University Press: Cambridge), Zimbabwe takes its name from the most spectacular of its many stone ruins that were built by indigenous people from the thirteenth century to the fifteenth century.

⁴⁴ Although there is much more that has happened on Zimbabwe's socio- economic and political landscape beyond 2010 which impacts on people's health and the health care system, the scope of this study is delimited to 2010 because that is the year when the crumbling public health care system started to be revived and some facilities which had become redundant were re-opened. Throughout the study, reference will be made to some key events and situations beyond the scope of the study to show some similarities and dissimilarities.

⁴⁵ Bond P. and Manyanya M. (2002) *Zimbabwe's Plunge: Exhausted Nationalism and the Search for Social Justice* (University of Natal Press: Pietermaritzburg), 1.

⁴⁶ Bond P and Manyanya M. (2002) *Zimbabwe's Plunge*, 1.

⁴⁷ Jim Yong Kim, Joyce V.M. and Gershman J (eds.) (2000) *Dying for Growth: Global Inequality and the Health of the Poor* (Boston: Common Courage Press), 3.

as they fail to pay for the health fees and in most cases even when they can raise the required user fees, the relevant/prescribed medication is unavailable and there are no adequate health personnel to administer proper health care. As much as the development theory pushes health seekers to utilise modern health care facilities and the evangelical churches forbid their members from consulting either traditional or faith healers, the alternative seems impractical and leaves them in a real crisis and a dilemma. In response to such a dilemma, indigenous communities resort to indigenous resources as they utilize the readily available local health-care systems in the form of traditional medicine and faith healing. This chapter lays the foundation for an understanding of the Karanga community's agency in facilitating and accessing alternative health-care systems. It also gives some indicators as to how a crumbling public health care system provides fertile ground for understanding religion as a significant health asset.

2.2 Overview of Zimbabwean History

The Republic of Zimbabwe was formerly known as Southern Rhodesia (1911-1964); Rhodesia (1964-1979) and then Zimbabwe-Rhodesia (1979-1980). The country shares a 125mile (200km) border on the south with the Republic of South Africa and is bounded on the south-west and west by Botswana, on the north by Zambia and on the north-east by Mozambique. Its total area is 150 873 square miles (390 759 square kilometres).⁴⁸ The capital is Harare (formerly called Salisbury). The current population is estimated to be slightly over 13.1 million.⁴⁹ Approximately 98% of the population is Black (the Shona composing about 80%, the Ndebele about 18%) and of the remainder, less than 3% are White, Mixed and Asian.⁵⁰

2.2.1 The Pre-Colonial Period, 1000-1889

To understand Zimbabwe, one needs to know something about the psyche of its people. The first inhabitants were the Bushmen or San people, who lived there for approximately 100 000 years before they were driven out by Bantu African tribes who were moving from

⁴⁸ Kriger N. J. (1992) *Zimbabwe's Guerrilla War : Peasant Voices* (Cambridge University Press: Cambridge):1

⁴⁹ Encyclopedia Britannica "Zimbabwe's Demographical Structure" [www.britannica.com/eb/article? to cld=44152](http://www.britannica.com/eb/article?tocl=44152) [Accessed on 25 July 2013].

⁵⁰ Hunter G et.al (2001) *Voices of Zimbabwe: The Pain, The Courage, The Hope* (Alfa (Pvt) Ltd, Johannesburg& London), 1.

south of the equator. For untold thousands of years, the Bushmen or San people occupied most of southern Africa, including Zimbabwe, “living in a lush, well-watered but isolated Eden where game was plentiful and the trees produced fruits in abundance”.⁵¹ In the second century BC, the Pygmies began moving down the length of Africa from present-day Burundi and the Democratic Republic of Congo. By the year 1000, the Shona had arrived in the country where they eventually settled and claimed it as theirs. By the twelfth century the Shona, an enterprising people, were building with stone, creating the temple and walled enclosures at Great Zimbabwe, from which the country takes its name. By 1400, the Shona had colonised most of the present-day Zimbabwe, and 400 years later the San had moved further into the south. During Great Zimbabwe’s golden age, other branches of the same central African people had also migrated south. The Korekore settled north-east of present-day Harare and extended their domain to the Zambezi valley, where a pre-Shona group, the Tongas, dwelt on either side of the river.⁵²

The five main language groups of the Shona are the Karanga, Korekore, Manyika, Ndau, and the Zezuru.⁵³ Representing over 80% of the country’s population, the Shona tribe is the most dominant indigenous group in Zimbabwe. The Karanga people located in Masvingo, the South Eastern province of the country, particularly the rural community of Murinye near the Great Zimbabwe area are the special focus of this study. The Shona held sway over Zimbabwe until 1840, when the Zulu chief Mzilikazi of the Ndebele “swept into the country from the south, slaughtering all before him”. The Ndebele king regarded all the land between the Limpopo and the Zambezi as his domain and all the people living in it as his subjects. Over the next half a century the Shona were hunted relentlessly, and all other tribes had to pay tribute to the Matebele king, a tax just to stay alive.⁵⁴ During this period, there was apparently not much bio-medical medicine available; the people relied heavily on traditional herbs and traditional medicine. There was little contact with the outside world which later introduced modern medicine and modern health care institutions. There was however contact between the Shona people and Arab traders as early as 1400 and by the mid 1800s, several white hunters, traders and missionaries were visiting the Matebele kingdom. Mzilikazi, the Matebele, king was well known for his great

⁵¹ Hill G. (2003) *The Battle for Zimbabwe: The Final Countdown* (Zebra Press: Struik Publishers), 26.

⁵² Kriger N. J. (1992) *Zimbabwe’s Guerrilla War: Peasant Voices* (Cambridge University Press: Cambridge), 1.

⁵³ Hill G. (2003) *The Battle for Zimbabwe*, 26.

⁵⁴ Farren L. (2001) “This Land is My Land?” in Hunter G et.al *Voices of Zimbabwe: The Pain, The Courage, The Hope* (Alfa (Pvt) Ltd, Johannesburg & London), 2.

love for roast fat from slaughtered cattle that caused him to suffer badly from gout for which he was treated by his missionary friend Robert Moffat of the London Missionary Society (LMS).⁵⁵ Mzilikazi was impressed by Moffat's personality and found him useful in curing his gout, a factor that might have played a significant role in influencing him to eventually grant Moffat permission to establish a mission station at Inyathi in Matebeleland in 1854, paving the way for missionary enterprises in Zimbabwe.⁵⁶ The first mission station was set up at Inyathi in September 1859,⁵⁷ when Robert Moffat led the first group of missionaries into the country.⁵⁸ These mission stations gradually and eventually transformed the African landscape in terms of introducing the educational and medical facilities⁵⁹ as will be explicated in the subsequent sections below.

2.2.2 The Colonial Period, 1890-1952

As will be elaborated below, the colonial period had far reaching repercussions on the majority of the Zimbabwean people's health, particularly because of their being pushed from their fertile and habitable land to areas that were not very good for human habitation, farming and livestock rearing. This historical phase can be divided into two sub-sections. The first is 1889-1923, which is sometimes referred to as the period during Company rule, referring to the British South Africa Company (BSAC). It was during this period when most of the land appropriation occurred. It is then followed by the 'Responsible Government' rule period which ushered in the 'White settlers' self-governing colony,' from 1923-1952, when further appropriation of the land occurred.

Great social stability characterised Zimbabwe prior to the settler-colonial epoch that began in 1890. Various Shona tributary societies and states had prospered for centuries and by the nineteenth century, the strong Ndebele state had established a distinctive tradition of barter trade, partly through the influence of Portuguese, Chinese and Arab merchants.⁶⁰ The basis of their production and the backbone of Zimbabwe's economy was the land. Unfortunately, this

⁵⁵ Hill G. (2003) *The Battle for Zimbabwe*, 30.

⁵⁶ Soderstrom H. (1984) *God Gave Growth: The History of the Lutheran Church in Zimbabwe, 1903-1980* (Mambo Press: Gweru), 9.

⁵⁷ Bhebe N. (1979) *Christianity and Traditional Religion in Western Zimbabwe 1859-1923* (Longman Group Limited: London), 28.

⁵⁸ Zvobgo C.J.M. (1991) *The Wesleyan Methodist Missions in Zimbabwe 1891-1945* (University of Zimbabwe Publications: Harare), 2.

⁵⁹ Soderstrom H. (1984) *God Gave Growth*, 10.

⁶⁰ Bond P. and Manyanya M. (2002) *Zimbabwe's Plunge*, 3.

social stability was suddenly disrupted in 1890 by the Pioneer Column's invasion led by Cecil John Rhodes, the leader and owner of the BSAC.

King Mzilikazi had died on 9 September 1868⁶¹ and his son Lobengula succeeded him in 1870. Being illiterate, Lobengula was tricked into signing a forged document in 1888 popularly known as the Rudd Concession which stated that Lobengula had signed and agreed to the occupation of the whole country by European settlers.⁶² It is this same document that was manipulated by Rhodes and the BSAC to occupy the entire country and take over most of the productive land.⁶³ Rhodes rewarded all his soldiers and all those who accompanied him with large pieces of land in the most fertile regions.⁶⁴ According to Norma Kriger, “a hallmark of Company (BSAC) rule was its policy of selling land cheaply and quickly to attract white settlers and revenue”.⁶⁵ Racial policies and practices tended to shift in small but significant ways under different constitutional orders. From 1920 onwards, the majority of Europeans in colonial Zimbabwe were committed to the policy of segregation with respect to land ownership. Chengetai Zvobgo highlights that the key to the whole debate was the law which stated that a native “may acquire, hold, encumber and dispose of land on the same conditions as a person who is not a native”.⁶⁶ Robert Palmer elaborates the same point, noting that the driving force behind the movement towards land segregation was the “intense hatred displayed by the overwhelming majority of European farmers at the idea of Africans buying land in their midst”.⁶⁷ This sort of attitude persisted and intensified in the following years further aggravating African resentment and agitation leading to outbreaks of wars of resistance as will be explicated below.

After 1923, Zimbabwe became a self-governing colony ruled directly by white settlers. For the next thirty years, a policy of separate development governed race relations. Africans

⁶¹ Bhebe N. (1979) *Christianity and Traditional Religion in Western Zimbabwe 1859-1923*.

⁶² Regarding the dilemma that he found himself in, Lobengula is reported to have once expressed it this way, “Have you seen a chameleon catching a fly? It approaches the fly from behind. It stands for a while. Then it moves carefully forward, lifting slowly one leg after the other. When it is close enough, it throws out its tongue and swallows the fly. England is the chameleon and I am the fly.”Hanna, A.J., (1962) *The Story of Rhodesia and Nyasaland* (Johnson:London), 81.

⁶³ Kriger N. J (1992) *Zimbabwe's Guerrilla War*, 51.

⁶⁴ Zvobgo C.J.M. (1991) *The Wesleyan Methodist Missions in Zimbabwe*: 139. For more elaborate information regarding the quantity and quality of land allocated to the invaders, see this author, pages 139-154.

⁶⁵ Kriger N. J (1992) *Zimbabwe's Guerrilla War*, 52.

⁶⁶ Zvobgo C.J.M. (1991) *The Wesleyan Methodist Missions in Zimbabwe*, 143.

⁶⁷ Palmer R.H. (1968) “The Making and Implementation of Land Policy in Rhodesia, 1890-1936” (University of London PH.D. thesis: London), 260-1.

could only occupy top positions in their own areas; however, in land set aside for whites, they had to accept white domination.⁶⁸ The passage of the Land Apportionment Act of 1930 divided the country into two roughly equal parts. One half was for the tiny white minority, where no black was allowed to own property or even reside without permission, and the rest containing the poorer soils, and receiving the lowest rainfall, for the black original inhabitants of Zimbabwe.⁶⁹ After the passage of the 1930 Land Apportionment Act, most of the fertile land was in the hands of invaders. Ezra Chitando succinctly puts it, “colonial conquest entailed the removal of blacks from fertile territories and consigning them to rocky spaces”.⁷⁰ There were private estates throughout the country and rights of ownership were issued. The concept of private ownership of land was not familiar to the indigenous people of the country. Prior to the advent of the BSAC, land was in plentiful supply, people settled in an area, grazed their cattle and grew their crops and moved on to fresh land when it was exhausted. They were almost all illiterate and understood neither the importance of the pieces of paper (title deeds) issued to white settlers, nor that they signified their own exclusion from most of the land they lived in.⁷¹

An administration system was set up to guarantee the settlers’ provision for more land and African traditional leaders (kings, chiefs and headmen) were excluded from the newly constituted political administration.⁷² Africans were not only disenfranchised, but also lost their land rights. Graham Philpott poignantly expresses it in these words “the land is the place where struggles for domination and control have been played out, it is the place where black people of this continent have been made landless in the land of their birth.”⁷³ Before the invasion by the BSAC, kings or their representatives had been custodians of land for their community because it belonged to the community, but now that authority was in the hands of

⁶⁸ Kriger N. J. (1992) *Zimbabwe’s Guerrilla War*, 52.

⁶⁹ McLaughlin J. (1996) *On the Frontline: Catholic Missions in Zimbabwe’s Liberation War* (Baobab Books: Harare), 3.

⁷⁰ Chitando E. (2008) “The Role of the Churches in the Struggle for Liberation in Southern Africa: A thematic Survey”, in Adogame et.al *Christianity in Africa and the African Diaspora: The Appropriation of a Scattered Heritage* (Continuum International Publishing Group: London), 53.

⁷¹ Farren L. (1993) “This Land is My Land?” in Bakare S (ed) *My Right to Land in the Bible and in Zimbabwe*, 2.

⁷² Palmer R. (1977) *Land and Racial Discrimination in Rhodesia* (Berkeley : University of California Press), 38.

⁷³ Philpott G. (1998) “Land is Storied Space: The Church and Land in Southern Africa”, *Bulletin for Contextual Theology in Africa* 5/3, 4.

the Europeans.⁷⁴ White encroachment on African land bred resentment and rebellions. The land allocated for blacks who were much more numerous than the whites became inadequate for their requirements as their numbers increased. This led to several uprisings from the local people in an effort to reclaim their land from the invaders. The most notable are the 1893 Matebele war and the 1896/7 Ndebele-Shona uprisings which were both ruthlessly crushed by the power of the settlers' superior weaponry.⁷⁵ The land issue has remained a bone of contention in Zimbabwe and the main goal of the liberation struggle was to reclaim the land.⁷⁶ Europeans also monopolized all political and industrial power and Africans were denied any form of participation in politics. The then Rhodesian Prime Minister Sir Godfrey Huggins and his government maintained a patronising attitude, insisting that "Africans should not participate in politics until there was a large number of 'intelligent' Africans with the capacity for politics".⁷⁷ This also raised animosity especially among the few educated Africans as will be illustrated in the following historical phase.⁷⁸ Preceding the exploration of the next historical phase, the discussion will pause to discuss the introduction of missionary health care in Zimbabwe because it was during the aforementioned historical period that missionary health care began to take root, grow and spread rapidly within the country.

2.3 Missionary Health Care in Zimbabwe

The opening up of missionary expeditions to the Zambezi were a direct result of Doctor David Livingstone's⁷⁹ first journey to Africa and the appeals which he made to Britain on his return. "The whole character of Doctor Livingstone's work, with his insistence on medicine, practical pursuits and healthy trade, left its stamp on later missionary enterprises."⁸⁰

⁷⁴ Bakare S. (1993) *My Right to Land in the Bible and in Zimbabwe* (Zimbabwe Council of Churches: Harare), 40.

⁷⁵ Farren L. (2001) "This Land is My Land?," 2.

⁷⁶ Gann L.H. and Henricksen T.A. (1981) *The Struggle for Zimbabwe: Battle in the Bush* (Praeger Publishers: New York), 8.

⁷⁷ Zvobgo C.J.M. (1991) *The Wesleyan Methodist Missions in Zimbabwe*, 152.

⁷⁸ Ranger T.O. (1970) *The African Voice in Southern Rhodesia (1898-1930)* (Heinemann:London) ,183.

⁷⁹ According to Wills A.J. (1985) *An Introduction to the History of Central Africa: Zambia, Malawi and Zimbabwe* (Oxford University Press: Oxford) p96, the uniqueness of Livingstone's career lies in the fact that he understood the Africans in a way that no other man of his time had done, and showed them to the world as having qualities, failings and emotions no different from those of people in more familiar societies. His sympathy for many African customs and beliefs and his respect for much of their medical practice endeared him to Africans right across the continent. To them he was the 'Ngaka', the Doctor. His reputation accounted as much as anything for the tolerant reception granted to the pioneer missionaries by most Africans north of the Zambezi.

⁸⁰ Wills A.J. (1985) *An Introduction to the History of Central Africa: Zambia, Malawi and Zimbabwe* (Oxford University Press: Oxford), 97.

Following in the footsteps of Doctor Livingstone, early missionaries were very enthusiastic to provide medical services. Missions have always been the primary providers of health care for Africans. Care for the bodily welfare of the people has always been an integral part of the Christian mission and missionaries always seek to cure people from their ailments. According to Hugo Soderstrom, “when a missionary left to settle and build a mission in the bush, he was usually equipped with a box containing medicines. And even if he possessed a marginal medical knowledge he had to use his knowledge and medicines to the last drop”.⁸¹ It has to be acknowledged that the success of Christianity in Africa particularly in Zimbabwe had a lot to do with its provision of education and health care.⁸² Michael Gelfand aptly expresses it in these words “when one looks at the Christian mission services in Africa, one immediately realises that its medical arm constitutes a significant part of the total contribution”.⁸³ Jean-Marc Ela reiterates that the history of Christian missions in Africa is inseparable from medical and health programs. Ela notes that about two thirds of the Roman Catholic congregations operating in Africa were dedicated to medical work. “In time, each mission acquired a clinic as regularly as it built a school and the arrival of religious sisters to staff the clinic was usually the determining factor.”⁸⁴ Terrence Ranger contends that missionaries treated scientific hospital medicine as the medicine of Christendom.⁸⁵ G.H.Wilson succinctly puts it this way, “One feels that the medical work is the solid asset of the missionary work here...the care of the sick and afflicted without thought of reward or return bears witness to Christ as it did in Galilee long ago”.⁸⁶ The 19th century missionaries believed that their medical work carried on the healing work of Christ and medical doctors were seen as the true successors of Christ the healer, the one who proclaimed the gospel message “Heal the sick and say to them, the good news of God is at hand” (Luke 10: 9). In Acts 10:38, the scripture relates how he “went about doing good and healing all that were oppressed by the devils”.⁸⁷ Albert Schweitzer popularised the concept of the missionary doctor, noting that many

⁸¹ Soderstrom H. (1984) *God Gave Growth*, 54.

⁸² Zvobgo C.J.M. (1996) *A History of Christian Missions in Zimbabwe 1890-1939* (Gweru: Mambo Press), 202-214; 286-31.

⁸³ Gelfand M. (1973) “Medicine and the Christian Missions in Rhodesia, 1857-1930” in J.A. Dachs (ed) *Christianity South of the Zambezi* Volume 1 (Gweru: Mambo Press), 109-124.

⁸⁴ Ela J.M. (1989) *African Cry* (New York: Orbis Books), 75.

⁸⁵ Ranger T.O. (1978b) “Healing and Society in Colonial Southern Africa.” *Social History of South Africa Seminar* (School of Oriental and African Studies), 43.

⁸⁶ Wilson G.H. (1914) “Mponda’s.” in *Central Africa* No 32, 302.

⁸⁷ Feierman S. and Janzen J.M. (eds.) (1992) *The Social Basis of Health and Healing in Africa*. (California: University of California Press), 257.

missionaries felt themselves able to disinfect a wound or hand out aspirin or doses of quinine.⁸⁸

In Zimbabwe, particularly in Masvingo province, the major referral hospitals were erected mainly by missionaries, for instance Berejena Mission hospital was built by the Roman Catholic Missionaries and the Dutch Reformed Church (DRC) missionaries built Morgenster Mission hospital. The DRC Missionaries from South Africa led by Revd A.A. Louw founded its first mission station at Morgenster Mission on 9 September 1891 and it became their centre for missionary activities leading to the erection of a school, hospital, teachers' training college and a school for the deaf.⁸⁹ Morgenster hospital⁹⁰ is the major church-owned referral centre in Masvingo province; it is located just about 20 kilometres out of the provincial city Masvingo which houses the only other major referral centre, Masvingo General Hospital, a public hospital. Missionaries pioneered in bio-medical health care provision in all rural communities in Zimbabwe; for instance, the first permanent medical mission with a doctor was established at Mount Selinda, Chipinge in 1893 by the American Board of Commissioners for Foreign Mission. Doctor W.L. Thompson arrived at Mt. Selinda mission hospital in 1893 to work amongst the Ndau population.⁹¹ In Masvingo province, one of the most prominent was Doctor J.T. Helm who came to Morgenster mission in 1894 under the Dutch Reformed (DRC) Missionaries and became a leading figure in facilitating medical care to the Shona people and was well known throughout the country. Both of these mission hospitals (Mount Selinda and Morgenster) in time became the major referral centres in their districts and continue to provide essential medical services to the community up to the present moment. By 1930, five mission hospitals had been established in Zimbabwe.⁹²

A pattern of mission responsibility for African health and education, and government concern with the European needs was established during this period and persisted until independence.⁹³ The Rhodesian government did not build any hospitals in African areas. It was mainly concerned about the welfare of the white population. The government found it

⁸⁸ Ela J.M. (1989) *African Cry*, 75.

⁸⁹ Zvobgo C.J.M. (1991) *The Wesleyan Methodist Missions in Zimbabwe 1891-1945* (University of Zimbabwe Publications: Harare), 4.

⁹⁰ Morgenster hospital's services and its patients forms one of the major cases for this research

⁹¹ Gelfand M. (1973) "Medicine and the Christian Missions in Rhodesia...", 113.

⁹² Soderstrom H. (1984) *God Gave Growth*, 54-55.

⁹³ Kriger N. J. (1992) *Zimbabwe's Guerrilla War*, 61.

cheapest and easiest to let the various missions care for the health of the African people. Mission schools and hospitals received government grants for staff salaries and running costs, and there were continued grants of land for expansion in rural areas.⁹⁴ The missions tried their best according to their financial resources which often were insufficient. For instance, the Church of Sweden Mission was willing to support the medical mission in Zimbabwe by sending money and workers. In 1960, the objectives for the medical mission were given this formulation:

All care of the sick must be of first class medical standard (expertise) which presupposes central hospitals and well equipped medical institutions. In case it is desirable to run plain local clinics, it should be done provided that well trained African personnel are available. The work at such clinics should fit into the central medical organization and be subordinated to the central hospital. The medical mission should include training of African personnel.⁹⁵

The medical work was developed along these guidelines. The training of nurses also aimed at inspiring the students to serve their patients spiritually. Training in evangelization was kept on a very practical level. Getting qualified nurses was not as great a problem as getting qualified doctors for the church hospitals. Doctors, nurses and hospitals were badly needed in the rural areas.⁹⁶

Having highlighted how missionary health care commenced in Zimbabwe, the chapter proceeds to explore the subsequent historical developments within the whole country, developments that impacted on people's welfare and inevitably impacting their health care situation.

2.4 The Federation Period, 1953-1963

From 1953 to 1963, Southern Rhodesia (Zimbabwe) formed a federation with the British Protectorates of Northern Rhodesia (Zambia) and Nyasaland (Malawi), "uniting the three Central African territories in a loose union controlled partly by European authorities in Salisbury and partly by the imperial government in London."⁹⁷ During this period, especially in the late 1950s, the white minority government in Rhodesia faced mounting pressure from Britain; "their federal status could only be renewed on condition that they make considerable

⁹⁴ Weller-Linden (1980) *Mainstream Christianity to 1980 in Malawi, Zambia and Zimbabwe* (Mambo Press: Gweru), 89.

⁹⁵ Soderstrom H. (1984) *God Gave Growth*, 99.

⁹⁶ Soderstrom H. (1984) *God Gave Growth*, 100-101.

⁹⁷ Gann L.H. and Henricksen T.A. (1981) *The Struggle for Zimbabwe*, 18.

progress towards racial partnership”.⁹⁸ In 1957, Sir Garfield Todd, the premier for Southern Rhodesia, tried in vain to ensure the registration of all Africans with ten years’ education on the voters’ roll so that they could participate in electing members of parliament.⁹⁹ He had such high regard for the needs and rights of the African populace such that his personality and his policies cost him support within his own party (United Federal Party) whose majority were predominantly racist and strongly believed that the Africans were still politically immature.¹⁰⁰ Todd was forced to resign as premier in January 1958 and was succeeded by Sir Edgar Whitehead. In April 1958, Garfield Todd left the United Federal Party to revive the old United Rhodesia Party, based on Liberal and African support.¹⁰¹ “In view of the realignment of parties, a general election was clearly necessary, and in May [1958] the Southern Rhodesia Parliament was dissolved”.¹⁰² The election was held on 5 June 1958, but unfortunately, less than 1 600 Africans had registered and not all of these participated in the voting process. “The result was a moderate victory for the United Federal Party, the United Rhodesia Party returned no member, and Todd himself was defeated.”¹⁰³ African resentment and discontent with the federation proceeded to further disillusionment and African nationalists intensified their efforts of conscientising the masses to resist the federation and all that it stood for, resulting in continued unrest throughout the federation.¹⁰⁴

In a bid to quell African nationalists’ discontent and unrest in Southern Rhodesia, in 1961 “the Rhodesian parliament passed an unprecedented body of social and economic legislation improving African wages, education and amenities;”¹⁰⁵ they also made provision for African parliamentary representatives.¹⁰⁶ In exchange for this minimal concession to African political

⁹⁸ Wills A.J. (1985) *An Introduction to the History of Central Africa: Zambia, Malawi and Zimbabwe* (Oxford University Press: Oxford), 331-367.

⁹⁹ Good R.C. (1973) *U.D.I. The International Politics of the Rhodesian Rebellion* (Faber & Faber: London), 36-38.

¹⁰⁰ Good R.C. (1973) *U.D.I. The International Politics of the Rhodesian Rebellion* (Faber & Faber: London), 38 records some of the racist remarks passed to Sir Edgar Whitehead by William Harper who would later play a leading role in Rhodesia’s shift to the right. On 23 August 1960, Harper argued that “if Africans were seated in the Legislative Assembly, they will share the restaurant with us and they will share the bars with us. We will be living cheek by jowl with them and what sort of legislation can the people of this country expect when we ourselves are being conditioned to living cheek by jowl with Africans.”

¹⁰¹ Wills A.J. (1985) *An Introduction to the History of Central Africa*, 334-335.

¹⁰² Wills A.J. (1985) *An Introduction to the History of Central Africa*, 335.

¹⁰³ Wills A.J. (1985) *An Introduction to the History of Central Africa*, 335.

¹⁰⁴ Good R.C. (1973) *U.D.I. The International Politics...*, 38-41.

¹⁰⁵ Good R.C. (1973) *U.D.I. The International Politics...*, 36.

¹⁰⁶ For an elaborate explanation of these concessions, see Wills A.J. (1985) *An Introduction to the History of Central Africa: Zambia, Malawi and Zimbabwe* (Oxford University Press: Oxford):353-354, See also Good R.C. (1973) *U.D.I. The International Politics of the Rhodesian Rebellion* (Faber & Faber: London), 36-40.

advancement, Britain gave up almost all its constitutional powers to protect Africans from discriminatory legislation.¹⁰⁷ On the other hand, the whites in Southern Rhodesia were getting anxious that Britain might insist on further constitutional concessions to Africans and by 1962, they were agitating “to be rid of any vestige of Crown control, even though Britain had never once used its constitutional powers to veto discriminatory legislation.”¹⁰⁸ Repressive laws went hand in hand with reforming legislation. The federation continued to undergo immense pressure as the “British government became increasingly reconciled to decolonization.”¹⁰⁹

There was also mounting pressure from the African indigenous population. Several developments concerning African nationalism occurred and several African nationalist movements sprouted during this period.¹¹⁰ The African educated elite were pressing and lobbying for African independence and respect for African rights especially the right to vote, representation in parliament and ownership of property, particularly the right to own land. The Southern Rhodesia African National Congress (SRANC) was founded in 1958, with Joshua Nkomo as leader. It was banned by the Rhodesian government in early 1959 and most of its leadership detained or restricted in terms of the state of emergency declared throughout the Federation in response to the perceived threat from emergent Black Nationalism.¹¹¹ The National Democratic Party (NDP) was formed in 1960 but it was also banned within a few months. Soon after the banning of NDP, Joshua Nkomo again spearheaded the formation of Zimbabwe African People’s Union (ZAPU) in 1961, which was in turn banned in less than a year. In exile, the name ZAPU continued to be used and ZAPU was subsequently one of the two major liberation movements in contestation with the Rhodesian regime.¹¹² Nationalist leaders had agreed not to form another Party in the event of the banning of ZAPU; however, a group dissatisfied with the leadership and policies of Nkomo and his immediate lieutenants, especially what they regarded as a lack of militancy and unwillingness to undertake the armed struggle, broke ranks in August 1963 to form the Zimbabwe African National Union

¹⁰⁷Gann L.H. and Henricksen T.A. (1981) *The Struggle for Zimbabwe*, 17.

¹⁰⁸ Kriger N. J. (1992) *Zimbabwe’s Guerrilla War*, 52.

¹⁰⁹ Gann L.H. and Henricksen T.A. (1981) *The Struggle for Zimbabwe*, 19.

¹¹⁰ According to Gann L.H. and Henricksen T.A. (1981) *The Struggle for Zimbabwe: Battle in the Bush* (Praeger Publishers:New York) ,40, agitation and hostility against European rule increased after the creation of the Federation, the balance of power rested with the local whites; Africans were “largely fobbed off with posts of a purely honorific kind.”

¹¹¹ See Gann L.H. and Henricksen T.A. (1981) *The Struggle for Zimbabwe*, 40-43.

¹¹² Wills A.J. (1985) *An Introduction to the History of Central Africa*, 354-356.

(ZANU). It was founded under the leadership of Ndabaningi Sithole and was also banned less than a year later. It became the major force in the struggle against the Smith regime in the 1970s.¹¹³

The federation eventually broke up in 1963, as Northern Rhodesia and Nyasaland became independent black states, respectively named Zambia and Malawi.¹¹⁴ Southern Rhodesia, (then known as Rhodesia) failed to obtain the status of an independent British dominion that the whites had expected to get. Instead the country remained in its ambiguous constitutional position as a self-governing colony under the terms of a constitution earlier agreed upon by British and Rhodesian delegates in 1961.¹¹⁵ The Rhodesian parliament remained a predominantly white dominated cabinet with a tiny minority section comprising of property owning Africans.¹¹⁶ The 1961 constitution had been designed to allow for some African progress, as African incomes increased, more Africans would become eligible for participation in parliament with more voting powers. The rate of progress was however, very slow and therefore the whites in the meantime enjoyed full autonomy. Nonetheless, the majority of white Rhodesians were fearful that a British Labor government would use its remaining powers to change the terms of the constitution “in a manner harmful to white interests. Political uncertainty worsened the country’s parlous economic conditions; the white Rhodesian establishment stood discredited by the break-up of the federation”.¹¹⁷ Fearing that Britain would eventually grant political independence to Africans, the white minority government declared independence unilaterally in 1965, a move that changed the whole socio-political landscape for Zimbabwe¹¹⁸ as will be elaborated below.

¹¹³ McLaughlin J. (1989) *On the Frontline*: 290-293. See also Wills A.J. (1985) *An Introduction to the History of Central Africa: Zambia, Malawi and Zimbabwe* (Oxford University Press: Oxford), 304-367.

¹¹⁴ Wills A.J. (1985) *An Introduction to the History of Central Africa*, 357-361.

¹¹⁵ See footnotes 64-66.

¹¹⁶ Gann L.H. and Henriksen T.A. (1981) *The Struggle for Zimbabwe*: 19. See also Wills A.J. (1985) *An Introduction to the History of Central Africa: Zambia, Malawi and Zimbabwe* (Oxford University Press: Oxford), 331-367.

¹¹⁷ Gann L.H. and Henriksen T.A. (1981) *The Struggle for Zimbabwe*, 20.

¹¹⁸ Kriger N. J. (1992) *Zimbabwe’s Guerrilla War*, 3. See also Wills A.J. (1985) *An Introduction to the History of Central Africa: Zambia, Malawi and Zimbabwe* (Oxford University Press: Oxford), 367-390.

2.5 Unilateral Declaration of Independence (UDI) and the Aftermath, 1965-1979

Despite Britain's strong disapproval¹¹⁹ of the proposal for unilateral action without the concurrence of the whole Rhodesian population and the denunciations from the "politically aware Rhodesian Africans",¹²⁰ the Rhodesian Front, under its leader Ian Smith, who was also the new Prime Minister for Rhodesia defiantly and unanimously voted in support of UDI¹²¹ both on 5 November 1964 and on 7 May 1965.¹²² In October 1965, the British government invited Ian Smith to London for talks, reiterating the need for ensuring a tangible guarantee of African political progress before Rhodesia's independence could be granted. No agreement was reached in this meeting and upon Smith's return to Salisbury, "the former Rhodesian Premier Garfield Todd, now a nationalist supporter and a member of ZAPU, was placed under house arrest and a unilateral declaration of independence (UDI) appeared imminent".¹²³ On 5 November 1965, a state of emergency was declared in Rhodesia and six days later, Smith's government unilaterally and illegally severed political ties with Britain. On 11 November 1965, Ian Smith issued his Unilateral Declaration of Independence for Rhodesia.¹²⁴ In words never to be forgotten, Ian Smith proclaimed the settlers' ephemeral triumph, "...We have struck a blow for the preservation of justice, civilization and Christianity, and in the spirit of this belief we have this day assumed our sovereign independence. God bless you all."¹²⁵

The passing of the Unilateral Declaration of Independence for Rhodesia provoked worldwide controversy. Britain had to immediately come up with a tactful and decisive response to this outright rebellion and the majority agreed upon some "British-initiated economic sanctions to bringing about a return to constitutional government in Rhodesia. The principal argument turned, not on whether to impose sanctions but how tough they should be, not on whether to

¹¹⁹ According to Good R.C. (1973) *U.D.I. The International Politics of the Rhodesian Rebellion* (Faber & Faber:London) ,46, lengthy exchanges of correspondence, two visits to Salisbury in February and July 1965 by British Ministers and a second visit to London by Smith in October produced no progress whatsoever. Not even the eleventh hour attempt by the British Prime Minister Harold Wilson who visited Salisbury on 25 October bore any fruit in averting U.D.I.

¹²⁰ Wills A.J. (1985) *An Introduction to the History of Central Africa*, 364-365

¹²¹ For more information about UDI and its impact on Zimbabwean history, please see Chengetai Zvobgo, "Church and State in Rhodesia: From the Unilateral Declaration of Independence to the Pearce Commission, 1965-72 in *Journal of Southern African Studies*, Volume 31, Number 2, (22) June 2005, 381-402 .

¹²² Wills A.J. (1985) *An Introduction to the History of Central Africa*, 364-365.

¹²³ Wills A.J. (1985) *An Introduction to the History of Central Africa*, 365.

¹²⁴ Good R.C. (1973) *U.D.I. The International Politics*, 50.

¹²⁵ Linden I. (1980) *The Catholic Church and the Struggle for Zimbabwe* (London:Longman), 87.

effect change in Rhodesia through sanctions but how dramatic the anticipated change would be.”¹²⁶ Heavy economic sanctions were imposed against Rhodesia, all of Rhodesia’s imports from and exports to Britain were cut off.¹²⁷ The passing of UDI also aggravated the Rhodesian African population even further.¹²⁸ From that point on, the political and religious developments in Zimbabwe became increasingly polarized. On the one hand, Smith’s strictly speaking illegal minority regime adopted unashamedly racialist policies, which also hit the churches such as the Land Tenure Act and new legislation for African education.¹²⁹ On the other hand, the African population embarked on forming political parties to coordinate the resistance against the Smith regime in the 1970s.¹³⁰ Their frustrations were expressed in the increasing number of refugees leaving the country and in more coordinated efforts by Zimbabwean politicians in exile to favour the cause of the liberation of their country.¹³¹ Many people in both rural and urban communities supported the liberation struggle with the promise that upon independence, land would be redistributed equitably.¹³²

Although many nationalist leaders were born and educated in missions, in the late 1950s and early 1960s, African nationalism became more aggressive and in most cases, hostile to Christianity which was seen to support the *status quo*. The trade unionists also criticized the churches for “softening the people into acquiescence to the settler government”.¹³³ The missionaries who came to Zimbabwe together with the colonial authority had enjoyed many privileges; they were granted large pieces of land where they started erecting health centres and mission schools. For instance, Cecil John Rhodes the leader of the Pioneer Column offered the Jesuit priests four large farms and free stands in the urban areas and the Catholic Church eventually became one of the biggest landholders in the country, owning nearly

¹²⁶ Good R.C. (1973) *U.D.I. The International Politics*, 53.

¹²⁷ Good R.C. (1973) *U.D.I. The International Politics of the Rhodesian Rebellion* (Faber & Faber:London) ,68-73, explains how these sanctions inflicted severe damage on all Rhodesians, their supply of oil was cut off, farmers could not export their agricultural produce, especially tobacco which was the backbone of the economy.

¹²⁸ The negative impact of the resultant sanctions as well as the determination to overthrow the illegal and racist Smith regime so as to regain their land and political freedom spurred on many patriotic Zimbabweans to join the liberation struggle.

¹²⁹ Kriger N. J. (1992) *Zimbabwe’s Guerrilla War*, 52.

¹³⁰ McLaughlin J. (1996) *On the Frontline*, 290-293.

¹³¹ Hallencreutz C. F. (1988) “Policy of Religion: The New Framework” ” in Hallencreutz C.F. and Moyo A. (eds.) *Church and State in Zimbabwe* (Mambo Press: Gweru), 11.

¹³² This promise has taken decades to be fulfilled, to the frustration and disappointment of many, leading to sporadic land invasions in the late 1990s and into the 2000s as will be explained in subsequent historical phases

¹³³ Brand C.M. (1977) “African Nationalists and the Missionaries in Rhodesia” in Bourdillon M.F.C (ed.) *Christianity South of the Zambezi* Vol.2 (Mambo Press: Gweru), 240.

190 000 acres.¹³⁴ Chengetai Zvobgo notes that by 1925, a total of 325 730 acres of land had been granted by the BSAC to various missionary bodies for mission purposes.¹³⁵ In addition, the missionaries purchased a total of 71 085 acres such that by the end of 1925 the various missionary groups held a total of 406 200 acres of land.¹³⁶ Missionaries worked hand in glove with colonial authorities¹³⁷ and local African leaders to gain access to new territory and to secure protection and funding for their enterprise. In their lifestyle, behaviour and activities, they were often indistinguishable from the colonial officials and the settler population.¹³⁸ Although missionaries tried their utmost to provide health-care during the Smith regime and the subsequent period of the liberation struggle, the intensity of continuous fighting impacted heavily on people's health, forcing many health facilities to close down. The next section discusses the issue of health care provision during these years.

2.5.1 Health-Care during the Armed Struggle

Inadequate and inferior government provision of health and education for Africans compared with Europeans aroused African indignation towards the settler regime. In a bid to sabotage all the services provided by the Smith regime, the guerrilla forces closed down all public facilities including the dip tanks. This had far reaching repercussions, for instance, the closure of dip tanks is said to have reduced the national cattle herd in the tribal trust lands by up to one third. This caused further misery for the people as their cattle became vulnerable to tick bone diseases and foot and mouth disease causing further harm to the nutrition of farmers and peasants.¹³⁹

¹³⁴ Mashingaidze E.K. (1978) *African Frontiersmen and the Extension of Christianity's Northern Hinterland* (Kyrkohistorisk arsskrift, Uppsala).

¹³⁵ Zvobgo C.J.M. (1991) *The Wesleyan Methodist Missions in Zimbabwe*, 6-7.

¹³⁶ Zvobgo C.J.M. (1991) *The Wesleyan Methodist Missions in Zimbabwe...* highlights that much of this land was acquired without the permission of African chiefs and their people, See pages 6-7.

¹³⁷ According to C.P. Groves (1955), *The Planting of Christianity in Africa Volume 111*, p103-4 Rhodes' generous attitude towards the missionaries in Zimbabwe created 'a situation to which no other territory in Africa could offer a parallel.'

¹³⁸ According to T.O. Ranger (1968), "The nineteenth century in Southern Rhodesia", in Ranger T.O. (ed.) *Aspects of Central African History* (Heinemann: London) p 140, from their experiences with the Ndebele state's hegemony on the Shona and the country at large, the missionaries were convinced that their enterprise in Zimbabwe had little chance of success until Ndebele power was broken, and that this could only be done by force. For this reason, missionaries welcomed the BSAC forces in Mashonaland in 1890

¹³⁹ Kriger N.J. (1992) *Zimbabwe's Guerrilla War*, 88.

Government provision and financing of health services was biased in favour of urban health services for Europeans throughout the pre-independence period. The Rhodesian government did not build any hospitals in African areas. It was mainly concerned about the welfare of the white population. The government found it cheapest and easiest to let the various missions care for the health of the African people.¹⁴⁰ For instance, in 1976 the government provided one hospital bed for every 1,261 Africans compared with a corresponding 1:255 ratio for whites. Government grants to mission schools and hospitals remained small when compared with state expenditure on the Europeans' needs, and missions continued to rely chiefly on overseas funds.¹⁴¹ There was an enormous discrepancy in the distribution of the health budget; although Salisbury contained 9% of the population, it absorbed almost 30% of the annual expenditure. Much can be said of the availability of medical personnel - they too responded to market pressures, which in this case meant racial lines. During this period, the country had 855 doctors, or roughly one doctor per 8 000 head of population. However, 280 of these were chiefly engaged in caring for the registered members of white medical societies, implying that there was one doctor per 830 white people. For the rural population the ratio was one doctor per 100 000 African patients.¹⁴² Missions provided two-thirds of all rural beds, which is still the case in the present era.¹⁴³ The Rhodesian government encouraged African councils to provide health care in the rural areas. By 1977, the councils had established about 363 clinics, mostly built with volunteer local African labour and supported in part by fees. However, by 1977 the central government provided only 9% of its total health budget in grants to local authorities, missions, and voluntary organisations.¹⁴⁴

The differences in health and health care closely matched the striking disparities in income, employment, land ownership and housing. Black workers' living conditions were appalling especially in the urban areas. The construction of formal apartheid-style townships formalised the already prevailing slum living conditions.¹⁴⁵ For instance, in the African residential areas in Salisbury, a town in which it might be said general standards were the highest in the country, less than half of those lucky enough to have homes also had electricity. Living

¹⁴⁰ Soderstrom H. (1984) *God Gave Growth*, 55.

¹⁴¹ Kriger N.J. (1992) *Zimbabwe's Guerrilla War*, 61.

¹⁴² Hitchens C and Stephen D (1991) *Inequalities in Zimbabwe*, 13.

¹⁴³ The present era refers to the year 2013

¹⁴⁴ Gilmurray J. (1979) *The Struggle for Health* (London: Catholic Institute of International Relations),33-39.

¹⁴⁵ Alexander J et.al (2000) *Violence and Memory: One Hundred Years in the 'Dark Forest' of Matebeleland* (Oxford: James Currey), 150.

conditions were very cramped, with most houses having three rooms or less and sustaining an average family of six at the least. In the countryside, the number of African households with access to electricity was only 2%.¹⁴⁶ Running or purified water was and still is very rare.¹⁴⁷ Wages, whether for formal or seasonal workers, were very low.

Since most rural populations were either cramped in tribal trust lands and some had sought refuge in urban areas, there were population explosions, leading to very high infant mortality rates. Infant mortality during this period was estimated at 122 per thousand for blacks and 17 per thousand for whites. The malnutrition rates were very alarming, mainly because Africans were packed into tribal trust lands with poor soil and little capacity for producing more than subsistence food or in the urban areas where they lacked any form of sustainable livelihood. According to Eddie Cross, the chief economist of Agricultural Marketing Authority, the average annual maize intake in the tribal trust lands fell from 385 to 231 pounds per annum, implying that there was a 40% drop in basic nutritional requirements.¹⁴⁸ Clinics recorded a sharp rise in hunger diseases such as kwashiorkor. A survey conducted by J.H.M Axton in 1973 analysing the paediatric admissions to Harare hospital revealed that the majority of children admitted were underweight for their age and malnutrition and deficiency disease was usually the first or second diagnosis for around one third of all children admitted.¹⁴⁹

During the colonial period in most rural settings in Africa, western medical care was usually available only in missionary facilities and mission vehicles often served as ambulances.¹⁵⁰ “As the first major infiltration of liberation forces was beginning to bring all the issues into the burning focus of a guerrilla war at the end of 1972, the church found itself involved in the course of the liberation struggle, especially the mission stations in the rural communities.”¹⁵¹ Consequently, it was inevitable that most mission hospitals provided the liberation fighters with medical supplies and cared for some of the wounded fighters. This made them very unpopular with the colonial authorities, forcing most of the missions to close down during

¹⁴⁶ Hitchens C and Stephen D. (1991) *Inequalities in Zimbabwe Report No. 8* (London : Minority Rights Group), 12.

¹⁴⁷ This is according to 2009 standards following the outbreak of a cholera epidemic in late 2008 and early 2009 which killed more than 4 000 Zimbabweans. The intervention of the international community eventually stemmed the tide of the epidemic.

¹⁴⁸ Cited by Hitchens C and Stephen D. (1991) *Inequalities in Zimbabwe*, 12.

¹⁴⁹ Hitchens C and Stephen D. (1991) *Inequalities in Zimbabwe*, 13

¹⁵⁰ Ela J.M. (1989) *African Cry*, 76.

¹⁵¹ Soderstrom H. (1984) *God Gave Growth*, 182.

this period. A number of missionaries belonging to various denominations in Zimbabwe were killed during the war. The first three in December 1976 were Roman Catholic priests. About 40 missionaries, their relatives included, lost their lives between 1976 and 1980. Most people subscribe to the notion that the murders were committed by government soldiers. Soderstrom succinctly explains it:

Many missionaries supplied guerrillas with food, medicine and medical care, and were generally sympathetic and were a more obvious target for the Rhodesians than the guerrillas, many of whom had been educated at mission schools.¹⁵²

St Albert's is one good example of a mission that worked hand in glove with the guerrillas, providing them with supplies from the mission, organizing meetings with local communities and assisting in recruiting youth to join them. As a result, it was the first victim of "Protected Villages" which were commonly referred to as "Keep" by the local people.¹⁵³ These were enclosures intended to isolate the nationalist guerrillas from the rural population. The Rhodesian forces moved into the mission unannounced, surrounded the school with barbed wire and installed powerful searchlights and the school was used as a holding and interrogation centre for approximately 4 000 inhabitants of the surrounding community.¹⁵⁴

After the trial at St Albert's, these villages became widespread, by mid-1974, approximately 47 000 people in Chiweshe, north of Salisbury had been moved into 21 villages and another 13 500 in Madziwa had been relocated in ten villages. There were approximately a total of 70 000 people in such villages, most of them were along the Zambezi Valley. Intended to isolate the guerrillas, this counter-insurgency measure resulted in thousands of peasant families being moved into guarded settlements where they lived in poor and crowded conditions, allowing little meaningful activity. Due to stringent curfew regulations, it was difficult to cultivate enough food. Starvation was a great plague, because the curfew hindered people from ploughing their fields. The security forces often destroyed the food stores when they suspected that the guerrillas would get the supplies.¹⁵⁵ There were inadequate sanitary conditions and people were starved most of the time. They suffered brutality at the hands of

¹⁵² Soderstrom H. (1984) *God Gave Growth*, 182.

¹⁵³ For more information on Protected villages, see Kriger N. J (1992) *Zimbabwe's Guerrilla War: Peasant Voices* (Cambridge University Press: Cambridge), and McLaughlin J., *On the Frontline...and Lan D Guns & Rain: Guerrillas & Spirit Mediums in Zimbabwe* (London: James Currey)

¹⁵⁴ McLaughlin J. (1991) *On the Frontline*, 85.

¹⁵⁵ Soderstrom H. (1984) *God Gave Growth*, 180.

the camp guards; women and children were raped and abused.¹⁵⁶ Poor hygiene and sanitary facilities led to outbreaks of trachoma and typhoid. The death toll during the fighting rose due to all those who were maimed and injured, and those who died of lack of medical care or proper food. Medical personnel were killed for giving medical assistance to the guerrilla soldiers. Some fled for their lives. Most rural clinics and hospitals were forced to close because they were suspected of having treated wounded guerrillas or were suspected of being able to do so. The few that remained open were maintained by the African staff, sometimes at the risk of their lives. Most missionaries who worked in the rural clinics and hospitals were forced to flee and this meant a considerable decrease in the health care offered to the population. As a result, large numbers of people died from untreated injuries, or illnesses for which no preventive or immediate remedial treatment was available.¹⁵⁷

The escalation of the war in 1978 led to an increase in the suffering of the rural population to such an extent that thousands of rural people tried desperately to escape by fleeing to the towns, where they could live free from harassment, torture and possible death. Plastic shelters, appalling deprivation in terms of food, water and sanitation, were preferable to life in the rural areas at that time.¹⁵⁸ Worse still, the Rhodesian Ministry of Health with all its fine hospitals and dedicated staff continued to emphasize curative to the detriment of preventive care. The 1978/9 estimates reveal an allocation of 86.7% spending on curative care and only 9% on preventive care.¹⁵⁹ That was the situation on the eve of independence such that when the country attained its independence on 18 April 1980 with Robert Gabriel Mugabe as the president, one of the government's major priorities was to address the provision of health care and attempt to smoothen the discrepancies.

2.6 Health Care in the First Decade of Independence, 1980- 1990

For periodisation purposes, this first decade of independence will be referred to as the Pre-ESAP (Economic Structural Adjustment Programme) period, in contradistinction to the next decade after the institutionalisation of ESAP which will be referred to as the ESAP and Post-ESAP periods respectively. This is meant to highlight the changes and developments that

¹⁵⁶ McLaughlin J. (1996) *On the Frontline*, 24.

¹⁵⁷ Hansson G (1992) *Vashandiri, Mbuya and the Impact of the Second Chimurenga* (Licentiate Dissertation at the Department of Theology: University of Uppsala), 49-50.

¹⁵⁸ Auret D. (1992) *Reaching for Justice: The Catholic Commission for Justice and Peace 1972-1992* (Mambo Press: Gweru), 123.

¹⁵⁹ Hitchens C and Stephen D (1991) *Inequalities in Zimbabwe*, 13.

occurred on the socio-economic landscape impacting on people's health before, during and after ESAP.

As we have seen, before independence, health services were highly unequal, with better care and more money spent for the high-income white community who suffered less disease than for the lowest income rural peasant and commercial farm worker communities who had the highest levels of ill health. Government expenditure per white patient was twice that per black patient and 389 doctors served in towns and cities compared to 11 doctors in rural areas where 80% of the population lived.¹⁶⁰ Because health has always been one of the most important social concerns of Zimbabwean people, the government that came to power in 1980 was quick to address these disparities. Attacking these unfair inequalities and addressing the link between the main health problems and poverty was the priority concern of the government's first health policy, *Planning for Equity in Health*.¹⁶¹ The newly formed Ministry of Health had great plans for the country. It wanted to implement primary health care all over the country ensuring that no inhabitant would travel more than eight kilometres to a health facility. A health care system was to be built where patients could be referred from one level to the next, beginning from the patient's local clinic near their home.¹⁶² Primary health care was the main vehicle for improving health care provision and this entailed:

- Health education
- Nutrition education and food production
- The expanded programme on immunisation
- Control of communicable diseases like diarrhoea, malaria and TB
- Building safe and accessible water supplies and sanitation
- Ensuring adequate generic drug supplies and sanitation
- Providing basic and essential preventive and curative care
- Participation of communities.¹⁶³

Health was linked to development, and communities working with the health sector also mobilised and used increased support for education, particularly female education,¹⁶⁴ safe

¹⁶⁰ Loewenson R. (1989) *Health in Zimbabwe: Community Perspectives* TARSC Monograph/98 (Harare), 11.

¹⁶¹ Ministry of Health (1984) *Planning for Equity in Health* (Government Printers: Harare),3.

¹⁶² Dahlin O., (2001) *Zvinorwadza: Being a Patient in the Religious and Medical Plurality of the Mberengwa District, Zimbabwe* (Universitetryckeriet: Upssala), 102.

¹⁶³ Loewenson R., (1998) *Health in Zimbabwe*, 10.

water and sanitation, better ventilated and maintained housing and improved family food production. The general health standards improved significantly. Life expectancy at birth rose from 45 years in 1960 to 60 in 1985.¹⁶⁵ Infant mortality dropped from 96 per 1 000 live births prior in 1980 to 47 per 1 000 in 1990. Maternal mortality was halved to about 168% per 100 000; and diseases like malaria, TB and skin diseases also fell.¹⁶⁶ More health infrastructure was constructed and there was greater access to health care. More qualified personnel entered the system and in the 1980s, employment in the health sector grew by an average of 5% per year, to reach 25 000 by 1990. In 1980, there was one health worker for every 467 people and by 1990 there was one for every 391. Much emphasis was placed on preventive and simple curative care such as immunisation campaigns, environmental health and treatment of communicable diseases (TB, STIs), and primary health care services were subsidized. A big shift was achieved between 1980 and 1985 and around 7% to 14% of the Ministry of Health (MOH) budget was allocated to preventive services.¹⁶⁷

These vast improvements were achieved through the corporate effort of several service providers in the country including inter alia:

- The Ministry of Health, the largest provider
- Local government services
- Missions, with 30 mission hospitals and 50 clinics in rural areas
- Industrial services on mines and agro-estates
- The private sector, mainly general practitioners, private clinics and private beds in government hospitals
- Army medical services and
- Voluntary organisations that offered special health inputs (such as rehabilitation).¹⁶⁸

¹⁶⁴ Hansson G. (1996) *Mwana Ndi Mai: Toward an Understanding of Preparation for Motherhood and Child Care in the Transitional Mberengwa District, Zimbabwe* (Studia Missionalia Upsalicensia, no.LXV. Upssala: Swedish Institute of Missionary Research).

¹⁶⁵ Zimbabwe Human Development Report 2003, (2003) *Redirecting our responses to HIV and AIDS: Towards reducing vulnerability-the ultimate war for survival* (University of Zimbabwe Publications:Harare), 8.

¹⁶⁶ Loewenson R., (1998) *Health in Zimbabwe*, 10.

¹⁶⁷ Chibanda S., (1996) *Adjustment and Women's Health in Zimbabwe: The Current Financial Crisis* an Unpublished Report Prepared for the Women Action Group (Harare).

¹⁶⁸ Loewenson R., (1998) *Health in Zimbabwe*, 10-11.

Health care was provided at primary level through community based structures and rural health centres; at secondary level through hospitals and services; at tertiary level, through provincial hospitals and services; and at quaternary level, through the central referral facilities such as Parirenyatwa hospital in Harare and Mpilo hospital in Bulawayo. The changes in health care were mainly brought about by central government, working with and through local government, mission health institutions and other service providers.

Investment in health in the early 1980s was most profound at the primary levels. Between 1980 and 1998, about 290 rural health centres were built and staffed, 160 war-damaged clinics were reconstructed and another 160 were upgraded with 766 Rural Health Clinics by 1997, each serving an average of 9 000 people. Mobile clinics extended mother and child care to remote areas so that ante- natal care reached 90% of pregnant women and more than 70% of deliveries occurred under the supervision of trained personnel. In 1990 under-five mortality stood at 59.9 per 1 000 live births while maternal mortality was 283 per 100 000 live births.¹⁶⁹ By 1997, immunisation coverage in children under the age of one year stood at 87% for BCG; 85% for polio; 83% for measles. To increase access, free medical care was introduced for low-income groups earning less than Z\$150 a month in September 1980 and outpatient attendances increased dramatically. In November 1992, the fee exemption income was increased to Z\$400.¹⁷⁰

Since the major emphasis lay on Primary Health Care (PHC), the strategy aimed at broadening social participation in health activities. This was heavily drawn from the liberation ideology as indicated by the Ministry of Health's stance, "The guerrilla medical cadres developed an ideology of service to the people and mobilization of masses to promote their own health and this fine tradition will be carried out over (*sic*) in Zimbabwe's health service to improve the people's health in the shortest possible time."¹⁷¹ The primary mechanism to give effect to a policy of participation in which communities mobilised around their own health needs was the Village Health Worker (VHW) initiated during the liberation struggle. They were to be trained and spread countrywide, each of them covering about 500-1 000 people. The VHW was primarily an agent of positive change through communities

¹⁶⁹ Zimbabwe Human Development Report 2003, (2003) *Redirecting our responses to HIV and AIDS*, 9.

¹⁷⁰ Loewenson R. *Health in Zimbabwe*, 11.

¹⁷¹ Ministry of Health (1985) *Planning for Equity in Health* (Harare: Government Printers), 5.

mobilising to promote their own health.¹⁷² The VHW would constitute a link between the patients in the villages and the medical staff at the health institutions. A case in point is Bondolfi Mission in Masvingo. The Mission was approached by local ZANU (PF) party leaders to train VHWs elected at public meetings within each village. About 293 VHWs were trained for six months in:

- Nutrition,
- Child care,
- Hygiene, sanitation and basic home treatment.¹⁷³

They brought about significant achievements in the building of wells and toilets, helped at clinics, organised the feeding of undernourished children and promoted food production. The VHW was backed by a range of other community based cadres, including community based distributors in family planning services, health education and STIs. Traditional midwives were trained to perform safe deliveries, recognise complications, promote breast feeding and refer patients to the nearest health centre with the objective of reducing maternal mortality. Together, these community cadres managed to produce considerable achievements in community health. All health services in each district, whether administered by the Ministry of Health, the district council or mission, were integrated.

It is clear then that the investments made in health in the 1980s (Pre-ESAP) produced significant reductions in morbidity and mortality, reduced differentials between urban and rural communities and improved access to preventive and curative services.¹⁷⁴ However, as will be discussed in the following section, in the 1990s, the combined effects of

- HIV and AIDS
- Drought
- The negative impact of and the non-realization of the objectives of the Economic Structural Adjustment Programme (ESAP)
- The sporadic and uncoordinated Land Reform and Redistribution programme
- Despotic and draconian government policies and political instability

¹⁷² Dahlin O (2000) *Zvinorwadza*, 102.

¹⁷³ Loewenson R. *Health in Zimbabwe*, 11.

¹⁷⁴ Loewenson R. and Chisvo M (1994) *Transforming Social Development: The Experience of Zimbabwe* (Report prepared for UNICEF: Harare).

- Poor economic performance
- High levels of poverty & inequality and
- The reduction or withdrawal of funding from the international community which used to finance most health programmes

led to a stagnation or reversal of all these gains, raising new health challenges against a background of unresolved environmental, reproductive, communicable and non communicable disease risks.¹⁷⁵

An interlocking series of all these factors brought about a massive national health crisis that the country is still struggling to come out of by the year 2013. Below is an exploration of the series of events and government policies that have impacted negatively on people's health.

2.7 ESAP and the Aftermath, 1991-1999

2.7.1 HIV and AIDS, Poverty, Inequality and Disintegrating Health Services

The period between 1991 and 1999 ushered in a new era on the Zimbabwean socio-economic and political landscape. The first major and transformative move was the introduction of ESAP, a move that has left its imprints indelibly marked on Zimbabwe's history as will be unpacked in the following discussion.

The country's economy has a strong bearing on the health system. Once regarded as the emerging star of post-colonial Africa, Zimbabwe is now¹⁷⁶ a nation teetering on the brink of economic and political collapse.¹⁷⁷ Throughout the first decade of independence, Zimbabwe's economy was highly regarded in the western circles. The economy grew at an average of 4% per year and substantial gains were made in education and health. Zimbabwe was handling its finances well and between 1985 and 1989, it had cut its debt service ratio in half. However, because the economy relied heavily on western financial institutions for funding, the government eventually succumbed to the international pressure to liberalise its economy in

¹⁷⁵ Ministry of Health and Child Welfare (1997) *National Health Strategy for Zimbabwe, 1997-2007* (Harare: Government Printers).

¹⁷⁶ The 'now' refers to the period between 1991 and 2008 when Zimbabwe's socio-economic and political situation was at its worst.

¹⁷⁷ Price-Smith A.T., and Daly J.L. (2004) "HIV/AIDS, State Capacity and Political Conflict in Zimbabwe" July 2004 www.usip.org/pubs/peaceworks/pwks53.pdf Downloaded from the website on 10 December 2004.

order to comply with their international funder's expectations. Consequently, in January 1991, Zimbabwe adopted its Economic Structural Adjustment Programme (ESAP) designed primarily by the World Bank. The programme called for the usual prescription of actions advocated by western financial institutions including:

- Privatisation
- Deregulation
- A reduction of government expenditures on social services and
- Deficit cutting.¹⁷⁸

Measures protecting local industry from foreign competition were also withdrawn. The result was a disaster for the people of Zimbabwe, especially the poor.¹⁷⁹ The previously stable attendance rates at the medical facilities plummeted after the introduction of user fees. The introduction of user fees for rural clinics in 1992 was instituted during the worst regional drought of the century. Immediately after fees were raised in 1991 and again in 1993/94, declines were noted in outpatient and antenatal attendance, prescriptions dispensed, admissions, X-rays, laboratory and dental services.¹⁸⁰ Some of the fee increases were dramatic, exceeding 1 000% and this impacted heavily on the utilisation of health services in both rural and urban areas.¹⁸¹ The real value of government medical stores drug fund fell by 13% from 1991-1992, while inflation reduced the real value of drugs supplied by 22% between 1990 and 1993.¹⁸²

Patrick Bond cites Zimbabwe's acceptance of strict structural adjustment of the economy in 1991 as an important reason for subsequent declines in social welfare, a stock market crash and rapid economic decline.¹⁸³ Guy Mhone echoes the same sentiment, reiterating how prior to ESAP, Zimbabwe's government prioritised social infrastructure spending, broadening and enhancing living standards throughout the 1980s which enabled it to significantly extend

¹⁷⁸ Zimbabwe Human Development Report (2003), 36.

¹⁷⁹ Elich G., "Swans Commentary: Zimbabwe Under Siege" 26 August 2002

www.swans.com/library/art/elich004a.html Downloaded from the website on 18 March 2004.

¹⁸⁰ Hongoro and C Chandiwana S (1994) "Effects of User Fees and Health Care in Zimbabwe" (Harare: Blair Research Institute).

¹⁸¹ Hongoro C and Kumaranayake L (2000) "Do they work? Regulating For-Profit providers in Zimbabwe" in *Health Policy and Planning* Volume 15 No. 4: 368-377 (Oxford: Oxford University Press).

¹⁸² Chisvo M. and Munro L. (1994) *A Review of the Social Dimensions of Adjustment* (Harare: UNICEF).

¹⁸³ Bond P., (2001) "Radical Rhetoric and the Working Class during Zimbabwean Nationalism's Dying Days" in *Journal of World Systems Research* Vol 17 No.1, 63.

education and health services to previously marginalized Zimbabweans. However, after giving in to the pressure to restructure in the early 1990s, “all that had been put in place in the previous decade started unravelling; the quality started deteriorating...There was just this assumption that ESAP would deliver through restructuring whereas things were collapsing.”¹⁸⁴ A 1994 survey in Harare found that 90% of those interviewed felt that ESAP had adversely affected their lives.¹⁸⁵ By 1995, over one third of Zimbabwe’s citizens could not afford shelter, clothing or a basic food basket, resulting in high nutritional deficiency. As a result, people’s health was adversely affected.¹⁸⁶ Rise in food prices forced many to reduce their food intake. Rises in fertiliser prices resulted in lower yields. According to the Poverty Assessment Study Survey of 1995, extreme poverty increased significantly during the 1990s, with an estimated 45% of households below the food poverty line in 1995, compared to about 26% in 1990. Based on the total consumption poverty line,¹⁸⁷ general poverty increased from around 40% of the total households in the late 1980s to 61% by 1995.¹⁸⁸

The cumulative outcome is that Zimbabwe continued to experience severe macro-economic instability characterized by unsustainable inflation rates of over 400%,¹⁸⁹ low foreign exchange reserves culminating in a real GDP decline of about 30% between 1999-2002 and a record negative GDP growth rate of -14.5% per annum in 2002 from a high of 7.0% per annum in 1990. Other manifestations of the worsening problem included erratic supplies of food and essential commodities, high build-up in external debt arrears and a decline in savings and investment.¹⁹⁰ The real cuts in health budgets and reductions in household incomes reversed all past health gains, reduced the quality of health care, demoralised

¹⁸⁴ Andreasson S. (2002) “Neoliberalism and the creation of ‘virtual democracy’ in the Global South” March 2002 [www.isanet.org/noarchive/andreasson Issa2002.pdf](http://www.isanet.org/noarchive/andreasson%20Issa2002.pdf) Downloaded from the website on 20 April 2004.

¹⁸⁵ Bond P., and Manyanya M., (2003) *Zimbabwe’s Plunge*, 37.

¹⁸⁶ Potts D. (1995) “Structural Adjustment and Poverty: Perceptions from Zimbabwe” in *Journal of Oriental and African Studies* (London: University of London).

¹⁸⁷ Total consumption poverty line refers to the level of income at which persons can meet their basic food and non-food needs.

¹⁸⁸ Zimbabwe Human Development Report, 2003,10.

¹⁸⁹ Zimbabwe continued to beat its own record of the highest inflation rates in the world outside a war situation, the last official recorded inflation rate for Zimbabwe in July 2008 was over 2.2 million per cent See Zimbabwe’s inflation rate a punishing 2.2 million per cent, 16 July 2008

<http://www.cbc.ca/world/story/2008/07/16/zimbabwe.html> (20 March 2009) For 2009, the media continued to approximate figures. Martin Fletcher in an article for February 2, 2009 entitled “Five-pound note buys two souvenirs and a wide smile in Zimbabwe” posted on <http://www.timesonline.co.uk/tol/news/world/africa/article5634865.ece> recorded Zimbabwe’s inflation rate to be exceeding 5 trillion per cent. Eventually, in February 2009, the local currency was officially declared out of circulation, having adopted multiple currencies, such as the United States Dollar, South African Rand and Botswana Pula.

¹⁹⁰ Zimbabwe Human Development Report, 2003, 11.

personnel in the health sector and their clients and led people to solve their health problems in ways that are not always effective for their own health or for the long term health of the nation. In 1980, the Ministry of Health was reported as providing 71% of health expenditure.¹⁹¹ Under ESAP, expenditures on health and education fell throughout the 1990s. Health expenditure as a share of GDP in real terms increased from 2.2% in 1980 to a peak of 3% in 1990. In 1995, it had declined to 2.2% of GDP.¹⁹² The Consumer Price Index (CPI) revealed that between 1990 and 2000, the cost of health and education services rose by 2106.3% and 857.2% respectively, relative to average prices.¹⁹³

The economy under stress continued to experience unprecedented levels of informalization or underground economic activities as the vulnerable population desperately tried to devise survival strategies. A large proportion of the structurally unemployed people, estimated at over 50% of the population in 2003,¹⁹⁴ were earning a living from generally insecure informal sector activities. These include cross-border trading, which is largely conducted by women, mineral panning¹⁹⁵ in selected provinces with mineral resources, petty trading, currency trading, and international migration (legal and illegal), among an endless list of survivalist options. Negative outcomes associated with these informal and non-traditional survival strategies include massive brain drain, particularly in the key social sectors of health and education and the increased risk of exposure to HIV and AIDS linked to high population mobility associated with many of the informal sector activities.¹⁹⁶

As such, when the HIV virus first struck Zimbabwe in 1985, it found already in place, ‘fertile socio-economic ground’ in the form of widespread socio-economic vulnerability,¹⁹⁷ which presented an ideal environment for its rapid spreading.¹⁹⁸ Like her Southern African neighbours Botswana and South Africa, Zimbabwe faced a devastating HIV and AIDS

¹⁹¹ Ministry of Health and Child Welfare, 1984.

¹⁹² Zimbabwe Human Development Report, 1998.

¹⁹³ Zimbabwe Human Development Report, 2004.

¹⁹⁴ By January 2009, approximately 94% of the population were not formally employed, meaning that fewer than half a million people in the country were formally employed.

¹⁹⁵ Commonly known as ‘chikorokoza’, ‘zungura’ or ‘chiyadzwa’ in Shona, one of the local languages.

¹⁹⁶ Zimbabwe Human Development Report, 2003, 11.

¹⁹⁷ Socio-economic vulnerability in this context is defined as ‘a process in which people are subjected to economic and social re-engineering in such a manner that they are left with little or no options of pursuing sustainable socio-economic survival strategies.’ For more information on this, please see Zimbabwe Human Development Report 2003, (2003) *Redirecting our responses to HIV and AIDS: Towards reducing vulnerability-the ultimate war for survival* (University of Zimbabwe Publications: Harare).

¹⁹⁸ Zimbabwe Human Development Report, 2003, 1.

epidemic which saw the economically active age group being decimated and funerals became commonplace in the 1990s.¹⁹⁹ As the HIV&AIDS epidemic hit hard on Zimbabwe, from 1990-1995, per capita spending on healthcare fell by 20% in real terms.²⁰⁰ Consequently, the country ended up under-spending on health and infrastructure while over-spending on interest, defence and general administration. This was highlighted through a series of workshops organised by the Zimbabwe Council of Churches (ZCC) on the national budgeting process in Zimbabwe. Through these workshops it was established that social services had been severely affected by the foreign and domestic debt-servicing burden, with 36% of the budget going into debt servicing. “Noting large allocations to defence and government ministers’ 150% salary increases, the ZCC cynically observed that the politicians who formulate the budgets seek treatment abroad hence; they do not prioritise the national health budget.”²⁰¹

GDP growth only reached 5% during one year, 1994 and averaged just 1.2% from 1991-1995. Inflation averaged more than 30% during this period, and never dropped anywhere near the 10% goal. The budget deficit was more than 10% of GDP during this era.²⁰² Real per capita recurrent expenditure by the Ministry of Health and Child Welfare from 1991-1995 was declining by 50%. On a per capita basis, health expenditure declined from U\$22 in 1990 to U\$11 in 1996.²⁰³ Hitherto, the public health budget was not enough to meet the health needs and since 1991, the per capita budget fell to a level where it could not even pay for prevention, clinics and district hospitals per capita. The decreases in health care spending resulted in reduced maintenance, delayed upgrades of deteriorating health facilities, shortages of essential drugs and the high rate of staff attrition to the private sector and abroad.²⁰⁴ By 1994, the share of the Ministry of Health expenditure on health had fallen by 29%, with 31% coming from individual direct payments and 12.2% from donor financing.²⁰⁵ The fast-growing HIV and AIDS epidemic also added to the crisis with hospitals failing to cope with the demand for services. By 1996, the health allocation on the budget was only 2.1% of GDP

¹⁹⁹ Chitando E (2002)., “‘Down with the devil, Forward with Christ!’ A study of the interface between religious and political discourses in Zimbabwe.” *African Sociological Review* 6, no.1

²⁰⁰ UNDP/PRF/IDS (1999) *Zimbabwe: Human Development Report 1999*, 33.

²⁰¹ Loewenson R. (1998) *Health in Zimbabwe*, 18.

²⁰² Bond P and Manyanya M (2003) *Zimbabwe’s Plunge*, 32.

²⁰³ Auditor General’s Report, 1996.

²⁰⁴ Dhilwayo R., (2001) “The Impact of Public Expenditure Management Under ESAP on Basic Social Services: Health Education” Paper presented at the University of Zimbabwe, Department of Economics, March 2001

²⁰⁵ Loewenson R., (1996) “Public Participation in Health Making People Matter” www.ids.ac.uk/ids/health Downloaded from the website on 5 March 2004.

at a time when the HIV and AIDS epidemic was devastating the young productive workers. The rural and district hospitals, where the majority of the people seek health care (about 80 per cent of the population) received less than 49% of the public health budget.²⁰⁶

Access to health care is critical in the health dimension, particularly under the HIV and AIDS epidemic environment. Between 1995 and 2001, the nation experienced a 43% decline in access to health.²⁰⁷ This has impacted heavily on life expectancy and mortality rates. Although infant and child mortality had declined during the 1980s, it has been on the increase particularly since the mid-1990s. Infant mortality increased from 40 to 65 per 1 000 live births, while under five mortality increased from 59 to 102 per 1 000 live births between 1985-89 and 1995-1999. This implies that one in 15 children will die before their first birthday and that one in ten children will die before attaining the age of five years, respectively.²⁰⁸ Immunization programmes whose coverage had risen during the period 1992-1994 were also affected negatively and started declining. The decline in vaccinations is attributed to the weakening health delivery system, shortage of drugs, high staff shortages and the presence of child and grandparent headed households due to the HIV and AIDS epidemic.²⁰⁹ Maternal mortality continues to pose a major problem for Zimbabwe, with most deaths occurring outside the health institutions i.e. in the community. Maternal mortality figures were estimated to be 283 deaths per 100 000 live births during 1984-1994, rising sharply to 695 per 100 000 live births during 1995-1999. This sharp rise in maternal mortality is largely attributable to the rapid spread of the HIV and AIDS epidemic and the decline of access to health care facilities.²¹⁰ The direct and indirect impact of the HIV and AIDS epidemic, the concomitant rise in poverty levels, and a weakened and overburdened health delivery system all combined together to militate against the whole population's access to health care.

Increasing poverty, poor environments, lack of access to health care and the rising tide of the HIV and AIDS epidemic fuel the resurgence of TB, which thrives on immune systems weakened by chronic infections and by malnutrition. A combination of all these factors also

²⁰⁶ Thompson C.B., (2003) "Globalizing land and food in Zimbabwe: Implications for Southern Africa" in *African Studies Quarterly* Vol.7 No.2&3

²⁰⁷ Zimbabwe Human Development Report, 2003, 7.

²⁰⁸ Zimbabwe Human Development Report, 2003, 18.

²⁰⁹ Zimbabwe Human Development Report, 2003, 9.

²¹⁰ Zimbabwe Human Development Report, 1999.

impacts negatively on human development through lowering life expectancy. Between 1990 and 2000, TB cases in Zimbabwe are estimated to have increased five-fold, from 9 132 cases in 1990 to 30 831 cases in 1995, and 51 918 cases in 2000.²¹¹ Life expectancy also decreased drastically during the same period ranging from -17 years in Midlands province, -16 in Matabeleland North and South, -15 Mashonaland East, -14 Masvingo province and the overall decline for the whole country is -14 during the same period. It is striking to note that life expectancy declined most in Midlands province and in Matabeleland North and South, provinces noted for informal sector income benefits. This decline in life expectancy also impacts negatively on human development through resource depletion and a general lowering of productivity.²¹²

It is evident that ESAP dismally failed to produce the positive results it was intended to achieve. The main areas targeted for action by ESAP were employment and training, monitoring and evaluation, cost recovery, removing food subsidies and social services. All these had far-reaching negative repercussions for the economy and the people's health. The most graphic depiction of the harshness of ESAP comes not only from the statistics highlighted above but also from the people themselves. Most of those interviewed described ESAP as "a predatory animal such as the lion or hyena who targets unfit animals which they first isolate from the fit ones... ESAP killed the happiness that came with independence".²¹³ Others referred to ESAP as "...pests, grain weevils which destroy what they did not assemble in the first place, pests therefore deserve to be destroyed, ESAP took away what the country had established through political independence, (progressive education policies and access to health care), it should therefore be eliminated."²¹⁴ In 1997, a meeting of 300 women from the United Methodist Church in Mutare noted the deterioration of the health services and reiterated that "ESAP has brought into people's lives horrendous suffering, increased poverty and starvation".²¹⁵ ESAP caused such untold misery and suffering for the people of Zimbabwe such that others came to interpret the acronym ESAP to mean "Elimination of

²¹¹Zimbabwe Human Development Report, 2003, 16.

²¹² Zimbabwe Human Development Report, 2003,16-17.

²¹³ Thompson C.B., (2003) "Globalizing land and food in Zimbabwe: Implications for Southern Africa" www.web.africa.ufl.edu/asq/v7/v7i2a10.htm Downloaded from the website on 14 May 2004.

²¹⁴ Nyathi T., and Makoni K., (2001) "ESAP and the Lives of Ordinary Citizens Today: Views of Ordinary Zimbabweans on effects of ESAP" Paper presented at the Structural Adjustment Participatory Review Initiative (SAPRI), Poverty Reduction Forum (Harare, 9-10 April 2001).

²¹⁵ Loewenson R. (1998) *Health in Zimbabwe*, 9.

Social Assistance of the People”.²¹⁶ Some even interpreted it to mean “Eternal Suffering for African People.”²¹⁷ This is mainly because it produced ever-increasing hardship, especially on poor families where four or five people dependent on one person’s income ended up with no source of livelihood after that person had been retrenched because of new labour policies under ESAP.²¹⁸

The economic and political crisis engulfing Zimbabwe from the mid-1990s onwards was the result of a combination of factors, chief among them being the deindustrialising effects of ESAP, the intransigent manner in which the Mugabe government sought to respond to this crisis as well as the outbreak and spread of the HIV&AIDS epidemic as will be explicated in the following sections. Although Zimbabwe’s ESAP was inaugurated in 1991 and expired in 1995, its after-effects continue to be felt even today.²¹⁹ It is apparent that the majority of Zimbabweans regarded ESAP as an evil that robbed them of all that had been gained before its inception. These structural adjustment policies also impacted heavily on employment in the public health sector as will be discussed below.

2.7.2 Shortage of Personnel in the Public Health Sector

Prior to the economic meltdown in the 1990s, public health institutions were the most commonly utilised health services. In 1993, it was estimated that about 92% of health services in Zimbabwe were provided by government institutions, 5% by mission hospitals and Non Governmental Organisations (NGOs) and the remainder by the private for profit sector.²²⁰ However, adequately staffing the public health facilities proved to be a much bigger challenge than building or even upgrading them. The strain was especially felt in the public health sector because there has always been a maldistribution between the public and the private health sectors since UDI. Although employment in the health sector grew by an average of 5% per year to reach 25 000 by 1990, however, the concentration of health workers in major cities meant that this general improvement did not translate into improvement for everyone, especially the rural population. The proportion of doctors in

²¹⁶ Dhliwayo R. (2001) “The Impact of Public Expenditure Management Under ESAP...”, 10 .

²¹⁷ Bond P., and Manyanya M (2003) *Zimbabwe’s Plunge: Exhausted Nationalism, Neoliberalism and the Search for Social Justice* (Pietermaritzburg: University of Natal Press) ,84.

²¹⁸ Hill G. (2003) “*The Battle for Zimbabwe: The Final Countdown* (Cape Town: Zebra Press), 17.

²¹⁹ Carmody P., and Taylor S., (2002) “Industry and the Urban Sector in Zimbabwe’s Political Economy” 8 February 2002 www.africa.ufl.edu/asq/v7/v7i2a3.htm Downloaded from the website on 15 May 2004

²²⁰ Hongoro C., and Kumaranayake L., (2000) “Do they work? Regulating For Profit Providers in Zimbabwe”

public (government or university) service rose by only about 10% between 1980/91 and 1989, leaving most medical practice in the private sector. Although the number of doctors graduating from the local university increased by about 40%, there was however a high loss from government service with less than 15% of graduates in government service five years after graduating. This unequal distribution of personnel in the private/ public sector was even worse in the case of specialists because there were only 29% of specialists in government between 1989 and 1998.²²¹ By 1998, about 60% of registered doctors were in the private sector, mainly in the urban areas. A further obstacle is that most of the doctors registered with the Ministry of Health also carry out private practice and spend much of their time in their private surgeries to the disadvantage of patients in the public institutions. This particularly presents a great cause of concern as staff- patient ratios in the public sector continue to fall.²²² Clearly, the negative effects of ESAP increased problems on the already strained public health sector and the number of personnel and the quality of service continued to deteriorate.

The health personnel situation in Zimbabwe did not improve substantially in the 1990s despite growing population needs. Personnel problems intensified due to the loss of trained personnel through the brain drain of doctors and nurses into the private sector and also into neighbouring and far away countries offering better salaries and conditions. Researchers and analysts have termed this mass exodus of health workers a ‘brain haemorrhage’ denoting the intensity and severity of these migrations.²²³ The total number of registered health staff in the country as of March 1995 stood at about 24 625. Specific scarcities in health professionals are overwhelming; for instance, in 1995, public health institutions were reported to be facing a critical shortage of pharmacists with only 72 out of the 450 pharmacists posts filled. Of the existing personnel in 1995, most continued to be concentrated in private practice, including 59% of doctors, 92% of pharmacists, 39% of general nurses and 38% of state certified nurses.²²⁴ By 1996, the number employed in the health sector had risen by only 1 000 to 26 000 and therefore reducing the number of health workers to one for every 454

²²¹ Loewenson R. (1998) *Health in Zimbabwe*, 12.

²²² Dahlin O. (2000) *Zvinorwadza*, 102.

²²³ Dube L. (2009) “HIV and AIDS Gender and Migration: Towards a Theological Engagement” in *Journal of Constructive Theology* Volume 15. No.2, 71-82.

²²⁴ USAID, 1996.

Zimbabweans, a ratio approaching the situation in 1980. It is apparent that the overall per capita supply of health workers has continued to decline.²²⁵

The loss of staff to outside countries and the private sector left the establishment in the public sector very small, with very few health personnel to deliver adequate care.²²⁶ The quality of care perpetually declined, and poor staffing, inadequate recurrent resource allocations and a massive increased workload due to HIV and AIDS compounded the loss of morale and added strain among the health staff. The Ministry of Health and Child Welfare Human Resource Master Plan, covering the period from 1993 to 1997, compared the number of actual posts within the Ministry with the identified requirements and noted the need for:

- 1 219 additional doctors
- 6 328 additional nurses (all grades and types)
- 139 pharmacists and 247 pharmacy technicians
- 294 scientists/ lab technicians and 122 laboratory technologists.²²⁷

In 1995, the Ministry of Health estimated that in a situation where government needed 400 more doctors, the medical school produced 85 annually, making training a necessary but insufficient approach in meeting the need. Over 450 doctors were lost between 1990 and 1997 to neighbouring countries, almost the same number as those trained during the same period. The Ministry noted that the causes of staff attrition needed to be addressed, including uncompetitive salaries. The permanent secretary in the Ministry of Health in 1995 stated: “No one wants to go and work when he [*sic*] knows he [*sic*] can get a better salary elsewhere... Health care has a sense of ethics and goodwill and we cannot call for goodwill if a person is disgruntled.”²²⁸ The health sector was also prejudiced by the fact that the country imports inputs, for instance drugs and equipment, however they produced for and were paid in the domestic market.²²⁹ As such, they lost rather than gained from the currency devaluations under ESAP. The health sector wages declined mainly because the price for services in the

²²⁵ Loewenson R. (1998) *Health in Zimbabwe*, 12.

²²⁶ Nzenza S. (1988) *Zimbabwean Woman: My Own Story* (London: Karia Press), 89.

²²⁷ Loewenson R. (1998) *Health in Zimbabwe*, 14.

²²⁸ Loewenson R. (1998) *Health in Zimbabwe*, 14.

²²⁹ Following the formation of the transition government between the Mugabe regime and the main opposition party MDC, from March 2009 civil servants started to receive their salaries in US\$ as a precautionary measure to cushion them from the prevailing extremely high inflation which made the local currency worthless.

sector are subject to public sector regulation which attempts to keep down costs of health service provision by not letting health service charges rise in line with inflation. This put a lot of pressure on health workers' wages and they ended up earning much less compared to other sectors such as manufacturing and finance. An assessment of the wages in terms of the Consumer Price Index revealed that health workers' wages declined from \$2 870 per year in 1980/84 to \$1 788 in 1995/96. Resultantly, the average health worker's wage in 1996 bought 62% of what it could in 1980/84.²³⁰ Rudo Gaidzanwa reiterates that the sharp cutbacks in Zimbabwe's health sector with which most doctors and nurses have had to cope affect their capacity to carry out their work effectively. Factors such as poor infection control, poor work environments, inadequate pay and benefits, new demands with inadequate inputs and high job stress push personnel out of health systems.²³¹ A combination of all these factors has forced many nurses and doctors to migrate to neighbouring countries which offer better working conditions, especially to Botswana, South Africa, Mozambique and others have gone further away as far as Canada, United States and the United Kingdom.²³² All these grievances in the health sector culminated in a nation-wide strike by health personnel in 1996 as will be discussed below.

2.7.3 The Public Health Staff Strike in 1996: The Final Blow

The conditions of service for health workers deteriorated sharply due to budget cuts following the introduction of ESAP. The cumulative effects of reduced resource allocations, increased demands, increasing work stress and reduced salaries are an inflammatory combination for industrial action. The health personnel bedevilled by low morale, lack of motivation and long hours of work with low remuneration were forced to resort to undertaking an industrial action. There were so many unresolved grievances, some of which had not been addressed for over 15 years. The workers complained of being overworked due to staff shortages. For instance, in the medical wards of several major hospitals it was reported as typical to have one nurse and two nurse aides for 40 patients. The HIV and AIDS epidemic and TB brought tremendous pressure on the health delivery sector as the nation experienced a sharp increase in disease burden. Health staff also reported stress due to their

²³⁰ Loewenson R. (1998) *Health in Zimbabwe*, 24.

²³¹ Gaidzanwa R (1999) *Voting with their Feet: Migrant Zimbabwean Nurses and Doctors in the Era of Structural Adjustment* Research Report No. 111.(Uppsalla: Nordiska Afrikainstitutet), 81.

²³² Clarinet News "Zimbabwe state doctors strike for 8,000 percent pay rise," 25 October 2003
www.quickstart.clari.net/qs_se/webnews/wed/cc/Qzimbabwe-health-strike.R5pO_DO (22 December 2004).

increased risk to drug resistant diseases such as the outbreak of TB that occurred amongst nurses in 1993 at Chiredzi Hospital.²³³ They also complained of being undermined by the lack of equipment and drugs.²³⁴

For most nurses at public hospitals, the supply of gloves is a major area of contention. Nurses contended that before the 1990s cuts in supply, they could use up to 20 pairs of gloves per day. However, since the cuts, the nurses were restricted to less than five pairs of gloves per day and any more being regarded as wasteful. Some nurses indicated that they were often forced to keep soiled gloves in their pockets for re-use and others indicated that they even used bare hands since there is no difference between using bare hands and gloves that have so many tears and holes. Clearly, this compromises both the nurses' and the patients' health since it increases the risk of nurses being infected and their infecting other patients in turn. The issue of risk of infection or contracting HIV, TB or Hepatitis B has caused so much frustration and anxiety among health staff.²³⁵ One nurse reported working with 26 nurses who died of HIV or AIDS in two years. Others reported harassment of nurses who complained about being pricked by a needle, cut or exposed to blood or vomit, stating that such complaints are usually thrown back and at times the complainant is asked to fill in forms, being accused of insubordination. As such, most nurses kept quiet for fear of victimisation and harassment.²³⁶

Health workers also reported feeling powerless and stressed over their work and their inability to deal with their grievances. The nurses' superiors felt frustrated due to their failure to satisfy or manage the problems and demands raised by the nurses; on the other hand, nurses become angry because the complaints they make get no recourse. The nurses also got angry and frustrated with patients who blame them for shortages.²³⁷ One nurse was quoted saying, "We don't know where to put our anger. We are told by the superiors that we are uncooperative because we are making demands. We are told by the patients that we are rude,

²³³ Another TB outbreak in Chiredzi district was also reported in year 2000. The same district recorded the highest HIV prevalence among pregnant women in the same year. This could be indirect evidence that HIV prevalence was also very high among health staff. For more information on this, see Ministry of Health and Child Welfare Report, Zimbabwe, (2000).

²³⁴ Gaidzanwa R(1999) *Voting with their Feet*, 81.

²³⁵ Loewenson R (1998) *Health in Zimbabwe*, 23.

²³⁶ Loewenson R (1998) *Health in Zimbabwe*, 24.

²³⁷ Gaidzanwa R (1999) *Voting with their Feet*, 81.

and yes, sometimes we are rude, and they get mad at us.”²³⁸ Patients in turn get angry at the poor treatment they receive and there are reported incidences when patients spit and vomit intentionally on nurses to get back at them and show their anger at the type of care they get.²³⁹ This creates a vicious circle of anger and frustration among the health personnel and the patients.

The end result all this was that most of the public health personnel joined in the civil servants’ strike which for the first time united all Zimbabwe’s civil servants ignited by the government’s failure to pay promised wage increases.²⁴⁰ This was just the final spark that started off the strike that built on frustrations that had been mounting up in several sectors. In late 1996, a widespread strike by junior doctors and nurses crippled central and urban public services for a record 49 days resulting in wholesale dismissals and en-masse resignations, a severe blow that the country has not been able to recover to this day.²⁴¹

Although health workers in Zimbabwe are legally not allowed to strike since they offer essential services, and strikes are illegal in all essential services, they however felt the need to undertake industrial action since they felt that all other means of negotiation had failed. Furthermore, the Hippocratic Oath stipulates that a medical practitioner must abstain from acts of “mischief and corruption,” hence strikes by medical personnel are incompatible with the Oath unless harm to the patient can be avoided, for instance by the limited withdrawal of labour. Despite these restrictions, the health personnel still participated in the strike and the lack of a formal, mutually credible negotiating platform and the underdevelopment of industrial relations structures and skills in both employee and employer, undermined the various possibilities for effective resolution of the strike and prolonged the action for over a month.²⁴²

The 1996 strike is the most notable; it had far reaching repercussions, many lives were lost during the prolonged strike. The government’s response to the strike (i.e. firing many of them

²³⁸ Bartlett L. (1993) “Zimbabwe health strike: Zimbabwe’s health services collapsing as doctors strike”, www.aegis.com/news/afp/1999/AF990966.html (22 December 2004).

²³⁹ Loewenson R (1998) *Health in Zimbabwe*, 22.

²⁴⁰ Loewenson R (1998) *Health in Zimbabwe*, 27.

²⁴¹ Zenda C., (2003) “Doctors Strike: Final blow to dying Zimbabwe?” 30 October 2003.

www.fingaz.co.zw/fingaz/2003/October/October30/3977.shtml (22 December 2004).

²⁴² *The Herald* (1997) (Government Printers, 8 July 1997).

and threatening all of them with dismissal) further infuriated most of the already disgruntled workers who were demoralised by the fact that conditions were unlikely to improve within the public sector and they left to join the private sector or migrated to other countries. The staff shortages were exacerbated by the dismissal of staff after the industrial action. The permanent secretary in the Ministry of Health, Doctor P. Sikhosana, reported that by mid 1997, more than 800 nurses, including the 300 dismissed after the strike, had resigned from the ministry and a further 14 doctors had also resigned. This left the ministry with 1 500 vacant posts for nurses and 80 for doctors, resulting in further overworking the remaining personnel.²⁴³ Although the ministry increased the training capacity; only 50-60% of the staff was retained. This was attributed to the declining allocation of budget resources to health, subsequently poor working conditions and a health delivery system struggling to cope with an increase in diseases. In 1997, training continued to be the major way of addressing personnel needs; for instance, training posts were doubled from 760 general nurses per year, to 1 684 a year.²⁴⁴ This was the only possible strategy since the issues of wages and working conditions remained largely unresolved. However, it remains a limited strategy of addressing staff shortfalls since it does not address the major causes of attrition from the public sector. Hence, losses to the private sector continue to undermine the returns from such a massive investment.

2.7.4 The Negative Impact of Compensation paid out to Former Freedom Fighters, 1997-1999

The economic situation worsened in July 1997 when the former freedom fighters popularly known as ‘the war veterans’ led by the late Chenjerai Hunzvi, a medical doctor, started demanding compensation from the ruling government and went as far as demonstrating in the streets. They would settle for nothing less than a pension for life, a piece of arable land for each war veteran and an immediate payment of Z\$50 000 (US\$5 000). They caused such commotion, perpetrated massive destruction and threatened to invade white farms and take land by force if their demands were not met. Resultantly, President Mugabe eventually gave in to their demands. By Christmas 1997, all 50 000 of the people calling themselves war

²⁴³ *The Herald*, 8 July 1997 (Government Printers: Harare).

²⁴⁴ *The Herald*, 8 July 1997 (Government Printers: Harare).

veterans, most of whom had suspect credentials²⁴⁵, would receive a one-off sum of Z\$50 000, followed by a monthly pension of Z\$2 000 (US\$ 200) each, which was subject to future review in line with inflation.²⁴⁶

The World Bank questioned the feasibility of such an undertaking, in view of the lack of funds. Unfortunately, the government unwittingly ordered the Reserve Bank to print enough money to cover the payouts. In order to fund this programme, sales tax was raised from 15 to 17.5 per cent, the tax on electricity was increased and a fuel surcharge of 20 cents a litre was imposed. This was the beginning of Zimbabwe's economic plunge. International and local financiers pounded the Zimbabwe dollar; the reasons ranged from punishing Mugabe, to urgently transferring their Zimbabwe dollars to hard currency, to making money from selling the Zimbabwe dollar through a common form of currency speculation. On 14 November 1997, popularly known as the "Black Friday," the local currency tumbled from around Z\$10 to below Z\$30 to the US\$ over four hours of trading time. The currency crash was so severe, the worst ever experienced in such a short time in modern history. This made life unbearable for the working class which was already struggling to survive on meagre salaries. The trade union movement responded rapidly and organised the country's first post-independence national stayaway to protest against this move. On "Red Tuesday," 9 December 1997, Morgan Tsvangirai the secretary of the Zimbabwe Congress Trade Union (ZCTU), who later became the leader of the major opposition party Movement for Democratic Change (MDC),²⁴⁷ led a general strike.²⁴⁸ Thousands of people in Harare thronged the streets. The police reacted violently to the peaceful demonstrators who in turn became violent and started overturning cars and looting the shops. The Zimbabwe dollar again fell from around 21 to 40 against the US\$, leaving the economy in further disarray.²⁴⁹

By January 1998, price increases had been implemented on most basic goods but the hardest blow was maize meal, the staple food which would cost 36 per cent more. The

²⁴⁵ The term 'suspect credentials' denotes the fact that it was later revealed that most of those who claimed to be war veterans had never fought in the liberation struggle; worse still, some of them were even too young to have ever participated in the liberation struggle.

²⁴⁶ Hill G (2003) *The Battle for Zimbabwe*, 97.

²⁴⁷ On 11 February 2009, Morgan Tsvangirai was sworn in as Prime Minister of the transitional government for Zimbabwe to work together with Robert Mugabe his arch-enemy.

²⁴⁸ Bond P and Manyanya M (2003) *Zimbabwe's Plunge*, xi.

²⁴⁹ Hill G. (2003) *The Battle for Zimbabwe*, 98.

sending of troops into the DRC later in the same year was another major setback to Zimbabwe's economy since it was spending approximately US\$1 million a day into the DRC.²⁵⁰ Involvement in the war triggered a precipitous decline in Zimbabwe's economic performance and the value of the Zimbabwean dollar. In addition, it caused severe shortages of hard currency.²⁵¹ Doctors pointed to the cost of such a military intervention as outrageous in the face of the collapsing health services. Workers were more disgruntled as salaries had lost 75 per cent of their real value since 1980, and food prices had escalated by 500 per cent. It was also revealed that at 38 per cent, Zimbabwe had one of the highest average personal income tax rates in the world. All this led to further strikes and protests from the workers and the University students as well.²⁵²

By February 1999, the ZCTU had approved the formation of a union-based political party, MDC and the secretary Morgan Tsvangirai and his colleague, Gibson Sibanda resigned from the union executive to lead the movement, along with a well-known constitutional lawyer, Professor Welshman Ncube.²⁵³ The MDC through the opposition newspaper, (The Daily News)²⁵⁴ launched in March 1999, denounced Mugabe's rule as a disaster for the working class, pointing out that the social conditions were far worse than they had been at UDI, highlighting that 700 000 workers had lost their jobs since 1991. The public response was enormous; some academics, lawyers, human rights activists, university students as well as white Zimbabweans were attracted to the new party. In the past, people had suffered in silence but now their anger had a voice.²⁵⁵

²⁵⁰ Some analysts contend that Mugabe resented being displaced by the then South African President Nelson Mandela as the premier statesman of southern Africa. This war was a chance to draw Africa's attention on him. As the head of the SADC's Organ on Politics, Defence and Security; Mugabe believed he could reclaim his position as southern Africa's premier statesmen by aiding Kabila. Mugabe pitched the war as an effort to shore up a "democratically elected government". For more information see http://en.wikipedia.org/wiki/Second_Congo_War (5 March 2009).

²⁵¹ Bond P and Manyanya M. (2003) *Zimbabwe's Plunge*, 72.

²⁵² Alexander P (2000) "The Zimbabwean Working Class, The MDC and the 2000 Election", *Review of African Political Economy* 27, 85.

²⁵³ Hill G (2003) "*The Battle for Zimbabwe*", 105.

²⁵⁴ This newspaper was very popular with the working class, it chronicled all the ills perpetrated by the Mugabe regime but unfortunately, it was short-lived as it was banned from publication in September 2003, by the Mugabe government through their illegal repression of the media after having been subjected to three bombings, arrests of editors and staff and destruction of newspapers by ruling party militias, none of whom were arrested. All other private-owned newspapers were also banned.

²⁵⁵ Meldrum A (2004) *Where We Have Hope: A Memoir of Zimbabwe* (Great Britain: Murray Publishers), 115.

Amidst all this politico-economic turmoil, the medical personnel continued nursing the same grievances - long working hours, low salaries and inadequate equipment. A combination of all these factors culminated in another industrial action in September 1999, led by junior doctors who complained of broken equipment resulting in bloodstained linen from HIV&AIDS patients being hand washed, exposing the doctors to the danger of infection. One doctor at Parirenyatwa Hospital, the major referral centre in the country, described the situation as follows:

There is not even soap for doctors to wash their hands...and even if we could, there are no towels to dry them on. You can't examine patients properly because you don't have the right equipment. One week there will be no intravenous drips, next week, no blood supplies or x-ray films.²⁵⁶

The president of the Hospital Doctors' Association, Nyasha Masuka reiterated that they were striking not only for better salaries but for an overhaul of the entire health system which had reached a stage where they watched patients die because of lack of essential supplies. He was quoted saying, "junior doctors are doing the work of five doctors because the health service is so short-staffed. We sometimes work 56 hours continuously."²⁵⁷

The Health Minister Dr Timothy Stamps indicated that his efforts to win a bigger budget for health services and better pay for staff had failed. He expressed his sympathy with the junior doctors in these words; "we exploit them. We have been taking advantage of them for too long. You cannot get people to work as slaves."²⁵⁸

The impact of the 1999 strike was seriously felt by patients because, unlike in 1996 where army medical staff was brought into the hospitals to maintain basic services, in this case, that option was not open to the government. This is because most army medics were with Zimbabwe's troops in the Democratic Republic of Congo (DRC) where they were sent to support President Laurent Kabila against a rebellion.²⁵⁹

²⁵⁶ Bartlett L. (1993) "Zimbabwe health strike: Zimbabwe's health services collapsing as doctors strike", www.aegis.com/news/afp/1999/AF990966.html (22 December 2004).

²⁵⁷ Bartlett L. (1993) "Zimbabwe health strike."

²⁵⁸ Bartlett L. (1993) "Zimbabwe health strike."

²⁵⁹ Bond P and Manyanya M. (2003) *Zimbabwe's Plunge*, 72.

2.8 Land Invasions and the Consequent Economic Decline: Health System in Shambles, 2000-2001

The decade of 2000-2010 is the focus of this study since the fieldwork covers the period 2005-2007, seeking to establish the available health-care strategies adopted by health-seekers and health care providers in the face of a crumbling public health care system. It is therefore significant that a more detailed exploration of the socio-economic and political landscape during this period be explored in order to provide the setting and to show how such a setting impacted on people's health and the health care system. This will enable us to understand how people responded to the situation in the way they did.

As has been chronicled in the preceding discussion, the socio-economic and political environment in the country on the eve of 2000 had become so volatile, leaving the ruling government very vulnerable, causing it to lose popularity among the masses and amassing support for the MDC. As a result, when it proposed to amend the country's constitution giving more powers to the executive; increasing and consolidating the presidential powers which culminated in a constitutional referendum so as to accord the electorate to express their opinions through a vote, the majority outrightly resisted such a proposal and voted against it.²⁶⁰ The February 2000 constitutional referendum was promoted by the ruling government as "the people's chance to take Zimbabwe's democracy into the new millennium".²⁶¹ Conversely, the proposed draft constitution was described by the MDC as "a ruse to keep the ruling party in power" and they conscientized the whole population to vote "No" to this draft.²⁶² The civic coalition also called for a vote against the proposed constitution. On Monday 14 February 2000, the first results leaked out and although some rural areas had voted "Yes," some "No," however, in Harare and Bulawayo, the vote against the constitution had topped 70 per cent. The following night, Mugabe appeared on state television, announced the results and thanked people for voting peacefully and highlighted his acceptance of the referendum verdict. The people's reaction to the proposed new constitution was a clear sign that they were all fed up with the present government. Most people had not even read the draft document but they used the opportunity to send a message to the government.²⁶³

²⁶⁰ Meldrum A. (2004) *Where We Have Hope*, 120.

²⁶¹ Meldrum A. (2004) *Where We Have Hope*, 120.

²⁶² Hill G. (2003) *The Battle for Zimbabwe*, 106.

²⁶³ Hill G. (2003) "The Battle for Zimbabwe", 106.

Clearly, Zimbabwe's voters had delivered an unprecedented rejection of Mugabe just four months before the crucial parliamentary elections.²⁶⁴

The challenge to Mugabe's rule spread even within his own party, just a week after the referendum defeat, members of the Central Committee pressed him on when he intended to retire. In response, Mugabe insisted that it was not yet time for a discussion about his retirement. Andrew Meldrum chronicles the dramatic course of events during this fateful period:

Although Mugabe had merely put up a façade of acceptance of the referendum results, he was busy working on a strategy for reversing the referendum defeat... Within two weeks of the rejection of his constitution, he had come up with a new strategy that would crush his opponents, quell the stirring of unrest within his party and reinvigorate his image as the most radical African leader: the land invasions.²⁶⁵

Although the country had experienced two decades of land-reform failure, Mugabe managed to evoke the memory of an anti-colonial struggle and invoked the hope that only ZANU could resolve Zimbabwe's land inequality. Bond depicts the scenario in the following words:

In desperation, Mugabe resurrected ZANU's most militant, often virulent strain of nationalist demagoguery, attempting as time ran out to simultaneously 'solve' the long-standing land distribution problem, terrorise supporters of the opposition, and pass the buck for his own failings to the country's small white population, foreign countries (especially Britain and the US), imperialism in general and the IMF in particular.²⁶⁶

One evening, at the end of February 2000, the lead headline on the nightly news was 'Zimbabwean people reclaim the land that is their heritage'. The report revealed a parade of people dancing, waving the national flag and marching down a country lane onto a white-owned farm.²⁶⁷ This was Mugabe responding to the defeat of his constitution as well as revenging against the white commercial farmers who had been in the forefront of the campaign against the constitution. It was also a strategy of 'buying' votes from the land hungry peasants and small farmers who since the colonial era had been relegated to the country's worst soils and driest regions, alongside vast unutilised arable land on more than 4 000 white-owned commercial farms.²⁶⁸ Apparently, Mugabe used the land issue as his

²⁶⁴ Meldrum A. (2004) *Where We Have Hope*, 122.

²⁶⁵ Meldrum A. (2004) *Where We Have Hope*, 125.

²⁶⁶ Bond P and Manyanya M. (2003) *Zimbabwe's Plunge*, 75.

²⁶⁷ Meldrum A. (2004) *Where We Have Hope*, 126.

²⁶⁸ Bond P and Manyanya M. (2003) *Zimbabwe's Plunge*, 72; 75.

trump card, earmarking the rural votes where an estimated 80 per cent of the population lived. For the first time since independence, ZANU PF faced serious and highly organized opposition. The MDC enjoyed the support of urbanized workers as well as the backing of the affluent white community; this included the white farmers, with their ‘perceived influence’ over thousands of farm workers. ZANU PF’s best chance of winning the June 2000 elections was to capture the rural vote, including that of the farm workers, and to create a climate of hostility against Zimbabwe’s white population. To this end, within months of the formation of MDC, Mugabe announced that he was to commence a comprehensive land distribution programme and planned to seize white commercial farms to give to the ‘landless poor’. For many years, rural black people had been living on overcrowded communal land. The promise of highly productive, fertile land which for years had been giving white farmers a more-than-comfortable life-style was irresistible. At the same time, Mugabe sought to placate the dissatisfied war veterans by giving them the long-awaited land.²⁶⁹

Although land starved peasants and farm-workers who invaded a few white owned commercial farms during 1997-1998, egged on by the uproar over the land designation exercise, were regularly cleared off by the authorities, nonetheless, the 2000 land invaders had the full backing of the government. The government provided Z\$20 million (US\$500 000) to fund the war veterans who were the ring-leaders in the farm invasions.²⁷⁰ State-owned buses prowled Harare’s industrial estates looking for employment seekers whom they offered “Z\$50, a meal and a plot of land in exchange for joining the war veterans. They would be transported to a rural area close to town, where the real veterans would tell them what to do. They were ferrying people to the farms using stocks of chronically scarce fuel”.²⁷¹ Army officers and agents of the Central Intelligence Organisation were seen at the farms, speaking on mobile phones and organising the logistics of the invasions. The severity of attacks ranged from courteous negotiation to total occupation of the farmer’s home, forcing him and his family to withdraw to a neighbouring property or the safety of the nearest town. Meldrum depicts the whole exercise in the following words:

White-owned farms in every province were occupied by a motley of war veterans, ZANU -PF loyalists and unemployed youths. Within a few days the number of farms occupied grew from a handful to a few dozen and then a few hundred. Brandishing

²⁶⁹ For more information, see Hudleston S. (2005) *The Face of Courage* (Juta & Co. Ltd: Cape Town).

²⁷⁰ Hill G (2003) “*The Battle for Zimbabwe*, 108.

²⁷¹ Hill G (2003) “*The Battle for Zimbabwe*, 108.

clubs wrapped with barbed wire, axes and iron bars, the war veterans threatened the farmers and forced many to flee their properties. They slaughtered cattle and sheep for feasts and set up shanty camps on the properties; they disrupted planting and harvesting; they also beat farm workers and chased many of them away.²⁷²

In the first few days of the crisis, the police responded to calls for help and turned the veterans away; however, the police commissioner Augustine Chihuri then sent out word that his officers should not intervene in ‘political matters’, and rural communities were left to fend for themselves.²⁷³ Mugabe also commented that no action would be taken against the war veterans “because they were only demonstrating for their right to the land”.²⁷⁴

By the middle of March 2000, approximately 500 farms had been occupied, and the Commercial Farmers’ Union (CFU) had opened dialogue with the government. Union members offered to hand over a total of five million hectares for resettlement, without payment of any compensation but the offer was rejected. The Reserve Bank of Zimbabwe gave Mugabe a confidential report criticising the farm occupations and predicting major fall-out on three fronts:

- all foreign investment would disappear
- there would be no further money from the IMF
- Many farmers had mortgaged their properties, and unless they could grow and sell crops, they would default on their loans to the commercial banks, creating a financial crisis.²⁷⁵

In spite of all the warnings, Mugabe turned a deaf ear and allowed the land invasions to continue in full swing. Many people who were injured during this chaotic period struggled to access medical care at government medical institutions because the staff refused to admit people who had been beaten up by ZANU PF thugs, fearing to lose their jobs. Public health care workers were under strict instruction from the ZANU PF thugs not to attend to these politically motivated medical cases. This is because, the status quo had been declared to be in a state of war, the farm invasions process was codenamed *Hondo yeminda* [War/Struggle for Land].²⁷⁶

²⁷² Meldrum A. (2004) *Where We Have Hope*, 126.

²⁷³ Hill G. (2003) *The Battle for Zimbabwe*, 108.

²⁷⁴ Meldrum A. (2004) *We Have Hope*, 126.

²⁷⁵ Hill G. (2003) *The Battle for Zimbabwe*, 110.

²⁷⁶ Meldrum A. (2004) *Where We Have Hope*, 126.

By 19 May 2000, about 1 477 farms had been occupied, twenty people had been killed during the exercise and more than a thousand cases of torture were reported. One common form of torture that was enforced during the farm invasions was rape, most farm workers were women and children and the farm invaders used rape as a weapon to intimidate and force them out of the farms. Some male farm workers were also violated with sodomy. This also added the risk of further spreading infection of the HIV virus.²⁷⁷ By June 2000, when the parliamentary elections were held,²⁷⁸ so much violence between ZANU -PF and MDC had erupted such that many had died and thousands had been injured. The elections were held on 24 June 2000. Immediately as elections began, there were numerous accounts of intimidation and irregularities from around the country. These reports ranged from war veterans barricading polling stations to harassing, attacking or abducting polling agents. Some polling stations were issued with wrong voters' rolls; in other cases, the voters' rolls were missing altogether. Some voters were told to return the next day. Amidst all the chaos, intimidation and other electoral problems, the MDC scooped 57 seats as compared to the 62 ZANU PF seats. This was not sufficient to form a new government for Zimbabwe, but the seats won were more than the required third to block any changes that Mugabe might attempt to implement on the country's laws and constitution.²⁷⁹ More than 1 000 white owned commercial farms continued to be occupied by settlers in the months after the June 2000 election, with ongoing invasions in the northern and eastern-central parts of the country through 2001. Unfortunately, with resource shortages of fertilisers, pesticides, marketing support and credit, the sustainability of resettlement operations was rapidly thrown into question.²⁸⁰ The land invasions also added problems to the pre-existing economic crisis by destroying a substantial portion of commercial agriculture, which provided 45% of the country's foreign exchange revenue and livelihood for more than 70% of the population. This caused a sharp decline in foreign earnings as well as severe food shortages. Since the Zimbabwean government decided to redistribute land without compensating the white commercial farmers who had the land, the international community retaliated by withdrawing

²⁷⁷ Meldrum A. (2004) *Where We Have Hope*, 126.

²⁷⁸ Hill G. (2003) *The Battle for Zimbabwe*, 116.

²⁷⁹ For more information, see Hudleston S. (2005) *The Face of Courage* (Juta & Co. Ltd: Cape Town).

²⁸⁰ Bond P and Manyanya M. (2003) *Zimbabwe's Plunge*, 79.

aid to a variety of activities including agriculture. As land invasion continued, the fiscal deficit continued to rise.²⁸¹

All these fuelled the raging fires within the health sector which was already heaving under the sigh of increased burden of diseases; particularly the increasing numbers of HIV and AIDS related illnesses and deaths. Bryan Callahan catalogues the hardships and tragedies that have shaken the country for years on end:

Since independence in 1980, Zimbabwe's citizens have staggered under the weight of multiple burdens, including economic recession, IMF sponsored structural adjustments, government corruption, political violence, ethnic tensions, land scarcity, drought, and an HIV/AIDS epidemic that has killed many of the country's brightest and most productive people.²⁸²

By the end of 2000, the bankrupt government allocated even less of a declining overall budget to rural clinics, only 20%. The government also reduced grants to church related and local authority hospitals. Spending on preventive health care fell from its peak of 15% of the total health budget in the mid 1980s to 9.9% in 2001.²⁸³ This had far-reaching repercussions, especially in the light of the HIV and AIDS epidemic. Zimbabwe has experienced one of the world's most severe HIV and AIDS epidemics. In 2000, nine out of the eleven provinces in the country had HIV prevalence rates of 30% and above, with Masvingo and Midlands provinces being top of the list. Prevalence increased from 17.4% in 1995, to 25.1% in 2000, and to 33.7% in 2002.²⁸⁴ It was the second highest in prevalence after Botswana at 36% in 2002.²⁸⁵ By 2001, the country was suffering from a critically high infection rate of HIV and AIDS as one out of four adults in a population of approximately 11 million in Zimbabwe was living with the virus, that is a total of 2.0 million adults were infected,²⁸⁶ translating into an adult prevalence of 33.7%.²⁸⁷ This figure was the third highest in the world, behind Botswana

²⁸¹ Zimbabwe Human Development Report, (2003), 162.

²⁸² Callahan B., (2001) "Review of Terence Ranger's *Voice from the Rocks: Nature, Culture and History in the Matopos Hills of Zimbabwe*." *Philosophia Africana* 4, no.1 (2001), 83-88.

²⁸³ Loewenson R., (2000) "2001 Health Budget: Enough to Make You Sick"

²⁸⁴ By 2009 the prevalence rate is said to have steadily decreased from 25.7 percent in 2002 to 21.3 percent in 2004, dropping to 17.7 in 2006 and further down to 15.1 in 2008. See IRIN ZIMBABWE: HIV rate falls again, Thursday 7 May 2009 <http://www.irinnews.org/report.aspx?ReportId=75120>.

²⁸⁵ Ministry of Health and Child Welfare, Zimbabwe, 2000; UNAIDS, 2002.

²⁸⁶ Of these 2 million adults infected, 1.2 million or 60% are women, implying that there are more women infected than men.

²⁸⁷ Noguera M et al (2004) "Zimbabwe: Antiretroviral Therapy Programme Therapy Programme Issues and Opportunities for Initiation and Expansion" February 2004 www.deliver.jsi.com Downloaded from the website on 10 June 2004.

at 38.8% and Swaziland at 34.5%.²⁸⁸ According to Loewenson, HIV and AIDS has severely affected the overall health of the people in the Southern Africa region by impacting directly on individuals and their families and by placing additional burdens on economies, social structures and health services. Poorer people are disproportionately affected because they have fewer resources to deal with the impact of the epidemic on their daily lives.²⁸⁹ Mary Ndhlovu chronicles it all:

Not only goods, but also services are either not available or unaffordable. Starved of government finance, social welfare has long collapsed as a point of last resort for the destitute. Hospitals have no equipment or medicines and few qualified staff. A patient with a fracture is told to bring plaster of paris before his [*sic*] bone can be set...Doctors' fees, hospitals and medicines are unaffordable except for the elite and many procedures are no longer provided in the country. Employees on medical aid are not better off as the medical aid societies quarrel over rates and payment procedures, leaving the patients to pay cash and claim later. When a simple consultation, laboratory test and prescription may cost half a salary, or more, it will be rational for a worker to terminate medical aid subscriptions...leaving health care accessible only to the very rich.²⁹⁰

Access to ARVS also became an issue of major concern. Among the 2 million who were HIV positive, with approximately 600 000 having progressed to AIDS and needing life prolonging antiretroviral drugs, virtually the only ones who got them are the 5 000 who could afford them. Relief workers estimated that less than 1 000 Zimbabweans were receiving antiretroviral drugs through government or charitable programs, with little hope of expanding that number.²⁹¹ Worse still, inadequate food supplies jeopardized the administering of medication since most of the medications require observing a properly balanced diet. Children and HIV positive breast feeding mothers are sometimes given low priority in food distribution, leading to their rapid decline. People who live with HIV are precipitated into AIDS if faced with poor nutrition and stress, shortening their life expectancy and diminishing their quality of life. This has ripple effects in failure to properly treat TB, STIs and malaria, leading to drug resistant strains and continued transmission of infection.²⁹² By 2001, about 3 500 Zimbabweans were dying through a combination of poverty, malnutrition and HIV and

²⁸⁸ Zimbabwe Human Development Report, (2003), 49.

²⁸⁹ Ray S and Kureya T (2003) "Zimbabwe's Challenge: Equity in the Health Sector, Responses to HIV/AIDS in Zimbabwe" www.equinetafrica.org/policy.html Downloaded from the website on 22 June 2004.

²⁹⁰ Mary Ndhlovu M., "Zimbabwe in March 2004: Four Years From the Beginning of the Plunge", March 2004 www.worldhunger.org/articles/04/Africa/ndlovu.htm (7 August 2004).

²⁹¹ Ministry of Health and Child Welfare, Zimbabwe, 2000; UNAIDS, 2002.

²⁹² Zimbabwe Human Development Report, (2003), 49.

AIDS per week in an estimated population of 11 million.²⁹³ About 200 000 people (adults and children) are estimated to have died in 2001.²⁹⁴ These many deaths have important implications on the economy as a whole, by reducing population growth and life expectancy; lowering worker productivity and raising dependency ratios in rural areas since most patients retire to recuperate and sometimes die in the privacy of their rural homes receiving home based care from their families. According to the Global Human Development Reports, Zimbabwe's human development index (HDI) which peaked at 0.621 in 1985, declined to 0.551 by 2000.²⁹⁵ Population growth stagnated; for instance, the official population figures for Zimbabwe were 10.4 million in 1992 and 11.6 million for 2002, giving a population growth rate of 1.1% between 1992 and 2002, down from nearly 3% in the first decade of independence, 1982-1992. This is a huge drop, considering that the population was still at 11.6 million in 2002 and yet according to projections, in the absence of the HIV and AIDS epidemic it was expected to have grown up to more than 14 million by 2002.²⁹⁶ Life expectancy at birth declined from 61 years in 1990 to 43 years²⁹⁷ for the period 2000-2005. The impact of HIV and AIDS on life expectancy cannot be over-emphasized; the estimate of 43 years for Zimbabwe in 2000-2005 is 26 years lower than it would have been without HIV and AIDS.²⁹⁸

Rural communities have also been hardest hit since most patients resort to the rural areas due to their inability to pay for the rising cost of services in urban areas.²⁹⁹ The difficult macro-economic environment has resulted in a reduction of the social safety nets provided by the public sector.³⁰⁰ The home based care programme also poses a strain on the rural family's income and productivity. The challenge for many caregivers is the lack of resources and reduced productivity, as they care for their loved ones; it becomes difficult to go to the fields

²⁹³ Loewenson R., (2000) "2001 Health Budget: Enough to Make You Sick" *The Herald* 21 November 2000: (Government Printers: Harare).

²⁹⁴ Zimbabwe Human Development Report, (2003), 51.

²⁹⁵ Zimbabwe Human Development Report, 2002.

²⁹⁶ Matinhure N (2003) "Demographic research report," *Zimbabwe Human Development Report 2002/3*. Government of Zimbabwe, Mimeo: Harare.

²⁹⁷ This figure has been slashed to 33 years for women and 37 years for men during the period 2005-2009- the world's lowest. See Zimbabwe Association of Doctors for Human Rights (ZADHR), ZADHR statement on World Health Day, April 2008.

http://www.kubatana.net/html/sectors/zim065.asp?orgcode=ZIM065&year=0&range_start=1 (20 March, 2009)

²⁹⁸ Zimbabwe Human Development Report, (2003), 8.

²⁹⁹ World Bank (1996) *Understanding Poverty and Human Resources in Zimbabwe: Changes in the 1990s and Directions for the Future* (World Bank: Washington DC).

³⁰⁰ UNAIDS "Facing the Future Together: Report of the Secretary General's Task Force on Women, Girls and HIV/AIDS in Southern Africa" July 2004 www.unicef.org/publications Downloaded from the website on 20 September 2004.

leaving the patient unattended. Diminished agricultural productivity and ability to work for cash may lead families to sell their assets, reduce levels of childcare leading into a cycle of increased poverty and deprivation.³⁰¹ As a result, rural communities have been left to single-handedly take on the responsibility of caring for the sick and the dying and the increasing number of orphans whose parents die from HIV and AIDS.³⁰² The negative impact of HIV and AIDS and the high levels of inflation have incapacitated the families to cater for the material, emotional and psychosocial well being of the children, particularly orphans. Orphans face a plethora of problems which include poverty and stigmatization, which deepens the sense of isolation and alienation.³⁰³ Zimbabwe was reported to have the highest number of orphans per capita in the world - something in excess of 1.6 million, or one in four of all children. At this rate it was approaching the historic levels set in Rwanda after the genocide in 1994.³⁰⁴ The health care situation continued to deteriorate especially in view of the continued tension on the political terrain as MDC and Zanu PF continued to compete for support and control of the country, resulting in incessant clashes between supporters of the two opposition parties. As the 2002 presidential elections drew nearer, the atmosphere grew harsher and tenser.³⁰⁵ This will be explicated below.

2.9 Presidential Elections 2002: Violence, Torture, Intimidations and Death

Faced with strong MDC opposition, Mugabe and ZANU PF resorted to three principal tactics in the run-up to the March 2002 presidential election. First, they continued to deploy war veterans and youth militia to stir up things and to intimidate people in traditional MDC strongholds as well as in other areas faithful to ZANU PF. The closer the election loomed, the more the MDC executive, MPs, party workers and supporters were tested. There were reports of rape, torture, kidnapping, property damage or theft, cases of intimidation, schools being forced to close, as well as accounts of deaths or executions.³⁰⁶ The second tactic that the government employed prior to the presidential election was to frustrate and disenfranchise as

³⁰¹ Chirongoma S. (2006a) "Women, Poverty and HIV in Zimbabwe: An Exploration of Inequalities in Health Care" in Phiri I.A and Nadar S *Papers in Honour of Mercy Amba Ewudziwa Oduyoye* (Maryknoll, New York:Orbis Books),180.

³⁰² Zimbabwe Human Development Report, 2003, 85-93.

³⁰³ By 2008, approximately 1.3 million, or one fifth of all Zimbabwean children had lost a parent; most having been orphaned by HIV&AIDS. See UNICEF, Zimbabwe, Background. http://www.unicef.org/infobycountry/zimbabwe_1403.html (15 March, 2009).

³⁰⁴ Sokwanele, "Robert Mugabe: An appreciation on his 84th birthday" February 21, 2008 http://www.sokwanele.com/articles/mugabe84_21022007 (15 April, 2008).

³⁰⁵ Hudleston S. (2005) *The Face of Courage*, 76-77.

³⁰⁶ Hudleston S. (2005) *The Face of Courage*, 76-77.

many voters as possible.³⁰⁷ The third tactic that Mugabe's government deployed was to work towards discrediting and harassing his principal opponent Tsvangirai by portraying him as a 'puppet' of the West. Several violations and irregularities were committed during the election period,³⁰⁸ the whole voting and counting process was so flawed such that the MDC and several other independent election observers presumed that the announced 'victory' for Mugabe's ZANU PF would be unequivocally rejected as 'the biggest election fraud in history'.³⁰⁹ Many people were in tears a day after the elections results were announced, the thought of having to endure Mugabe for another six years was just too much. On the other hand, people had hoped that at least the violence would stop, but instead the youth militia stepped up their campaign, punishing those who had supported MDC during the election.³¹⁰ The ripples caused by the election and its outcome were not confined to Zimbabwe. In the African and international arena, there were fierce debates around events in the country and its future. Growing international isolation resulting from controversial government policies led to greatly reduced donor funds for the country with far reaching repercussions on an already crumbling public health care system.³¹¹

2.10 Public Health Personnel Strikes, Food Crisis and Further Deterioration of the Health-Care System, 2003-2005

As has been noted in the preceding section, the withdrawal of donor funds from the international community impacted heavily on the country's socio-economic sector and as such this had huge negative consequences on the public health care system, precipitating a humanitarian crisis which had been brewing for many years. This is shown by the fact that in 2003, the doctors went on strike three times in the same year complaining about the same old grievances, salaries and working conditions. The chronic shortage of foreign currency for equipment and essential drugs worsened the situation. In the September 2003 strike, nurses

³⁰⁷ The government knew that the higher the poll, the more likely it was that the vote would swing to the opposition. Consequently, at the start of 2002, thousands of Zimbabweans already registered on the voters' roll were summarily disenfranchised and were denied their democratic right to vote on Election Day. For more information, see Hudleston S. (2005) *The Face of Courage* (Juta & Co. Ltd: Cape Town).

³⁰⁸ Although there were some media reports highlighting that the MDC supporters were sometimes complicit to violence, this wanes thinly as compared to the violence perpetrated by ZANU PF supporters.

³⁰⁹ For more information, see Hudleston S. (2005) *The Face of Courage* (Juta & Co. Ltd: Cape Town), 75-95.

³¹⁰ Three MDC workers and supporters were abducted and buried alive. Some supporters were beaten up and others had their houses burnt down. See Hudleston S. (2005) *The Face of Courage* (Juta & Co. Ltd: Cape Town), 93 ff.

³¹¹ Results of the elections were contested in some sections of the international community, leading to statements to the effect that the country was being ruled by an illegitimate government. This chapter does not seek to get entangled in the pro and cons of this debate but to point out that the net effect of the withdrawal of donor funds is a developmental crisis which arguably perpetuated an already raging humanitarian crisis.

who shared the same grievances with the doctors also joined the strike.³¹² Ndhlovu clearly depicts the crisis, “in a month prices double in the shops and 20 000 Zimbabweans die of AIDS. In a year inflation soars from 220% to 620%....the public mood changes from hope and expectation of relief from the madness to deep, debilitating despair.”³¹³

These difficulties further worsened the health crisis by forcing more health personnel to migrate to greener pastures. A United Nations Development Programme-funded study released in 2004 estimated that doctors, nurses and pharmacists constituted about 25% of the 500 000 Zimbabweans in the Diaspora. Some 24% of all posts in all categories of staff (doctors, clinical officers, pharmacists and nurses) in all provinces were vacant.³¹⁴ By 2004, the country had just about 800 doctors, way below the required number of about 2 200.³¹⁵

A 2004 report released by an NGO monitoring group, the Food Security Network (FOSENET) based on information drawn from 52 districts noted that only half of the clinics in three Zimbabwean provinces had access to safe water³¹⁶ and the majority of the districts faced shortages of essential drugs. It also noted that only 58% of the selected monitoring sites in 53 districts spread across the country had access to health facilities within five kilometres of their homesteads.³¹⁷ The high cost of drugs was identified as another barrier to health services and FOSENET’s report noted that the fee levels in clinics varied widely from Zim\$120 (US 0.02 cents) to Zim\$45 000 (US \$ 8.43). Primary clinics and district hospitals did not provide medicine for HIV and AIDS related illnesses and patients had to travel to larger towns to access such treatment.³¹⁸ Both the public and those in the health sector had

³¹² Integrated Regional Information Networks (2003) “Zimbabwe: Nurses’ strike deepens health crisis”, 24 September 2003 www.reliefweb.int/w/rwb.nsf/0/aaef678482bdb56449256dea000738c3 (22 December 2004).

³¹³ Ndhlovu M., “Zimbabwe in March 2004: Four Years From the Beginning of the Plunge”, March 2004 www.worldhunger.org/articles/04/Africa/ndlovu.htm (7 August 2004).

³¹⁴ Humanitarian Assistance and Recovery Programme (HARP) (2002) Rapid Needs Assessment for the Health Sector in Zimbabwe www.who.org (22 October 2004).

³¹⁵ Zenda C. (2003) “Doctors Strike: Final Blow to dying Zimbabwe?”, 30 October 2003. www.fingaz.co.zw/fingaz/2003/October/October30/3977.shtml (22 December 2004).

³¹⁶ IRIN News (2004) “Zimbabwe: Clinics in three provinces do not have safe water” www.irinnews.org/report.asp?ReportID=41429&SelectRegion=Southern_Africa (22 December 2004).

³¹⁷ IRIN News (2004) “Zimbabwe: Clinics in three provinces do not have safe water” www.irinnews.org/report.asp?ReportID=41429&SelectRegion=Southern_Africa (22 December 2004).

³¹⁸ IRIN News (2004) “Zimbabwe: Clinics in three provinces do not have safe water” www.irinnews.org/report.asp?ReportID=41429&SelectRegion=Southern_Africa (22 December 2004).

hoped that the 2004 budget would allocate a specific budget for HIV and AIDS, a pandemic that was declared a national disaster in 2002, but unfortunately this was not the case.³¹⁹

The humanitarian crisis was compounded by the severe food shortages, and by the understandable reluctance of donor countries to commit to a radical programme of anti-retroviral treatment (as elsewhere on the continent) because of the regime's record of tampering with aid programmes.³²⁰ Clearly, the government's stance of restricting donor agencies' operations and its attempt to distribute donations on political lines had detrimental effects on the vulnerable needy communities. For instance, in 2004 the government not only forced the United Nations to scale back a general feeding program that had sustained millions during three years of crop failures, but barred the United Nations specialists from measuring the fall harvest that ended in June 2004. Starting from July 2004, all the NGOs were kept on short leash and Mugabe constantly reminded all and sundry that Zimbabwe is a 'sovereign' nation and therefore the government would rein in NGOs that are "conduits or instruments of interference in our national affairs".³²¹ That sort of mistrust permeates relations between the government and outsiders seeking to help it, forcing them to channel their resources to more hospitable beneficiaries. It is apparent that there is wisdom in the activists' continued calls for the government to reconsider its policies and work towards a more democratic state and re-engage the international community in order to effectively address the nation's health needs.

2.11 Perspectives from health-care workers, faith and traditional healers

Poverty and food insecurity features constantly among the factors listed by the health-care providers within all the three systems as having a negative impact on Karanga people's health. All the five western bio-medical practitioners who were key participants in this study cited poverty and food insecurity as factors that impact negatively on Karanga people's health and well-being. Moline mentioned poverty and food insecurity as taking centre stage, expressed in the following words, "poor people are generally food insecure and food insecurity impacts negatively on nutrition which will eventually impact on people's immune

³¹⁹ Hope Foundation Zimbabwe Inc., 12 August 2003 "HIV Drugs Out of Reach" www.givegain.com/cgi-bin/giga.cgi?cmd=cause_dir_news_&news_id=104&cause_... (18 June 2004).

³²⁰ Sokwanele, (2008) "Robert Mugabe: An appreciation on his 84th birthday" February 21, 2008 http://www.sokwanele.com/articles/mugabe84_21022007 (15 April, 2008).

³²¹ Sarah LaFraniere (2004) "Donor Mistrust Worsens AIDS in Zimbabwe" 19 July 2004 www.genderaids.com (23 August 2004).

systems”.³²² In the same light, Monica put it this way, “food insecurity, especially in times of drought or flooding and poverty which is closely related to crop failure and a sense of despair caused by the prevailing political and economic instability at a national level are factors that impact negatively on Karanga people’s health and well-being.”³²³ Violet also listed “poverty, drought, excessive rains particularly the recurring cyclones in the past few years and malnutrition” as factors impacting negatively on people’s health “especially considering that this is a rural community depending on subsistence farming.”³²⁴ Similarly, Patricia put it this way, “food insecurity, financial constraints, socio-political instability and lack of infrastructure are factors that impact negatively on people’s well-being, triggering various ailments among people who would be generally fit under normal circumstances.”³²⁵ In the same way, Richard identified “poverty, food insecurity and the unstable socio-economic and political situation as having ripple effects on Karanga people’s health.”³²⁶

Three out of the five prophet-healers who were key participants in this study also pointed out these inter-related factors. One of the prophet-healers, Phineas bemoaned the negative effects of food insecurity on the community’s health as well as among his household, particularly in view of those patients needing to stay in his homestead for longer periods whilst receiving treatment and he has to provide for their sustenance. He highlighted that this presents a challenge because sick people need to eat well.³²⁷ He put it this way,

A major challenge in my healing ministry is food insecurity. This is due to the fact that some of the patients come to live in my homestead for an extended period of time whilst receiving treatment and my family has to provide for their sustenance during their stay. This is problematic because Masvingo province, particularly Murinye district has suffered recurrent droughts during the past decade. Bearing in mind that people who are ill need to eat well, this presents a major predicament for my household...Although we have been receiving food aid from NGOs such as CARE International; however, the ration (allocation) that we receive only caters for the registered eligible members of my family. The unofficial regular patients who take residence in my homestead do not get an allocation... It would have been helpful if the government could also allocate food aid to prophet-healers and traditional healers as they do to the local clinics and hospitals.³²⁸

³²² Moline, Personal Interview, 5 December 2006, Shonganiso Clinic, Murinye.

³²³ Monica, Personal Interview, 7 December 2006, Mashenjere Clinic, Murinye.

³²⁴ Violet, Personal Interview, 7 December 2006, Mashenjere Clinic, Murinye.

³²⁵ Patricia, Personal Interview, 5 December 2006, Shonganiso Clinic, Murinye.

³²⁶ Richard, Personal Interview, 5 December 2006, Shonganiso Clinic, Murinye.

³²⁷ Phineas, Personal Interview, 12 December 2006, Murinye.

³²⁸ Phineas, Personal Interview, 12 December 2006, Murinye.

In the same light, another prophet-healer, Miriam, identified “poverty and food insecurity and the harsh economic climate” as factors that impact heavily on Karanga people’s health and well-being.³²⁹ She noted how sometimes “out of desperation, some people solicit the services of evil powers to ‘get rich quick’ with far-reaching repercussions on the whole clan”.³³⁰ Echoing the same sentiments, Takunda identified “poverty and food insecurity as factors that impact heavily on Karanga people’s health”. He added that this is worsened by the in-fighting between supporters of opposition parties who destroy their opponents’ “crops, livestock and homes, posing a huge strain on food security and people’s sense of security and well-being.”³³¹ Similarly, Patrick explained that “poverty which is mainly caused by crop failure in times of drought or flooding makes people so stressed out such that they become ill”.³³²

All the five traditional healers who were key participants in this study cited poverty and food insecurity as main factors impacting negatively on Karanga people’s health and well-being. Raramai highlighted “extreme poverty, extreme heat, and drought and water shortage” as negative factors affecting Karanga people’s health and well-being.³³³ Vonai also pointed out that “food insecurity/drought, unclean water sources and limited grazing land for livestock” are factors that impinge on Karanga people’s health and well-being, leaving them susceptible to various stresses and diseases.³³⁴ Nyaradzai pointed out that the issue of poverty is a heavy burden which has ripple effects on people’s health. She noted that it is sometimes due to poverty that out of desperation for survival or for food items, some people resort to stealing “other people’s possessions.”³³⁵ This anti-social behaviour robs the community of their peace of mind and impacts heavily on their health and well-being. In the same light, Shingirirai noted that “poverty and food insecurity diminish Karanga people’s health and well-being”. She highlighted how such factors usually force people to “engage in risky behaviour and lifestyles such as commoditising their bodies, poaching wildlife, illegal gold panning and selling illegal drugs and minerals”. Shingirirai further explained that all these activities “have far reaching repercussions on people’s well-being” as this is done “at the risk of losing their

³²⁹ Miriam, Personal Interview, 15 December 2006, Murinye.

³³⁰ This comment was made in connection with those who acquire *zvikwambo* to enrich themselves unaware of the long term negative effects of such an acquisition.

³³¹ Takunda, Personal Interview, 17 December 2006, Murinye.

³³² Patrick, Personal Interview, 19 December 2006, Murinye.

³³³ Raramai, Personal Interview, 20 December 2006, Murinye.

³³⁴ Vonai, Personal Interview, 21 November 2006, Murinye.

³³⁵ Nyaradzai, Personal Interview, 14 December 2007, Murinye.

lives in the process.”³³⁶ Top on the list of factors listed by Mufudzi as affecting Karanga people’s health negatively is the issue of food insecurity.³³⁷

2.12 Operation *Murambatsvina*³³⁸

The humanitarian crisis intensified during the infamous clean-up operation dubbed *Murambatsvina* [operation restore order/clean up/drive out trash/filth]; a clean-up campaign for demolitions and evictions that was launched by the government of Zimbabwe. It was described as a programme to enforce city by-laws to halt allegedly illegal activities and realise high standards of cleanliness in major cities and towns throughout Zimbabwe. It was carried out from 19 May to 12 June 2005, leaving about 700 000 people homeless, without access to food, water and sanitation or health care.³³⁹ This was also the period, during which the country was grappling with a food emergency, declining economic performance and the sharpest rises in child mortality in history. Poverty and food insecurity also accelerated the spread of HIV and AIDS since in desperation for food, people tend to adopt risky survival strategies such as transactional sex and migratory labour. The high incidence of HIV and AIDS and the recurrent droughts since the year 2000 impacted heavily on women and most poor households. A low social status, economic vulnerability, food insecurity and limited livelihood opportunities forced some desperate young women to resort to transactional sex in order to obtain food, money or consumable goods.³⁴⁰ Young people in Zimbabwe cynically refer to the practice as *food for work*.³⁴¹ By 2005, Zimbabwe was reported to have the world’s fourth-highest rate of HIV prevalence.

While campaigns to prevent and treat HIV in other African countries were benefitting from international aid, the political situation in Zimbabwe caused some foreign donors to either decrease aid for the country or halt it altogether. Whereas Zambia, the neighbouring nation

³³⁶ Shingirirai, Personal Interview, 15 December 2007, Murinye.

³³⁷ Mufudzi, Personal Interview, 16 December 2007, Murinye.

³³⁸ *Murambatsvina* literally means to ‘restore order/clean up/drive out trash/filth.’ It was a clean-up campaign for demolitions of informal settlements and businesses. It also entailed evictions of the majority urban population from their high density suburb residential dwellings.

³³⁹ For more information on these demolitions/evictions, See Chirongoma S (2009) “Operation Murambatsvina (Operation Restore Order/Operation Clean Up’): Its Impact and implications in the era of HIV and AIDS in contemporary Zimbabwe” in Hadebe Nontando and Chitando Ezra (eds) *Compassionate Circles: African Women, Theologians Facing HIV* (World Council of Churches Publications, Geneva, Switzerland), 71-94.

³⁴⁰ Mercy Amba Oduyoye “Cross-Generational Sex and its Impact on the spread of HIV” *People of Faith and the Challenge of HIV/AIDS* edited by Amoah E and Oduyoye M.A (Ibadan: Oluseyi Press Ltd. 2004), 302.

³⁴¹ UNAIDS Initiative: The Global Coalition on Women and AIDS “Facing the Future Together: Report of the Secretary’s TASK Force on Women, Girls and HIV/AIDS in Southern Africa”, July 2004 www.unicef.org/publications/SGs-report-final.pdf (20 September 2004).

with a similar HIV prevalence rate was receiving around US \$187 per HIV-positive person annually from foreign donors, in Zimbabwe, the figure was estimated to be just \$4.³⁴² While it is understandable that international donors did not feel comfortable to support the Zimbabwean government, it has to be acknowledged that it is really the general population who are negatively affected by this lack of assistance. One keeps asking a wrenching question “is the international community doing justice by withholding life-saving aid from the people who have become victims of their leaders’ political suicide?” The answer in all earnest is a strong and resounding, NO! Sebastian Chinhaira³⁴³ aptly sums it up in the following statement; “It really is true that when elephants fight, it is the grass that suffers.”³⁴⁴

2.13 The Last Kicks of a Dying Horse: Further Closure of Public Health Facilities and the Outbreak of a Cholera Epidemic, 2006-2008

The period between 2006 and 2008 was the worst in terms of the humanitarian crisis. By 2007, Zimbabwe was ranked by Médecins Sans Frontières as one of its "top ten" underreported humanitarian crises in the world.³⁴⁵ Faced with empty coffers, a fast crumbling health delivery system, isolation from the international community and shortages in medical aid scheme benefits, some patients were left to suffer with no relief in sight. The average life expectancy in the country plunged to 37 years for men and 34 years for women - these figures being even lower than for Sierra Leone, one of the poorest countries on the face of the planet which is still recovering from a period of bloody civil war.³⁴⁶ Child and maternal health deteriorated even further as reflected by a 2009 assessment of progress towards Millennium Development Goals on child and maternal health by the Ministry of Health and Child Welfare which revealed that between 1999 and 2006, infant mortality rate declined from 65 deaths per 1000 live births to 60, falling far short of the country’s desired target of

³⁴² UNICEF (2005), “Zimbabwe’s forgotten children.”

http://www.kubatana.net/html/archive/chiyou/050317unicef.asp?sector=CHIYOU&year=2005&range_start=61 [25 November 2005].

³⁴³ Sebastian Chinhaira is the Harare district co-ordinator of the Zimbabwean Network of People Living with HIV/AIDS (ZNNP+).

³⁴⁴ Plusnews website (2006), “Zimbabwe: HIV positive people floundering as economy sinks”

http://www.elegantbrain.com/edu4/classes/readings/327readings_fall09/r6_hiv_zimb.pdf (20 November 2006)

³⁴⁵ Healthline, Global healthbeat (2007) “Doctors Without Borders top ten underreported humanitarian crises 2007—Zimbabwe” www.healthline.com/blogs/healthline_connects/labels/poverty.html (10 August 2008)

³⁴⁶ Sokwanele, (2008) “Robert Mugabe: An appreciation on his 84th birthday”

February 21, 2008 http://www.sokwanele.com/articles/mugabe84_21022007 (15 April, 2008).

22 per 1000 live births. Observers stated that between 1,300 and 2,800 women and girls die each year due to pregnancy-related complications, arguing that most of these maternal deaths are avoidable. Jeffrey Muvundusi, a local journalist expressed the paradox between the government's policy and the reality of the situation on the ground in the following words "Under government policy, care for pregnant women, new mothers and infants should be delivered free of charge. But as the country's economy took a nose dive in the past decade health institutions had to devise their own means to raise their own revenue to meet costs."³⁴⁷ This saw more and more women delivering their babies at home.

The humanitarian crisis reached its peak when Morgan Tsvangirai, the presidential candidate of the main opposition party, Movement for Democratic Change (MDC), emerged victorious in the 29 March 2008 national election. It is significant to note that the MDC party garnered 1 195 562 which translated to 47.87% of the total votes meaning that it fell short of the 50.1% votes as stipulated in the new constitution to get an outright win against ZANU PF's 1 079 730 which translated to 43.24% of the total votes. However, this result was rejected by the ruling party (ZANU-PF). There was a re-run of the poll, during which ZANU-PF embarked on a reign of terror, torturing and intimidating mainly rural communities to vote for their 82 year old presidential candidate, who had been ruling for the past 30 years. Much of the violence was specifically directed against members of the opposition party, particularly those who acted as election agents or monitors in the recent elections. Villagers and school teachers from districts where the opposition predominated in the elections were main targets even though they had no political affiliations. There were reports of vicious attacks by so called war veterans even on defenceless women and children.³⁴⁸ In a plea for an end to political violence, the group known as Specialist Doctors in Zimbabwe noted that some 2 900 victims of political violence, some of whom subsequently died from their injuries, had been treated in the nation's hospitals.³⁴⁹ The country's National Association of Societies for the Care of the Handicapped reported that "limbs have been severed and mutilated ... people have

³⁴⁷ Muvundusi J (2011) 'Free treatment for pregnant women', 31 August 2011 <http://www.dailynews.co.zw/index.php/news/34-news/4054-free-treatment-for-pregnant-women.html> (30 April 2012).

³⁴⁸ Zimbabwe Association of Doctors for Human Rights (ZADHR) "Victims of organised violence and torture continue to flood the health system," June 26, 2008 www.kubatana.net (20 March 2009).

³⁴⁹ M&C Africa. "Zimbabwe medical bodies implore end to political violence." News June 8 2008. www.monstersandcritics.com/news/africa/news/article_1409963.php (10 August 2008).

been subjected to such brutal head injuries that their sight and hearing have been affected.”³⁵⁰ Doctors and nursing staff at rural hospitals were working under conditions of severe stress and many health workers reported intimidation with some having been specifically instructed by state agents not to treat opposition supporters. These health workers, who, according to some reports were treating up to 60 victims of torture and violence a day, were emotionally traumatised and depressed. One nursing sister treating victims in a rural clinic was observed to be “shaking so violently with fear that she was unable to write.”³⁵¹ This reign of terror forced many people to migrate either out of the country or to other parts of the country.³⁵²

As if that was not enough, the crisis situation was further exacerbated by the ZANU PF government policies that imposed erratic banning of all aid organisations and their agencies from distributing relief services on the pretext that they had campaigned in support of the main opposition party MDC during the March 2008 parliamentary and presidential elections.³⁵³ These organisations provided either food aid or ARVs or both to many Zimbabweans who are either infected or affected by HIV (approximately 90% of the population had been benefiting from these programmes). Banning the aid organisations has far reaching repercussions because the interruption of ARV treatment could result in drug resistance, declining health, and ultimately death. With no hope in sight of receiving food aid in view of the continued food scarcities in Zimbabwe or accessing ARVs for those infected by HIV, many were forced to cross over the border and seek for a better life and better opportunities.³⁵⁴

These mass migrations further fuelled the spread in HIV infections and HIV related deaths. Home-based care (HBC) for HIV related illnesses was disrupted and interrupted due to the

³⁵⁰ M&C Africa. “Zimbabwe medical bodies implore end to political violence.” News June 8 2008. www.monstersandcritics.com/news/africa/news/article_1409963.php (10 August 2008).

³⁵¹ Zimbabwe Association of Doctors for Human Rights (ZADHR) “Escalating cases of organised violence and torture, and of intimidation of medical personnel,” May 09, 2008 www.kubatana.net (20 March 2009).

³⁵² For more information on this subject, See Chirongoma S (2012) “In Search of A Sanctuary: Zimbabwean Migrants in South Africa” in Joel Carpenter (ed) *Walking Together: Christian Thinking and Public Life in South Africa* (ACU Press: Texas).

³⁵³ Most organizations had to bring their services to a halt in 2008 after having been given stern warnings by the ruling party militias that threatened to punish any aid workers that would be seen distributing aid in the rural communities, they were all accused of politicking rural folk.

³⁵⁴ Deibert, M (2008) RIGHTS: In South Africa, Zimbabwean Refugees Find Sanctuary and Contempt’ <http://ipsnews.net/news.asp?idnews=42225> (25 October 2009).

displacement of trained volunteers and clients who facilitated and utilized such services.³⁵⁵ Zimbabwe's hyperinflation eroded the salaries of health care professionals to such an extent that their monthly income was barely enough to cover a day's transport costs. In 2008 government doctors and nurses embarked on a strike action in protest at poor salaries and working conditions, forcing hospitals and clinics virtually to shut down. In their absence, student nurses provided health care for patients.³⁵⁶ For the larger part of 2008, the main referral hospitals in the country – Harare Central Hospital and Parirenyatwa Hospital in Harare and Mpilo Hospital and United Bulawayo Hospitals in Bulawayo where the health personnel in the demonstrations were employed - were virtually closed.³⁵⁷ Most district hospitals and municipal clinics were barely functioning or closed. Sick people in need of medical attention were being turned away from Zimbabwe's public hospitals and clinics; they were advised to consult private doctors in private facilities. This option was not open to the majority of Zimbabweans already struggling to make ends meet. Private doctors were charging exorbitant fees in foreign currency equivalents of between about US\$35 and US\$50, far beyond the reach of most people, unemployment rose above 80 percent, and the salaries of those with jobs often did not even cover monthly transport costs.³⁵⁸

Health officials complained that the public health care system had been paralyzed by drug shortages, insufficient medical supplies, the withdrawal of maternity services, dilapidated and poor infrastructure, equipment breakdowns, brain drain and a serious outbreak of cholera. Furthermore, they bemoaned how the withdrawal of maternity services at Harare and Parirenyatwa Hospitals meant that healthy women requiring elective and emergency caesarean sections, and unable to afford private health care, would needlessly die in child birth.³⁵⁹ To illustrate the gravity of this matter, it was noted that the cost of a Caesarean Section in private hospitals in Harare was in the region of US\$1 500, well beyond the means of the vast majority.³⁶⁰ Worse still, on 17 November 2008 the Medical School of the

³⁵⁵ These disruptions emanated during the infamous Murambatsvina clean-up operation which was initiated in 2005.

³⁵⁶ IRIN News "ZIMBABWE: Staff return to hospitals, but not to work", 24 Feb 2009. <http://www.irinnews.org/ReportId=82925> (20 March 2009).

³⁵⁷ Front Line "Violent dispersal of peaceful demonstration of health workers by the police" November 20, 2008 www.kubatana.net (20 March 2009).

³⁵⁸ IRIN News "Doctors' strike adds to country's pain" August 26, 2008 <http://www.irinnews.org/Report.aspx?ReportId=79994> (20 March 2009).

³⁵⁹ Zimbabwe Association of Doctors for Human Rights (ZADHR) "Collapsed health system violating health rights" November 19, 2008 www.kubatana.net (20 March 2009).

³⁶⁰ Zimbabwe Association of Doctors for Human Rights (ZADHR) "Pregnant women in grave danger" November 20, 2008 www.kubatana.net (20 March 2009).

University of Zimbabwe was closed indefinitely. Medical personnel argued that it had become impossible to continue to teach medical students in non-functioning health institutions. They added that it would not be possible to reopen the medical school or to provide quality training of health professionals for Zimbabwe's health system until the issues that led to its collapse were addressed.³⁶¹ They highlighted that they had tenaciously continued attempting to deliver health services despite the extremely challenging conditions of the prevailing health care system but had reached a point where their endurance was exhausted.³⁶² As a result, they planned a march to the offices of the Minister of Health and Child Welfare at Kaguvi Building in Harare to present a petition calling for urgent action to be taken to restore accessible and affordable health care to Zimbabwe's population. Despite the legitimate complaints that the health personnel were raising, their peaceful demonstrations were violently disrupted by the police. The local press reported how;

...on 18 November 2008, at approximately 8:00 am, heavily armed riot police prevented the protesters from proceeding with their march from where they had gathered on Leopold Takawira Street outside Parirenyatwa Hospital...The group then held their protest within the grounds of Parirenyatwa Hospital for 4 hours before riot police entered the hospital grounds at 11:45am and forcibly dispersed them, assaulting several health workers in the process.³⁶³

Faced by a constant breakdown in service delivery, economic collapse, food shortages and an outbreak of diseases, the country remained in dire straits. Otto Saki, acting director of the Zimbabwe Lawyers for Human Rights (ZLHR), said the plight of PLHIV had been worsened by the deterioration of the political and economic situation in Zimbabwe. He expressed the gravity of the matter in the following words:

We have recorded an increase in the cases of individuals failing to access ARV treatment. This is linked to the current collapse of the health delivery system and broader issues of governance...It has become increasingly difficult for PLWHAs to access antiretroviral (ARV) drugs and treatment for opportunistic infections because a number of health institutions, including two of the main referral hospitals in Harare, have closed some of their units due to lack of resources. In addition, the mass exodus of

³⁶¹ Zimbabwe Association of Doctors for Human Rights (ZADHR) "Collapsed health system violating health rights" November 19, 2008 www.kubatana.net (20 March 2009).

³⁶² Zimbabwe Association of Doctors for Human Rights (ZADHR) "Collapsed health system violating health rights" November 19, 2008 www.kubatana.net (20 March 2009).

³⁶³ Front Line "Violent dispersal of peaceful demonstration of health workers by the police".

health care workers, who have sought better working conditions and higher salaries overseas, has led to long queues in hospitals and clinics.³⁶⁴

AIDS activists shared resonance with the above sentiments. Sikhumbuzo Mvinjelwa, chairperson of the Zimbabwe National Network for People Living with HIV/AIDS (ZNNP+), explained their predicament in the following words:

We are facing a lot of challenges. The current situation has made it very difficult for most of our members, especially those in rural areas, to access treatment...Apart from access to health care; the transport costs are so prohibitive that it is not possible for patients to travel to the nearest health centre to collect drugs. Most of them end up defaulting from their treatment plan.³⁶⁵

These same issues were also raised by some of the participants interviewed during field research for this study. For instance, one of the nurses at Shonganiso clinic when asked about the challenges faced in their care-giving work had this to say:

There are several factors that can be highlighted as an impediment to our care-giving work at this station, for instance shortage of staff, lack of resources such as essential drugs and relevant equipment, particularly our inability to offer services for HIV Testing and Counselling in an era of a national outbreak of the HIV epidemic. There are several instances when we identify a need for some of the patients to be tested for HIV; however, because we do not have qualified personnel and relevant equipment to offer HIV Testing and Counselling at the clinic, we are forced to refer the patients to the nearest referral centres Morgenster Mission Hospital or Masvingo General Hospital which are far away (65km and 75km respectively). This presents a major predicament to our work because in many cases, the patients cannot afford transportation fees to travel to these referral centres and sometimes even when the patients scrounge around for transportation fees to go for testing and in the event that they test positive for HIV, it becomes financially and physically strenuous for patients to travel on a monthly basis to replenish their supplies for ARVs and other relevant check-ups. Worse still, these two referral centres are also reeling with large numbers of patients requiring HIV Testing and Counselling as well as ARVs such that there is massive backlog in rolling out ARVs to those in urgent need of the drugs.³⁶⁶

In the same light; Patricia, a nurse who was another key participant in this study also highlighted the fact that the HIV epidemic is presenting a huge challenge in their work

³⁶⁴ Nsingo Ephraim "HEALTH-ZIMBABWE: Shady Dealings with Antiretrovirals" 12 December, 2008 <http://www.ipsnews.net/news.asp?idnews=45086> (20 March 2009).

³⁶⁵ Nsingo Ephraim (2008) "HEALTH-ZIMBABWE: Shady Dealings with Antiretrovirals" 12 December, 2008 <http://www.ipsnews.net/news.asp?idnews=45086> (20 March 2009).

³⁶⁶ Patricia, Personal Interview, 20 December 2006, Shonganiso Clinic, Murinye.

because in many cases, the patients who come to consult will be presenting with HIV related symptoms and it becomes very problematic because some of these patients are defaulting in their ART. According to Patricia, there is a huge communication deficit between the local clinics and the two referral centres such that it jeopardises their chances of providing services to patients who would have been to the provincial hospitals. She acknowledged the fact that staff in these referral centres are also under severe pressure with heavy workloads such that they cannot afford time to give the relevant feedback on the patients' progress to the clinics that would have referred them.³⁶⁷

The situation of contaminated water worsened much further towards the end of 2008 and the first part of 2009 as 90% of the urban population's water sources were contaminated with raw sewage, leading to an outbreak of cholera which infected more than 80 000 and caused the deaths of more than 4 000 Zimbabweans.³⁶⁸ The cholera epidemic caused hundreds of preventable deaths with the disease having spread within Harare's suburbs, Mashonaland Central, East and West and Matebeleland South. Failure to contain and manage the outbreak was attributed to the inadequate supply of safe drinking water and broken down sanitation systems that often left residents surrounded by flowing raw sewage despite ad hoc financial intervention by the Reserve Bank of Zimbabwe and deployment of the Civil Protection Unit to attend to these issues.³⁶⁹ Other analysts captured the public health care crisis in the following words, "In short, under Mugabe's trusteeship healthcare in Zimbabwe now rests somewhere between the high dependency unit and the mortuary".³⁷⁰ It is in view of such a critical public health crisis that many Zimbabweans resorted to the use of traditional medicine and faith healing in order to bridge the huge gap left by the crumbling public health care system. Although most patients in Zimbabwe normally utilise both the bio-medical and traditional health-care systems, the majority were forced to rely only on the latter due to the prevailing crisis. Faith healing also became very popular in the face of escalating health

³⁶⁷ Patricia, Personal Interview, 20 December 2006, Shonganiso Clinic, Murinye.

³⁶⁸ Zimbabwe Association of Doctors for Human Rights (ZADHR) "Collapsed health system violating health rights" November 19, 2008 www.kubatana.net (20 March 2009).

³⁶⁹ Zimbabwe Association of Doctors for Human Rights (ZADHR) "Collapsed health system violating health rights" November 19, 2008 www.kubatana.net (20 March 2009).

³⁷⁰ Sokwanele, "Robert Mugabe: An appreciation on his 84th birthday" February 21, 2008 http://www.sokwanele.com/articles/mugabe84_21022007 (15 April, 2008).

costs.³⁷¹ Herbal and traditional cures became rampant as desperate people tried to seek relief from physical pain and imminent death. Hugh McCullum aptly depicts the whole scenario:

With the economic collapse and death at every turn, the enormously spiritual and cultural passage is fraying at the edges. Poor people cannot afford funerals; bodies are left in morgues, unclaimed to be buried in mass graves. Attending several funerals a week destroys the meaning of death and the role of ancestors. The culture crumbles. Witchcraft begins to thrive and older women are killed for casting an evil eye on a man who has become sick with HIV [sic]. Men seek out young women who are virgins, believing they will be purified and their blood purged of the disease.³⁷²

The last section of this historical analysis shows how the intervention of the international community and the ushering in of a new political dispensation made considerable in-roads in reviving the country's health care system and averting the humanitarian crisis.

2.14 The New Political Dispensation and the Consequent Revival of the Health Care System, 2009-2010

Through the intervention of the Southern African Development Community, a transitional inclusive government was formed between the Mugabe regime and the MDC in February 2009. However, since then, there was continual tension threatening a complete breakdown of government, with MDC calling for new elections.³⁷³ Although there were significant changes in the socio-economic and political realm after the formation of an inclusive government between the ruling party ZANU-PF and the main opposition party Movement for Democratic Change (MDC) in February 2009, working conditions and conditions of service in the public sectors were still not very conducive because all civil servants regardless of qualifications or nature of employment, were earning a uniform monthly salary of US\$ 150, an amount that is far below meeting the basic cost of living which was still very high. As a result, experienced and qualified personnel were still grabbing any opportunity to leave the country. A junior doctor, who declined to be named, explained that if the government had not withheld his medical certificate he would already have left Zimbabwe to offer his skills in another country. This statement was made in view of the fact that in accordance with new regulations, medical personnel have to complete up to four years of service before they can seek

³⁷¹ Patel V. (1998) *Culture and common mental disorders in Sub-Saharan Africa: Studies in primary care in Zimbabwe* (Psychology Press: Hove).

³⁷² McCullum H. (2003) 'Africa's looming AIDS apocalypse', 1 January 2003
<http://www.africafiles.org/article.asp?ID=1723> (24 November 2004).

³⁷³ "REPORT: Zimbabwe - Way forward," *ZimOnline: Zimbabwe's Independent News Agency*, 5 November 2009.

employment elsewhere.³⁷⁴ As such, the looming health-care crisis continued to haunt the country and most of the possible donors in the international community remained hesitant to pump in resources in the new government of national unity. The following statement succinctly sums up this crisis situation at the beginning of 2009,

The international donor community is willing to assist Zimbabwe but the problem is and remains the Zimbabwean government. The power sharing agreement has failed. It could never have worked with opposition party members and human rights activists being arrested and continually harassed. As long as the furore over power continues there will be no end in sight to the political turmoil that is causing untold harm and suffering to Zimbabwe's citizens. Until there are real and tangible democratic reforms that increase economic freedom and civil liberties for ordinary Zimbabwean citizens, international assistance will not be forthcoming given that these funds could potentially be used for other ends. To restore basic healthcare needs to Zimbabweans and to rebuild the healthcare system, some dramatic and far-reaching political and economic reforms are needed. Price controls and other artificial barriers preventing the market from functioning must be removed immediately and the Zimbabwean dollar must be replaced by a stable currency to curb hyperinflation.³⁷⁵

In view of the vulnerability context of the Zimbabwean majority, many activists and analysts criticised the international community for its “criminal and unethical politicisation” of aid. Their vantage point was that even if the ruling government was so tyrannical and untrustworthy, this could not justify the suffering, starvation and death of millions of innocent and needy people due to sanctions imposed on a government that is ruling them unjustly. There were calls for the international community to be more sensitive toward the plight of the vulnerable population and stop punishing them for their government's shortcomings by withholding aid. This is mainly because the ruling elite do not really feel the pinch since they have ready access to resources and can seek for specialist services outside the country. As such, it would be unfair for high income countries to withhold resources or for pharmaceutical companies to charge high prices and control patents where millions of people die. Human rights activists and organisations such as UNICEF continued to appeal to the international community to look beyond the politics and focus on Zimbabwe's children and the rest of the vulnerable populace.³⁷⁶ An emergency report on Zimbabwe's health crisis submitted by the Physicians for Human

³⁷⁴ IRIN News “ZIMBABWE: Staff return to hospitals, but not to work”, 24 Feb 2009 <http://www.irinnews.org/ReportId=82925> (20 March 2009).

³⁷⁵ Urbach Jasson “No Zion for Zimbabwe” 4 February 2009 <http://business.iafrica.com/opinion/1491620.htm> (25 March 2009).

³⁷⁶ UNICEF (2005), “Zimbabwe's forgotten children.”

Rights (PHR) succinctly painted the severity of the situation in a graphic way and also raised a clarion call to the international community to treat Zimbabwe's case as a crisis deserving urgent intervention to save lives and prevent more deaths;

... What happens when a government presides over the dramatic reversal of its population's access to food, clean water, basic sanitation, and healthcare? When government policies lead directly to the shutting of hospitals and clinics, the closing of its medical school, and the beatings of health workers, are we to consider the attendant deaths and injuries as any different from those resulting from a massacre of similar proportions?..The Mugabe regime has used any means at its disposal, including politicizing the health sector, to maintain its hold on power. Instead of fulfilling its obligation to progressively realize the right to health for the people of Zimbabwe, the Government has taken the country backwards, which has enabled the destruction of health, water, and sanitation – all with fatal consequences...These shocking findings should compel the international community to respond as it should to other human rights emergencies.³⁷⁷

The raging cholera epidemic was only averted by the concerted effort and intervention of the international community.³⁷⁸ International donors managed to lure health workers back to their posts with the promise of wages paid in foreign currency which had slowly started to become available as a result of the multi-currency policy introduced by Patrick Chinamasa during his tenure as Acting Minister of Finance prior to the Government of National Unity (GNU). By February 2009, striking Zimbabwean medical professional were returning to the wards after non-governmental organizations started paying monetary incentives, but many were not prepared to resume their duties. One of the nurses at Parirenyatwa hospital who declined to be named explained that she had received US\$100 as an allowance from humanitarian agencies, which had covered her monthly transport costs to the hospital but left little for daily living expenses. She expressed the health professional's sentiments in the following words:

It is almost like a sit-in, because what we are receiving at the moment falls far too short of what we have been striking for...The allowances from private donors are welcome but, unfortunately, they are not doing enough to address our plight...The donors have set the pace and it is up to the government to play its part so that we can start working in earnest once again.³⁷⁹

³⁷⁷ "HEALTH IN RUINS A Man-Made Disaster in Zimbabwe"

<http://physiciansforhumanrights.org/library/documents/reports/2009-health-in-ruins-zim-full.pdf> (20 March 2009).

³⁷⁸ For more information on the cholera epidemic in Zimbabwe, See

<http://physiciansforhumanrights.org/library/documents/reports/2009-health-in-ruins-zim-full.pdf>.

³⁷⁹ IRIN News "ZIMBABWE: Staff return to hospitals, but not to work", 24 February 2009
<http://www.irinnews.org/ReportId=82925> (20 March 2009).

Tsitsi Singizi, spokesperson for the United Nations Children's Fund (UNICEF) had this to say:

We decided to step in and help in rescuing the desperate situation in the health sector by disbursing top-up incentive allowances to striking health staff at public hospitals...This is a life-saving stopgap intervention, meant to complement government efforts to get the staff back at work; paying the workers their salaries remains the responsibility of the government.³⁸⁰

Singizi further explained that US\$5 million had been disbursed since January 2009 - a third of the salary budget for the year - with other non-governmental organizations committed to making their own contributions. The allowances were being paid to health employees via an independent international firm.³⁸¹

The humanitarian crisis in Zimbabwe is a classic illustration of how a modern economy cannot thrive in the absence of political stability, without smooth linkages to the international players. It is therefore apparent that in order for the country to revive an equitable national program to facilitate health care for all, this will require extensive international and national collaboration to mobilize essential financial and technical resources. The new government of national unity came into place amidst dire shortages of medical supplies and equipment - from sutures and intravenous fluids to HIV testing kits and chemicals for renal dialysis. Public health facilities had been effectively gutted and reduced to ghost institutions and most public health programmes had ground to a halt.³⁸² Analysts noted that against the backdrop of the new political dispensation;

Zimbabwe will still be confronted with the arduous task of rebuilding its moribund health system. Zimbabwe will need money and expertise to recoup even a shred of normality in its health services... It will take much time and effort to repair the devastated fabric of community, disruption of social solidarity, poverty, and decimated health system as a consequence of the political violence and the economic meltdown.³⁸³

³⁸⁰ IRIN News "ZIMBABWE: Staff return to hospitals, but not to work", 24 February 2009 <http://www.irinnews.org/ReportId=82925> (20 March 2009).

³⁸¹ IRIN News "ZIMBABWE: Staff return to hospitals, but not to work."

³⁸² WHO "Global, national efforts must be urgently intensified to control Zimbabwe cholera outbreak", 30 January 2009 http://www.who.int/mediacentre/news/releases/2009/cholera_zim_20090130/en/print.html (20 February 2009).

³⁸³ BMJ Editorial (2008) "Zimbabwe's Humanitarian Crisis" 12 August 2008 <http://www.bmj.com/content/337/bmj.a1286.full> (21 February 2010).

In the midst of this mayhem one organisation, the Zimbabwean Association of Doctors for Human Rights (ZADHR) has served as the moral conscience of the medical profession, braving the wrath of the Mugabe regime to wage an unequal battle with an autocratic government contemptuous of basic human rights. ZADHR has investigated and documented cases of gross human rights abuses and has consistently raised the alarm to what sometimes seems to be an “indifferent or impotent world, particularly in the southern African region”.³⁸⁴ The international medical fraternity can support this endeavour through advocacy and, where possible, by individuals volunteering their time and technical expertise to help alleviate the skills gap in the reconstruction of health systems and institutions. The people of Zimbabwe deserve the support of those who claim to uphold the traditions of healing and caring inherent in the medical profession.³⁸⁵

There has been a considerable shift since 2009 after the formation of the transitional government of national unity between Zanu PF and the main opposition MDC. Several international donors have extended their helping hands to inject some funding towards reviving major sectors such as health care, education and agriculture, although some are still hesitant to commit their funds especially to the Zanu PF officials, fearing misappropriation and embezzlement of funds. However, the health-care crisis and poor quality care offered in some public health care facilities still leaves a lot to be desired. For instance, maternal and child mortality remains alarmingly high countrywide. A case in point was the disturbing report of seven babies dying during delivery at Masvingo General Hospital on the same day on 26 November 2011. This was attributed to negligence by attendant staff at the hospital.³⁸⁶ The Masvingo General Hospital experience surpasses Zimbabwe’s prenatal mortality rate of 30 deaths per 1 000 people.³⁸⁷ On the other hand, several media reports have chronicled how women who fail to pay for maternity bills are held hostage together with their newly born babies in Zimbabwe’s public hospitals until their relatives come to their rescue and pay the

³⁸⁴ ReliefWeb. Statement Zimbabwe Association of Doctors for Human Rights—Victims of organized violence and torture continue to flood the health system. 26 June 2008.

www.reliefweb.int/rw/RWB.NSF/db900SID/KHII-7G433T (10 August 2008)

³⁸⁵ BMJ Editorial “Zimbabwe’s Humanitarian Crisis” 12 August 2008

<http://www.bmj.com/content/337/bmj.a1286.full> (21 February 2010)

³⁸⁶ Mafirakureva, G. and Kuzipa, P. (2011) “Would Your Wife Deliver at Masvingo General?” in *The Mirror*, 9-15 December, 1.

³⁸⁷ The Ministry of Health and Child Welfare, (2010) *The National Health Strategy for Zimbabwe, 2009-2013*, Harare: Government Printers, 25.

bills. If the bill is not paid in full, the mother and baby can be released but the hospitals withhold the baby's birth record until completion of payment.³⁸⁸

2.15 Conclusion

This chapter has discussed the history of health care in Zimbabwe, highlighting how upon independence, the government embarked on a policy of equity in health care. It has noted how the progress that was made in addressing inequality in health care started to go on a downward spiral from the early 1990s onwards. It explored the circumstances surrounding the health-care crisis, highlighting how the medical workers who were held in high esteem as trend-setters in social standards in the 1980s have over the past decade haplessly watched their status eroded, leaving them in no better position than semi-skilled workers toiling in the industries to survive from hand-to-mouth subsequently forcing most of them to migrate into greener pastures abroad.³⁸⁹ The chapter has reiterated that the socio-economic and political crisis engulfing Zimbabwe from the mid-1990s onwards was the result of a combination of factors, chief among them being the deindustrialising effects of ESAP, the intransigent manner in which the Mugabe government sought to respond to this crisis (e.g. land seizures)³⁹⁰ as well as the outbreak and spread of the HIV and AIDS epidemic. The recurrent shortage of food in the country since the year 2000 has also been identified as a major contributory factor impacting heavily on people's health since poor nutrition hinders immunity and exacerbates people's exposure to opportunistic infections. Poverty and food insecurity have been noted as key factors accelerating the spread of HIV and AIDS since in desperation for food, people tend to adopt risky survival strategies such as transactional sex and migratory labour. This has a negative impact on people's sustainable livelihood strategies since it makes them more vulnerable to poverty and exploitation. The seriousness of the HIV

³⁸⁸ For more information on such reports see Sachiti R (2011) "Its now pay first, or no discharge" *The Sunday News*, 8 June 2011 http://www.sundaynews.co.zw/index.php?option=com_content&view=article&id=12153:its-now-pay-first-or-no-discharge&catid=42:features-news&Itemid=134#.UoDBZGoaLIU (20 July 2012)

³⁸⁹ For more on migration of professionals from Zimbabwe, see Dube, L (2009) "HIV and AIDS Gender and Migration: Towards a Theological Engagement" in *Journal of Constructive Theology* Volume 15. No.2, 71-82 and Chirongoma S (2009) "Operation Murambatsvina (Operation Restore Order/Operation Clean Up): Its Impact and implications in the era of HIV and AIDS in contemporary Zimbabwe" in Hadebe Nontando and Chitando Ezra (eds) *Compassionate Circles: African Women, Theologians Facing HIV* (World Council of Churches Publications, Geneva, Switzerland), 71-94.

³⁹⁰ According to the World Bank report, Zimbabwe currently has the highest rate of inflation in the world, and the economy has shrunk by more than 70 percent since 2000, the time president Robert Mugabe embarked on his controversial land redistribution programme. See <http://www.ipsnews.net/news.asp?idnews=45086> "HEALTH-ZIMBABWE: Shady Dealings with Antiretrovirals".

and AIDS epidemic has also been noted, in view of the fact that it is a strong force in slowing down development especially by reducing life expectancy which has been drastically reduced to 37 and 34 for males and females respectively. The deterioration of the economy has also been identified as a determinant factor impacting on people's ability to access health care since prices for the services will be raised beyond the ordinary person's means. This long causal chain which runs from Mugabe's failed economic policies, to Zimbabwe's economic collapse, food insecurity and malnutrition, and the outbreaks of infectious diseases such as cholera and typhoid poses a huge burden to the already overwhelmed health care sector. Health seekers find themselves in a dilemma whereby they cannot access bio-medical health care, leaving them to utilise alternative health providers such as faith healers and traditional healers, a move regarded as retrogressive by the development philosophy. The chapter has also discussed the available health centres and the services rendered by these institutions. It has indicated some of the challenges faced by these health institutions and how they are struggling to cope in the prevailing socio-economic and political environment. Emphasis has been placed on the inaccessibility of health care to the poor majority and how people are caught up in a dilemma of wanting to utilise bio-medical health care but being unable to pay for the facilities or even to travel to the nearest health centre and sometimes even when they can afford it, the required services will be unavailable due to shortages of qualified personnel, shortages in equipment and medical supplies or all the factors combined together. It has been noted that in response to the health care crisis, people resort to indigenous resources such as traditional medicine and faith-healing, a subject which will be explored in more detail in chapters four and five as illustrated by the case-studies of individuals caught up in this dilemma, highlighting the various strategies they are adopting in navigating the dilemma at hand. However, before turning to the case studies, the next chapter (three) gives us some background information on Karanga people's conception of health and well-being (*utano*) so as to provide a setting for the manner in which they respond to any situation that diminishes or threatens health and well-being (*utano*).

Chapter Three

Karanga People's Conception of Health and Well-Being

3.1 Introduction

Chapter two presented a general overview of Zimbabwean historical developments; it explored the several socio-political and economic changes that the people of Zimbabwe have gone through and how these developments had a direct impact on the country's health-care system.

The chapter also highlighted how health as modernisation has been a far-fetched dream for the majority of poor Zimbabweans. It brought to light the crisis that most Zimbabweans find themselves in due to their failure to access western bio-medicine – it is unaffordable because of the neo-liberal economic impact on development and in most cases unavailable because of the total breakdown in the public health sector. It noted how such a situation leaves health seekers in a dilemma whereby they can only but rely on alternative health providers such as faith healers³⁹¹ and traditional healers³⁹², a move regarded as retrogressive by the western development philosophy.³⁹³ It also clearly showed that this particular society is not static but has experienced gradual change due to the impact of Christianity, colonialism and modernization.

Picking up from the previous chapter, this chapter (three) proceeds to reiterate that although Christianity, colonialism and modernization impacted heavily on the country's political organization, economy, kinship system, gender roles and customs, however the traditional beliefs and practices still prevail especially in view of how the community, particularly the

³⁹¹ As noted in the extensive writings on Zionist Churches by Daneel, M.L. (1971, 1974, 1983, 1987, 1988, 1989b, 1995), faith healing has been one of the most powerful and persuasive expressions of the gospel of good news. The term faith healing refers to a system whereby patients go to the 'healing prophets' or 'faith healers' who will pray for their healing, sometimes these healers administer holy water or holy oil and at times they 'extract' some objects from the patients' bodies.

³⁹² "Traditional health care systems" refers to the use of herbal or traditional cures either self-administered or administered by traditional healers.

³⁹³ Depending on the nature of the illness or at times the availability of health facilities/providers, some patients utilize all the three facilities concurrently e.g. one can first seek health care at the clinic and from there they visit either the faith-healers or traditional healers and in other cases they consult both.

Karanga people conceptualise the issue of health and well-being.³⁹⁴ This chapter gives a brief exploration of Karanga healthworlds, showing how the Karanga understanding of health and well-being shares some similarities with other African contexts. It seeks to fathom the inherent rich resources within the Karanga indigenous knowledge systems and how this influences the Karanga understanding of ill-health, healing and fullness of life. In other words, it foregrounds the Karanga fundamental need for health, healing and well-being in a holistic manner (physical, spiritual and emotional) within their religio-cultural perspective.

3.2 Karanga People's Healthworld³⁹⁵

As highlighted in chapters one and two, health and well-being are the central concerns for all African people and the Karanga are no exception. This is reflected in the manner in which African people emphasize preserving life and well-being. Benezet Bujo puts it across succinctly, "Africans believe life to be sacred but life is permanently threatened by death. The human person's task is to identify the enemies of life to defeat death...Tension between life and death does not affect the human person alone but the entire cosmos."³⁹⁶ Simon S. Maimela also foregrounds the fact that an African is born and groomed to participate in the preservation of vitality.³⁹⁷ Ezra Chitando writing about the Karanga concurs, "African beliefs and practices are a celebration of life. Life is good and must be enjoyed to the full. Life must be enhanced and celebrated. Traditional Africans are stubbornly earthbound, that is, they are

³⁹⁴ For a detailed discussion on this topic, see Shoko, T. *Karanga Indigenous Religion in Zimbabwe: Health and Well-Being* (Ashgate: Ashgate Publishing Limited, 2007); Dahlin O *Zvinorwadza: Being a Patient in the Religious and Medical Plurality of the Mberengwa District, Zimbabwe* (Universitetstryckeriet: Uppsala, 2000) and Gurli, H.(1996) *Mwana Ndi Mai: Toward an Understanding of Preparation for Motherhood and Child Care in the Transitional Mberengwa District, Zimbabwe* (Studia Missionalia Upsalieansia, no.LXV. Uppsala: Swedish Institute of Missionary Research). Writing within the Karanga-Shona people in Mberengwa, they reiterate the same viewpoint.

³⁹⁵ The author is indebted to ARHAP for this terminology. See Paul Germond and James R. Cochrane, "Healthworlds: Ontological, Anthropological and Epistemological Challenges on the Interface of Religion and Health," in *Reasons of Faith: Religion in Modern Public Life* (University of Witwatersrand: Wits Institute for Social and Economic Research (WISER), 2005); James R Cochrane "On Healthworlds". WHO Seminar, Washington DC. 8 Feb 2007. Based on a paper presented at the Annual Meeting of the American Academy of Religion, *Panel on Religion, Health and Social Justice: African Perspectives on a Global Issue*, 18-21 Nov 2006, Washington D.C.; ARHAP. 2006. "Appreciating assets: The contribution of religion to universal access in Africa." Cape Town: Report for the World Health Organization, African Religious Health Assets Programme; Thomas, L., B. Schmid, M. Gwele, R. Ngubo, and J.R. Cochrane. 2006. "Let us embrace: The role and significance of an integrated faith-based initiative for HIV and AIDS." Cape Town: (ARHAP) African Religious Health Assets Programme.

³⁹⁶ Bujo, B. (2009) "Ecology and Ethical Responsibility from and African Perspective" in Murove, M.F. (ed) *African Ethics: An Anthology of Comparative and Applied Ethics* (University of KwaZulu-Natal Press: Pietermaritzburg), 282.

³⁹⁷ Maimela S.S. (1985) "Salvation in African Traditional Religions", *Missionalia* 13:2, 63-77.

not preoccupied with the idea of a world to come...The dominant belief is that one should live to a ripe old age...Traditional African beliefs and practices promote a pro-life agenda.”³⁹⁸

Hence the traditional African reveres life; there is a preoccupation with longevity and abundance in the physical life. Anything that threatens or diminishes life is to be resisted and avoided. A celebration of life underpins the traditional worldview and every effort is made to protect one against death. Consequently, any death-dealing forces or actions must be eradicated.³⁹⁹ This view is also reinforced by Klaus Nurnberger, “Death can be defined as the loss of vitality. As such it is a serious matter, *in fact the most serious matter one can think of*. This is particularly true for a culture that is intensely geared to the fullness of life. It is immensely feared in all traditional societies, as it should be.”⁴⁰⁰ [Emphasis, Mine]

In the same light, Chitando poignantly explains the traditional African attitude towards death as follows:

The anthropological beliefs in African Traditional Religions are predicated on the understanding that death is a fundamental human problem... *Death is an enemy that must be fought vigorously, which accounts for the use of protective charms and amulets...*Death is seen as a negative force that upsets the life of the community....Death is seen as an aberration that must be addressed urgently. African Traditional Religions therefore seek to promote life and undermine death...In traditional philosophy, life triumphs over death.⁴⁰¹ [Emphasis, Mine]

The African community therefore strives to preserve and to protect life and anything that promotes well-being is embraced and cherished.

Within the African worldview, health and well-being is always conceived in a communal and holistic perspective. Bujo aptly puts it this way; “African thought and action are deeply determined by the community.”⁴⁰² Consequently, each and every person “has the duty to do

³⁹⁸ Chitando E (2007a) *Living with Hope: African Churches and HIV/AIDS 1* (WCC Publications: Geneva),47-48.

³⁹⁹ See Chitando E. (2007a) *Living with Hope* and Chitando E (2009) *Troubled But Not Destroyed* (WCC Publications: Geneva).

⁴⁰⁰ Nurnberger K. (2007) *The living dead and the living God: Christ and the ancestors in a changing Africa* (Pietermaritzburg: Cluster Publications), 25.

⁴⁰¹ Chitando E. (2007a) *Living with Hope*, 48-49.

⁴⁰² Bujo B. (1998). *The Ethical Dimension of Community. The African Model and the Dialogue between North and South*, (Nairobi: Pauline Publications Africa), 189.

good to his or her neighbour, especially relatives, clansmen and -women and friends... These are obligations which aim at promoting the well-being of the community”.⁴⁰³ The sense of duty that one has towards others in the community emerges out of a realization that the preservation of life is dependent on the efforts of others.⁴⁰⁴ Peter Kasenene also reiterates that rituals are performed to strengthen and maintain vitality and unity with the community since within the African worldview; a person is not detached from the community.⁴⁰⁵ Chirongoma and Manda put it succinctly:

The African conception of life is therefore communal; one belongs to a community or society. In this regard, the health and well-being of individuals and the whole community is everyone’s concern. The sickness of one community member affects the well-being of the entire community and everyone will try to assist the individual who has fallen ill. Hence, the sick individual is never alone; he/she remains connected to the people through their concern with restoring his/her health.⁴⁰⁶

Hence, Africans operate on the premise that “Everybody’s behaviour and ethical action have consequences for the whole community: the good contributes to the increase of life, while evil destroys or at least reduces life”.⁴⁰⁷ As such, before undertaking a specific task or journey, an African would perhaps ask oneself “will the outcome of a chosen action earn the pleasure or wrath of the ancestors or community?”⁴⁰⁸ Osma Mbombo affirms that African patients never go and consult a traditional healer alone, “a group of people left a particular village for the *nyanga*’s village. When they are confronted with illness, a group of people invariably comes so that they can listen [*ukupulaphula*]. They come to listen for this person, or listen with this person. When they come out of the consulting room, what the doctor has said is also the concern of those who are waiting.”⁴⁰⁹

⁴⁰³ Kasenene P. (1994) Ethics in African theology, in: Villa-Vicencio, C. and de Gruchy, J.W. (Eds) *Doing ethics in context. South African perspectives*, (Cape Town: David Phillip Publishers):141

⁴⁰⁴ Bujo B. (1998) *The ethical dimension of community. The African model and the dialogue between North and South*, (Nairobi: Pauline Publications Africa),189.

⁴⁰⁵ Kasenene P. (1994) “Ethics in African theology”

⁴⁰⁶ Chirongoma S. and Manda D.L. (2008) “*Ubuntu* and women’s health agency in contemporary South Africa” in Steve de Gruchy, Sytse Strijbos and Nico Koopman (eds) “*From our side: emerging perspectives on development and ethics*” (Rozenberg Publishers:Amsterdam),195.

⁴⁰⁷ Bujo B. (1998). *The ethical dimension of community*, 189.

⁴⁰⁸ Prozesky M. (2006) *Introducing comparative and applied ethics*, (Unilever Ethics Centre: University of KwaZulu-Natal), 20.

⁴⁰⁹ Mbombo O. (1996) Practising medicine across cultures: conceptions of health, communication and consulting practice, in Steyn, M. and Motshabi, K. (Eds) *Cultural synergy in South Africa. Weaving strands of Africa and Europe* (Randburg: Knowledge Resources), 115.

Chirongoma and Manda also affirm that the typical African patients will “never go to the hospital alone, but are accompanied by relatives or friends.”⁴¹⁰ There are two reasons for this: firstly, to ensure that they understand the causes of the patient’s illness, and secondly, to show solidarity “during suffering and sickness.”⁴¹¹ What this also implies is that for an African, “disease is always an indication that something in human relations is wrong.”⁴¹² As Chirongoma and Manda put it, “this is because the cause of illness is not always physiological, but it could be caused by a disruption in social relationships. Thus, even friends and relatives are examined in order to determine who has wronged whom.”⁴¹³

In this manner, “the individual’s ailment is understood in terms of relatedness and interrelatedness between the individual and all those realities that constitute existence”.⁴¹⁴ With particular focus on the Karanga, Shoko puts it succinctly, “absence of illness and disease bring relief and joy. This is a result of good relationships with the spirits, maintained through a series of rituals...Failure to perform requisite rituals and violations of traditional rules create danger.”⁴¹⁵

The Karanga traditional system of therapy for illness and disease⁴¹⁶ is anchored on ritual activity which entails communication with guardian spiritual entities. There are diviners,

⁴¹⁰ Chirongoma S and Manda D.L. (2008) “*Ubuntu* and women’s health agency in contemporary South Africa”, 195.

⁴¹¹ Bujo B. (1998). *The ethical dimension of community*, 189.

⁴¹² Bujo B. (1998). *The ethical dimension of community*, 182.

⁴¹³ Chirongoma S and Manda D.L. (2008) “*Ubuntu* and women’s health agency in contemporary South Africa”, 195.

⁴¹⁴ Murove M.F. (2005) “African bioethics: An explanatory discourse,” *Journal for the Study of Religion*, 18(1), 16-36.

⁴¹⁵ Shoko T. (2007) *Karanga Indigenous Religion in Zimbabwe*, 35.

⁴¹⁶ According to Budd, J (2010) “The Difference between Illness and Disease: A Key Concept for Student Nurses” [http:// www.NANDA.org/the-difference-between-illness-disease-key-concept-6779904.html](http://www.NANDA.org/the-difference-between-illness-disease-key-concept-6779904.html) (6 March 2014), within the medical fraternity, there are clear distinctions between illness and disease. An illness refers to the human response to disease. For instance, how a patient responds to a diagnosis of diabetes. Mentally, a newly diagnosed diabetes patient may experience denial. This denial can include refusing to monitor glucose levels or change dietary habits. Physically, a diabetes patient may experience abnormal blood glucose levels resulting in hyper/hypoglycemia. The four stages of illness can be summarized as follows: 1. Experiencing signs and symptoms; 2. Assuming the sick role, or validating the sickness; 3. Seeking medical care; 4. Assuming dependent role while recovering. On the other hand, a disease is an alteration of the mental and/or physical structure of the human body or mind. Diseases can have numerous causes: biological (like viruses), chemical (like drugs or heavy metals), genetics, physical agents (like temperature extremes), and alterations in immunity or metabolism (like allergies or hormonal disturbances.) With disease comes specific signs and symptoms that manifest themselves, allowing physicians/medical experts to diagnose their patients. A physician can diagnose a patient as being diabetic (disease.) But if that diabetic patient does not monitor his glucose levels or make necessary changes in his diet, the nurse can diagnose him with risk for unstable glucose levels (illness.) Thus, nursing is concerned with illness while medicine (or a physician) is concerned with disease.

herbalists, traditional healers (*n'anga*)⁴¹⁷ and often a combination of all three, but they are not responsible for the performance of the religious rites. This responsibility rests solely on the head of the family i.e. the father or grandfather whose main duty is to safeguard the family's welfare.⁴¹⁸ To maintain and increase its welfare, he has to ensure that the family members do not do anything which displeases the ancestral spirits. He must also ensure that such sacrifices are acceptable to the ancestral spirits.⁴¹⁹ There is also considerable use of herbal treatments, extractions and exorcisms administered by bio- medical practitioners and experienced elders. The overriding aim is to cure illness and disease and restore health.⁴²⁰ Clearly, it is apparent that "in the African world-view, life should be lived to the fullest and in appreciation of others. There is a strong impulse to secure life through the practice of good habits. Illness or any other type of misfortune is therefore interpreted as the work of evil especially if customary practices are being upheld."⁴²¹

Traditional medicine is a fundamental practice of the Karanga religion. People's experiences of illness and disease, death and misfortune call for healing. Although the influx of mission churches and the rise of independent churches have exerted an impact on traditional religion among the Karanga, however traditional religion still enjoys considerable adherence/following especially when it comes to people's health and welfare. Shoko writing about the Karanga in Mberengwa sums it up this way:

The Karanga traditional beliefs and practices prevail despite condemnation by Christianity...The *n'anga* still plays a crucial role to divine the causes of illness and disease and provide healing. Spirits are the prime cause...The Lutheran church set up hospitals and clinics and highlighted physical and natural causes and bio-medical

⁴¹⁷ *N'anga* is a Shona term used to refer to a traditional medical practitioner/ traditional healer or diviner. See Murove, M.F. (2009) "African Bioethics: An Exploratory Discourse" (pp.155-177) in Murove, M.F. (ed) *African Ethics: An Anthology of Comparative and Applied Ethics* (University of KwaZulu-Natal Press:Pietermaritzburg) and Shoko, T. (2007) *Karanga Indigenous Religion in Zimbabwe*, 46.

⁴¹⁸ See M.F.C. Bourdillon, *The Shona Peoples: An Ethnography of the Contemporary Shona, with Special Reference to their Religion* (Mambo Press:Gweru, 1976); G.L.Chavunduka, *Traditional Healers and the Shona Patient* (Mambo Press:Gweru, 1978); M. Gelfand, *Medicine and Magic of the MaShona* (Cape Town: Juta and Co., 1956); M. Gelfand, *Witch Doctor: Traditional Medicine Man of Rhodesia*, (London, 1964); M. Gelfand et.al., *The Traditional Medical Practitioner in Zimbabwe: His Principles of Practice and Pharmacopoeia* (Mambo Press:Gweru,1985); C. Kileff and P. Kileff (eds), *Shona Customs:Essays by African Writers* 1970); J.M. Schoffeleers (ed), *Guardians of the Land:Essays on Central African Territorial Cults*, (Mambo Press: Gweru, 1978).

⁴¹⁹ Soderstrom H. (1984) *God Gave Growth: The History of the Lutheran Church in Zimbabwe, 1903-1980* (Mambo Press: Gweru), 64.

⁴²⁰ Dahlin O. (2001) *Zvinorwadza: Being a Patient in the Religious and Medical Plurality of the Mberengwa District, Zimbabwe* (Universitetstryckeriet: Uppsala), 93-100.

⁴²¹ Chirongoma S and Manda D.L. (2008) "Ubuntu and women's health agency in contemporary South Africa", 196.

treatment. Independent churches emphasize spiritual causes and apply faith healing. *The Karanga may use one or two medical systems, but for most people traditional healing is the basis of their health and well-being.*⁴²² [Emphasis, Mine]

M.V. Gumede also affirms that “over 80% of Black patients visit the traditional healer before going to the doctor and the hospital”.⁴²³ Writing about the Shona from a general perspective throughout Zimbabwe, M.F.C. Bourdillon came to the following conclusion.

In some rural areas, people still go routinely to traditional healers and trek to a clinic or hospital as a last resort. In the towns, many people now go to a clinic or hospital and revert to traditional medicine only when the doctors and nurses are no longer seen to be useful. Others go to both types of medicine, depending on the circumstances.⁴²⁴

Clearly, this shows that the average Shona person relies significantly on traditional medicine and most scholars who have written on this subject ascribe this trend to the fact that traditional medicine addresses the patient from a holistic perspective, addressing the psychological and social issues whereas scientific medicine is concerned primarily with the physical and chemical world.⁴²⁵ The fact that the traditional health care system handles illness in a holistic manner and has ease of access is also highlighted by Murove who asserts that “...the inherited western health care system does not provide an adequate understanding of life, death, health and disease within the African context. Most Africans live in traditional communities with easier access to traditional than western doctors”.⁴²⁶ It is in light of the Karanga people’s healthworlds that the next section discusses the Karanga understanding of evil and witchcraft. It lays bare the fundamental role played by the *n’anga* in divining causes of misfortune and ill-health especially in the context of a strong belief/fear of witchcraft.

⁴²² Shoko T. (2007) *Karanga Indigenous Religion in Zimbabwe*, 56.

⁴²³ Gumede, M.V. (1990) *Traditional healers: A Medical Practitioner’s Perspective* (Skotaville Publishers: Braamfontein), iii.

⁴²⁴ Bourdillon M.F.C. (1993) *Where Are The Ancestors?: Changing Culture in Zimbabwe* (University of Zimbabwe Publications: Harare), 97.

⁴²⁵ See Bourdillon M.F.C. (1993) *Where Are The Ancestors?*; Chavunduka G.L., *Traditional Healers and the Shona Patient* (Mambo Press: Gweru, 1978); M. Gelfand, *Medicine and Magic of the MaShona* (Cape Town: Juta and Co., 1956); M. Gelfand, *Witch Doctor: Traditional Medicine Man of Rhodesia*, (London, 1964); M. Gelfand et al., *The Traditional Medical Practitioner in Zimbabwe: His Principles of Practice and Pharmacopoeia* (Mambo Press: Gweru, 1985).

⁴²⁶ Murove M.F. (2009) “African Bioethics: An Exploratory Discourse,” 158.

3.2.1 The Karanga Conception of Evil, Misfortune and Witchcraft (*Uroyi*)⁴²⁷

Like many other African cultural traditions, the Karanga have an underlying belief in witchcraft (*uroyi*). According to Shoko, the Karanga regard most illnesses and misfortunes to be the result of witchcraft.⁴²⁸ It is befitting to reiterate at the outset that although, “officially witchcraft is outlawed and imputations illegal and subject to heavy penalties under the Witchcraft Suppression Act 1899, but for the Karanga witchcraft is an existential reality. The practice is not questionable. Stories and accounts of witchcraft and confessions testify to the existence of witchcraft.”⁴²⁹

It is also significant to note that although before 2006 Zimbabwe used to have the Witchcraft Suppression Act 1899 (Chapter 73) which assumed that witchcraft does not exist, however in 2006 there was drastic reform. The Witchcraft Suppression Act was repealed by the coming into force of the Criminal Law (Codification and Reform Act of 2006, Section 89).⁴³⁰ Under the former legislation, witchcraft was entirely banished. It was illegal to accuse anyone of being a witchcraft practitioner.⁴³¹ However, the reform recognizes the existence of witchcraft and criminalizes only witchcraft practices that are harmful to others.⁴³² It has been argued that one of the reasons behind this reform is that to most Zimbabweans, especially those who grew up in the rural areas, it is absurd to say that the supernatural does not exist.⁴³³ There are numerous reports in the local media relating acts or confessions of witchcraft. Some communal traditional courts in Zimbabwe still address issues of witchcraft and those accused of witchcraft are either disowned/banned from the community or made to pay a fine usually in the form of livestock, in some instances, they are asked to undo/reverse the harm inflicted on their victims.⁴³⁴ Gordon

⁴²⁷ *Uroyi* is a Shona term denoting the act of witchcraft, one who practices *uroyi* is referred to as a *Muroyi*, translated as a witch/wizard. See Shoko, T. (2007) *Karanga Indigenous Religion in Zimbabwe*, 43-48 and Dahlin, O. (2001) *Zvinorwadza: Being a Patient in the Religious and Medical Plurality of the Mberengwa District, Zimbabwe* (Universitetstryckeriet: Uppsala), 71-74; Dube L., Shoko T. and Hayes S. (2011) *African Initiatives in Healing Ministry* (UNISA Press: Pretoria), 25-43.

⁴²⁸ Dube L, Shoko T and Hayes S (2011) *African Initiatives in Healing Ministry* (UNISA Press: Pretoria):34

⁴²⁹ Shoko T. (2007) *Karanga Indigenous Religion in Zimbabwe*: 46. See also Shoko, T. (2010) “Traditional Healing: Continuity and Change” in Chitando E and Togarasei L (eds) *Faith in the City: The Role and Place of Religion in Harare* (Universitetstryckeriet: Uppsala), 93-94.

⁴³⁰ Visit http://www.chr.up.ac.za/undp/domestic/docs/legislation_57.pdf.

⁴³¹ Also visit <http://www.wwrn.org/article.php?idd=21276&sec=39&cont=3>.

⁴³² See section 98 of the Criminal Law (Codification and Reform) Act of Zimbabwe.

⁴³³ Visit <http://news.bbc.co.uk/2/hi/africa/5134244.stm>.

⁴³⁴ See Shoko T. (2007) *Karanga Indigenous Religion in Zimbabwe*, Shoko, T. (2010) “Traditional Healing: Continuity and Change”, Dahlin, O. (2001) *Zvinorwadza* and Hansson G. (1996) *Mwana Ndi Mai* and

Chavunduka, who was a practising traditional healer and the first president of the Zimbabwe National Traditional Healers' Association (ZINATHA), and also the vice-chancellor of the University of Zimbabwe from 1992-1996, had this to say,

Traditional courts accept the view that witches exist. In the past, once an individual was found guilty of practising witchcraft, he or she was sentenced by the court. The sentence took various forms. In extreme cases the witch was beaten or even killed. Other witches were ordered to leave the village and had their houses destroyed. Ostracism was the mildest form of punishment. Some witches were cured. In such a case a doctor was ordered to neutralize or eliminate the evil spirit that possessed the witch.⁴³⁵

In Zimbabwe it is an offence to groundlessly or by the purported use of non-natural means accuse another person of witchcraft.⁴³⁶ Although many traditional courts as well as family gatherings still try certain cases of witchcraft, legally they are not permitted to do so. According to the law of Zimbabwe such cases must be referred to the formal courts. Those who feel that they have been wrongfully accused of witchcraft can report the case to the formal courts but there are instances when some people confess to having practiced witchcraft. Commenting on this paradox, Chavunduka put it this way,

Many diviners, for example, when faced with a case of witchcraft are reluctant to name the witch for fear of prosecution but they do indicate to the patient who the witch is, in a way which leaves no doubt in the patient's mind as to his identity. The diviner indicates someone in general without specifying a name. For example, he says, 'one of your co-workers', 'one of your neighbours', 'one of your wives', and the patient fixes on some definite person, whom he already thinks has reason to wish him harm. The suspect is then pursued as a private enemy by his victim or self styled victim.⁴³⁷

As such, a belief in witchcraft is fundamental in understanding the Karanga worldview.

Lilian Dube describes witchcraft [*uroyi*] as “antisocial behaviour...caused either through possession by an ancestor or alien spirit who was a witch or by securing bad charms and spells from an evil diviner [*n'anga*]”.⁴³⁸ One who performs acts of witchcraft is known as a witch [*muroyi*]. According to Chavunduka,

A witch is defined in social anthropology as a person in who dwells a distinctive and inherent evilness, whereby he harms his fellows in mysteriously secret ways. Often it is thought that the witch need merely wish to harm his victim and his witchcraft then does

Mwandayi C “Men Suffering Violence Perpetrated by Women: A Challenge for the Church in Zimbabwe” in Chitando and Chirongoma (ed) *Churches and Gender-based Violence: Theological Responses* (forthcoming)

⁴³⁵ Chavunduka G.L., (1980) “Witchcraft and the Law in Zimbabwe” *Zambezia* V111 (ii),129-130

⁴³⁶ See section 99 of the Criminal Law (Codification and Reform) Act of Zimbabwe.

⁴³⁷ Chavunduka G.L., (1980) “Witchcraft and the Law in Zimbabwe” *Zambezia* V111 (ii), 142-143.

⁴³⁸ Dube L, Shoko T and Hayes S (2011) *African Initiatives in Healing Ministry* (UNISA Press: Pretoria), 27.

this, or it may be enough for him merely to feel annoyance or jealousy against someone for the power to set itself in operation without his being aware of the fact that it has done so. Witches are thought able to do extraordinary things which are beyond the capabilities of ordinary human beings. They are thought capable of travelling great distances at night, or of having the ability to turn themselves into hyenas, or of going out in spirit and killing a victim while their bodies remain at home in bed.⁴³⁹

In the same light, Shoko describes a witch [*muroyi*] as follows; “*muroyi* is a person with a distinctive and inherent evilness who harms his fellows in mysterious and secret ways. It is intrinsic and propelled by spirits at a sub-conscious level. A witch wields sinister power which is harmful.”⁴⁴⁰

In addition, Dube explains the practise of witchcraft in the following words:

Witches are believed to possess powers that enable them to do their nefarious work by night. They are believed to possess death-dealing charms. Underlying the whole struggle for life against the power of evil is belief in the power to affect others through the use of charms, especially treated substances.⁴⁴¹

The key suspects of witchcraft are women, particularly those with excessive qualities. In many cases it is poor, old and lonely widows, more so women who live an anti-social life who are prime suspects. In some cases, women who stand out in the community particularly the extremely beautiful ones, unusually light in complexion or the very ugly and very dark in complexion, or even extremely hard-working women are suspected/accused of witchcraft.⁴⁴² Dube explicates some key reasons that make women to feature as the prime suspects of witchcraft,

Witchcraft is believed to stem from jealousy, malice, envy, hatred and grudges. These vices are associated with women, who, being the weaker sex are unable to fight and therefore are believed to resort to witchcraft in dealing with their enemies. This is also partly because women are often outsiders or strangers [*vatorwa*] in the communities; they live as wives having married outside their totemic clan areas.⁴⁴³

⁴³⁹ Chavunduka G.L., (1980) “Witchcraft and the Law in Zimbabwe” *Zambezia* V111 (ii), 132.

⁴⁴⁰ Shoko T. (2007) *Karanga Indigenous Religion in Zimbabwe*, 43.

⁴⁴¹ Dube L, Shoko T and Hayes S (2011) *African Initiatives in Healing Ministry*, 29.

⁴⁴² Shoko T. (2007) *Karanga Indigenous Religion in Zimbabwe*, 43.

⁴⁴³ Dube L, Shoko T and Hayes S (2011) *African Initiatives in Healing Ministry*, 29.

Dahlin and Shoko also concur that witchcraft is “usually associated with women of alien blood”.⁴⁴⁴ “Women are aliens in the family. Alien blood is dangerous and susceptible to witchcraft. Women are scapegoats for evil and ritually unclean. They are exempted from religious, social and cultural functions.”⁴⁴⁵ Shoko sums it up in the following words: “Witches are seen as malicious human beings, especially older women who are motivated by hatred and jealousy. It is also a nocturnal craft with a nightmare quality.”⁴⁴⁶

In other cases, men who are very successful in life especially in material terms can also be suspected of gaining their riches through bewitching others by use of charms and medicine.⁴⁴⁷

Most often *uroyi* is thought to be caused by jealousy. There are several reasons for people to be jealous. One main reason among women is the area of fertility; a very high value is placed on the bearing of children in traditional African society, and women who have lost children or are barren are therefore of little account.⁴⁴⁸ As a result, such women might engage in witchcraft in order to make others fear and obey them; that is, they will be attempting to build up a reputation as powerful individuals and in the process, enhance their status in the community.⁴⁴⁹ Since fertility brings about respect and a higher status in the family, as well as a means for a woman to acquire the status of an ancestor [*mudzimu*],⁴⁵⁰ it is highly valued.⁴⁵¹ This is because in the traditional Shona understanding of existence, physical death is the beginning of the process of dying as one enters into the ancestral community. The dead are thought not to disappear after death but to remain in the vicinity of their homestead where they have been buried. After a stipulated period, a

⁴⁴⁴ See Dahlin O. (2001) *Zvinorwadza: Being a Patient in the Religious and Medical Plurality of the Mberengwa District, Zimbabwe* :71-73; Shoko ,T. (2007a) *Karanga Indigenous Religion in Zimbabwe* :43 and Shoko, T. (2010) “Traditional Healing: Continuity and Change” in Chitando E and Togarasei L (eds) *Faith in the City: The Role and Place of Religion in Harare* Universitetstryckeriet:Uppsala, 85-89.

⁴⁴⁵ Shoko T. (2007) *Karanga Indigenous Religion in Zimbabwe* , 43.

⁴⁴⁶ Shoko T. (2010) “Traditional Healing: Continuity and Change, 89.

⁴⁴⁷ See Shoko T. (2007) *Karanga Indigenous Religion in Zimbabwe*, 43 and Dube L, Shoko T and Hayes S (2011) *African Initiatives in Healing Ministry*, 29 and 34.

⁴⁴⁸ Crawford J.R. (1967) *Witchcraft and Sorcery in Rhodesia* (London: Oxford University Press), 61-2.

⁴⁴⁹ Chavunduka G.L., (1980) “Witchcraft and the Law in Zimbabwe” *Zambezia* V111 (ii), 138.

⁴⁵⁰ The Shona terms *mudzimu* (singular) and *vadzimu* (plural) are used to refer to the spiritual form of the dead relatives, commonly referred to as ‘the living-dead’. For more information, see Nurnberger N. *The Living dead and the living God: Christ and the ancestors in a changing Africa* (Pietermaritzburg: Cluster Publication, 2007); Kirwen M.C. *African Cultural Knowledge: Themes and Embedded Beliefs* (Nairobi: MIAS Books, 2005) and Aschwanden H. (1987) *Symbols of Death* (Mambo Press: Gweru).

⁴⁵¹ See Aschwanden H. (1982) *Symbols of Life* (Mambo Press: Gweru):24-25 and Bediako, K (1997) *Christianity in Africa: The renewal of a non-Western religion* (Edinburgh: Edinburgh University Press), 218ff.

ritual/ceremony *kugadzira* [domesticating/bringing back home the spirit of the dead] is performed by the living relatives whereby the spirit of the dead person is transformed into a proper *mudzimu*. This ceremony is usually initiated by one's offspring and in some instances those who died childless will have no-one to perform this ceremony for them and their spirits will be lost as they continue hovering around with nobody to transform them into *vadzimu*. This is particularly why leaving behind progeny, especially male offspring, is central and essential to the traditional Karanga people.⁴⁵² Becoming a *mudzimu* is the highest goal that one can attain, only then is s/he fully appreciated as a member of the family, honoured and feared. However, to reach that goal a person must have begotten children who can remember them and continue the bloodline. Hence, the ancestors [*vadzimu*] depend on the recognition of their offspring for their continued authority and belonging; if they are not remembered, they will be excluded from the community and become victims of fading memories or homeless spirits. The more children and grandchildren a person has, the more powerful s/he is considered as a *mudzimu*. This is the reason why there is so much rivalry and so much pressure surrounding the issue of fertility and procreation, to such an extent that some people might be jealous of others who have more offspring and might end up bewitching them. Furthermore, those who are childless are always subject to being suspected of being envious of those with offspring and as such they become prime suspects of witchcraft.

Wealth, high quality education or a good job are other possible reasons attracting jealousy.⁴⁵³ Displaying a good life or celebrating any success/achievements implies in general taking the risk of being the target of *uroyi*.⁴⁵⁴ Anything out of the ordinary makes one a target of witchcraft e.g. a family's success can arouse envy from the witches/wizards, making them targets of witchcraft. This explains the reason why in many Karanga families within Murinye district, graduation parties and expensive weddings are not usually celebrated in the rural homes but mostly these are held in urban areas with just a few close/trusted associates invited from the village. Newly born babies are usually delivered in urban hospitals, safely kept in the urban areas and will only be taken to the

⁴⁵² See Dahlin O. (2000) *Zvinorwadza*, Hansson G. (1996) *Mwana Ndi Mai*, Shoko, T. (2007) *Karanga Indigenous Religion in Zimbabwe*, Shoko, T. (2010) "Traditional Healing: Continuity and Change" and Dube L, Shoko T. and Hayes S. (2011) *African Initiatives in Healing Ministry*.

⁴⁵³ Dahlin O. (2000) *Zvinorwadza*, 73.

⁴⁵⁴ See Gelfand M. (1967) *The African Witch* (London: E&S. Livingstone LTD), 50.

village usually after six months when they are no longer so vulnerable. This is meant to cushion such family members from the prying eyes of *varoyi*. Hence the traditional Shona live in constant fear of either being accused of witchcraft or being bewitched. Dahlin sums it up in the following words: “Suspicions (and allegations) of *uroyi* are almost always directed towards people who are known to the victim and invariably after something destructive has occurred, a death or an illness.”⁴⁵⁵ Moreso, any deviant and anti-social behaviour can cause a person to be suspected of witchcraft as explained by Chavunduka:

... In some parts of the country a person who is habitually surly, who builds his house in the bush far away from other people, who neither invites others to eat with him nor accepts invitations from neighbours to share their food or drink, is likely sooner or later to be accused of witchcraft or sorcery by someone. He will be accused of witchcraft or sorcery because he is a deviant. Such accusations are likely to continue until the individual is encouraged to conform to accepted standards of social behaviour of that area, such as friendliness, good manners, hospitality and generosity.⁴⁵⁶

Since witchcraft is a key existential reality which affects Karanga people’s health and well-being, the role of the *n’anga* in protecting the Karanga against this threat and in prescribing an effective cure becomes central. The next section therefore focuses on a brief exploration of the pivotal role of the *n’anga* among the Karanga community.

3.2.2 The N’anga as a Central Agent for Health and Well-Being

It is important to begin this section by acknowledging that although some people manipulate the role of the *n’anga* for purposes of securing negative charms or casting evil spells on unsuspecting innocent victims and some *n’anga* have been accused of causing ill-health and diminishing well-being, this chapter seeks to reinforce the positive role of the *n’anga* in restoring and securing health and well-being. In view of the fact that *n’angas* are knowledgeable in how to catch witches/wizards and exorcise spirits, and since they work through spirits themselves, people are often ambivalent towards them. Early Christian missionaries and anthropologists misunderstood them and wrongly termed them witchdoctors, a paradoxical term because the two roles ‘witch’ and ‘doctor’ work in total contradiction to each other; a witch aims at destroying, diminishing or destabilizing communal health and well-being whereas a traditional healer/doctor works towards restoring and protecting communal health and well-being. The term witchdoctor as used

⁴⁵⁵ Dahlin O. (2000) *Zvinorwadza*, 73.

⁴⁵⁶ Chavunduka G.L., (1980) “Witchcraft and the Law in Zimbabwe” *Zambezia* V111 (ii), 142.

by westerners is therefore erroneous and attributes to the traditional medical practitioner more powers to harm than to heal.⁴⁵⁷ This chapter therefore makes use of the term *n'anga* or traditional doctor/traditional medical practitioner/traditional healer in order to affirm the positive role that they play within the African society, particularly the Karanga traditional community. The ambiguous and ambivalent role of the *n'anga* as perceived by some Shona people is aptly explained by Dube as follows:

The ambiguity between the diviner [*n'anga*] and the witch [*muroyi*], however results from the fact that both use medicine or herbs [*muti/mushonga*] as well as power symbols...medicines can both cause and cure diseases, and bring both misfortune and good fortune. It is one's ability to manipulate them that brings fame and power.⁴⁵⁸

In the same light, Dahlin also highlights the ambivalence and the overriding suspicion that some people hold regarding the role of the *n'anga* and the practice of witchcraft in the following words:

A *n'anga* often has a small horn or calabash containing special medicine believed to be potent with beneficial powers. The container holds oil with roots and twigs, and sometimes parts of animals or birds. It is used to heal the sick, protect against *varoyi* [witches], increase soil fertility, and prevent insects and animals from destroying crops. People have a deep respect for it. There is however, a belief that *varoyi* also have such containers. This is one of the reasons why ordinary people have ambiguous feelings towards *n'anga*. Are they to be trusted, or do they also engage in destructive activities and thus harm people if aggravated?⁴⁵⁹

Writing on the same subject, Bourdillon also reiterates the paradoxical role of some 'unscrupulous' *n'angas* out for financial gain in the following words; "although most traditional healers are good people, using their skills to help others, occasionally we find a healer whose primary goals are power and money. Such a person may suggest anything his clients find plausible. And occasionally, desperate or unscrupulous clients may be looking for a desperate remedy."⁴⁶⁰

⁴⁵⁷ For a detailed discussion on this subject See Mbiti J.S (1990) *African Religions and Philosophy* (Heinemann Educational Publishers:Oxford) and Murove, M.F. (2009) "African Bioethics: An Exploratory Discourse" in Murove, M.F. (ed) *African Ethics: An Anthology of Comparative and Applied Ethics* (University of KwaZulu-Natal Press: Pietermaritzburg), 155-177.

⁴⁵⁸ Dube L, Shoko T and Hayes S (2011) *African Initiatives in Healing Ministry*, 28.

⁴⁵⁹ Dahlin O. (2000) *Zvinorwadza*, 96-97. See also Gelfand M. et. al 1985,8.

⁴⁶⁰ Bourdillon M.F.C. (1993) *Where Are The Ancestors?*, 111.

Bourdillon goes on to explain how certain ‘supposedly’ powerful magic involve doing outrageous things and how some *n’angas* mislead their clients into committing incest, ritual murder or criminal action such as committing rape in search of a cure for HIV or AIDS.⁴⁶¹ Several case studies in chapters four and five centre around how some people acquired *zvikwambo* from these dubious *n’angas* and how such a practice impacts negatively on communal health and well-being. Shoko also explains how some ‘unscrupulous’ *n’angas* can abuse their power to inflict harm on some intended victims through the practice of sorcery which is predominantly practiced by men and is categorised as another branch of witchcraft.

Sorcery also features as a dominant source of illness. It is a counterpart of witchcraft practiced by men... Sorcery involves ritual manipulation of natural forces for evil purposes. It is often practiced by unscrupulous *n’angas* who abuse their powers for financial gain. A sorcerer may brew and transmit diseases to an intended victim by setting up lethal traps with medicines and by remote control mechanisms. They apply poison in food or drink or through contact with nail clippings, hair or scrapping up dust from human footprints. As a result, illnesses caused by sorcery include *chitsinga*, some form of physical disorder, *chikwinho* that tugs and paralyses hands or legs and *chivhuno*, which results in loss of power.⁴⁶²

As such, it is significant to acknowledge that there are some *n’angas* who misappropriate their knowledge and use it for negative and evil purposes, but at the same time, it is because of the overriding fear of witchcraft that the positive role of the genuine *n’angas* becomes essential for purposes of restoring health and well-being and addressing the disequilibrium caused by those who perpetrate evil. This is a paradox that the Karanga existential reality presents.

In view of the above discussion, the role of the *n’anga* becomes pertinent because the traditional Karanga person lives in perpetual fear of witchcraft [*uroyi*]. Aschwanden puts it succinctly, “the Karanga lives strictly within his [sic] circle (i.e. the extended family and the clan). His [sic] immediate feelings towards another clan are fear and mistrust, and the main reason for this is dread of the ubiquitous witchcraft.”⁴⁶³

⁴⁶¹ Bourdillon M.F.C. (1993) *Where Are The Ancestors?*, 111.

⁴⁶² Shoko T. (2010) “Traditional Healing: Continuity and Change,” 89.

⁴⁶³ Aschwanden H. (1987) *Symbols of Death* (Mambo Press: Gweru), 114.

This constant fear of witchcraft centralises the role of the *n'anga* because it is only him/her who can shield ordinary members of the community from witchcraft or in some instances exorcise the evil perpetrated by *varoyi*, and in other cases divine, detect and castigate *varoyi*. Dube aptly describes the role of the *n'anga* in the following words: “In many cases, after a death or misfortune, diviners are consulted during witch hunts to identify the witch [*muroyi*]. A *n'anga* may diagnose and treat unexplained or mysterious diseases, predict events in the future or supply protective medicines against witchcraft.”⁴⁶⁴

The *n'anga* plays an important role in divination and healing. S/he is referred to as a diviner-healer. As a diviner, the *n'anga* provides advice to complex questions or problems which affect people. Illness and disease constitute the greatest problem.⁴⁶⁵ Minor illness and disease like colds and flu do not worry the Karanga, these are normally referred to as *zvirwere zvinobva pasi*, [ailments that come from the ground] i.e. they are due to natural causes. Such ailments will eventually vanish without having received any treatment or they can be remedied with a mild herbal cure without complications. Serious illness and disease such as chronic headaches, chest pains, swollen legs, persistent stomach aches and mental illness are causes for concern. They linger for a long time and resist treatment. In this context of illness and disease people approach a traditional medical practitioner to diagnose the cause and prescribe a solution.⁴⁶⁶ Although witchcraft is normally identified as a major cause for illness, the *n'anga* can also detect other causes of illness. Murove clearly delineates the role of the African traditional doctor in the following way:

The missionary's and anthropologist's characterisation of the African traditional doctor as a 'witch' or 'witchdoctor' is a misnomer. One cannot be witch and doctor at the same time. Knowing how to cure witchcraft cannot turn one into a witch. Similarly, a western-trained medical doctor who knows how to treat disease cannot be named a 'disease doctor' or 'virus doctor.' Referring to African traditional doctors as witchdoctors was obviously intended to imply that they specialised only in treating witchcraft.⁴⁶⁷

⁴⁶⁴ Dube L, Shoko T and Hayes S (2011) *African Initiatives in Healing Ministry*, 28.

⁴⁶⁵ Shoko T. (2007) *Karanga Indigenous Religion in Zimbabwe*, 46.

⁴⁶⁶ Masango J. (1990) *The Understanding of Misfortune among the Karanga of Dewure West in Gutu district: Masvingo Province, Zimbabwe*. B.A. thesis in the Department of Religious Studies, Classics and Philosophy, University of Zimbabwe. See also Aschwanden, H. (1987) *Symbols of Death* (Mambo Press: Gweru); Dahlin, O. (2000) *Zvinorwadza: Being a Patient in the Religious and Medical Plurality of the Mberengwa District, Zimbabwe* and Shoko T. (2007) *Karanga Indigenous Religion in Zimbabwe*.

⁴⁶⁷ Murove M.F. (2009) “African Bioethics: An Exploratory Discourse” in Murove, M.F. (ed) *African Ethics: An Anthology of Comparative and Applied Ethics* (University of KwaZulu-Natal Press: Pietermaritzburg), 155-177.

In many instances, the *n'anga* can also identify family and/or communal spirits as the prime cause of illness and disease. They strike when the living fail to live up to their social obligations through omissions and negligence. They also bring illness when people violate taboos such as eating [*mutupo*] a totemic animal; working on days dedicated to the spirits of the land [*chisi*] [communal traditional holidays]; committing incest; bestiality and murder. Failure to fulfil social obligations such as payment of bride price, particularly the beast meant for the bride's mother [*mombe youmai*] or debts with people of alien blood invite misfortune. Also ill-treating a spouse, parents, widows or orphans in your care, particularly beating your own mother provokes the vengeance of the spirits.⁴⁶⁸ Generally, the Karanga believe that the *midzimu* spirits are essentially positive, but if they are provoked, they can either turn against you and cause misfortune or they can withdraw their protection and allow witches or your enemies to bring illness.⁴⁶⁹ Shoko depicts the role of the spirits and the integral role of the *n'anga* in diagnosing the cause of ill-health and subsequently restoring health and well-being as follows:

The spiritual realm features as the main source of illness and disease. It is a realm of benevolent and malevolent potency...all serious and complex illnesses are accredited to *vadzimu* [ancestors] as the cause. *However, beliefs in witchcraft and sorcery also account for illness, disease and misfortune. Such beliefs in fact constitute an integral part of the Karanga traditional religious and cultural system.* From the onset of illness and disease, the Karanga contemplate the appropriate means to restore individual and societal health through the mechanism of diagnosis executed by the *n'anga* who employs various techniques to detect and reveal the unknown and hidden causal elements of illness and disease.⁴⁷⁰[Emphasis Mine]

In the same light, Murove explains the role of the *n'anga* in diagnosing and treating diseases from a holistic perspective in the following words.

African traditional doctors have a crucial, if not indispensable, role to play in African bioethics because they provide an understanding of health almost absent in most western-oriented health institutions. While these work under a mechanistic pattern in their diagnosis and treatment of disease, the traditional doctors' approach is holistic. Disease and suffering are understood to be caused by a situation of disharmony in human, environmental and spiritual relationships. Through their diagnostic procedure with bones, snuff or tail traditional doctors learn not only about the cause of illness but also what must be done to restore harmonious relationships. The traditional doctors'

⁴⁶⁸ See Gelfand M. *et al.* (1985) *The Traditional Medical Practitioner in Zimbabwe* (Gweru: Mambo Press).

⁴⁶⁹ Aschwanden H. (1987) *Symbols of Death* (Mambo Press: Gweru), 45.

⁴⁷⁰ Shoko T. (2007) "Karanga Religious Perception of Health and Well-Being" *Journal for the Study of Religion* Volume 20, No.1, 38-39.

diagnoses are not restricted to the patient; the whole family is implied.⁴⁷¹ [Emphasis Mine]

S.S. Campbell concurs, “Within this holistic cast, a person may develop disease by disregarding harmonious relationships with the ancestors, fellow human beings and the environment”.⁴⁷² A sickness that afflicts an individual is understood as a communal sickness; hence the diagnosis given by the traditional doctor is a family or communal diagnosis.⁴⁷³ Healing is very important in the Karanga traditional religion. The *n’anga* divines the causes of illness and disease and provides healing.⁴⁷⁴ Since the Karanga experience diseases as a threat to their lives, diagnosis centred on the *n’anga* is crucial. The *n’anga* applies different methods to determine the cause of the problem and to prescribe appropriate medication.⁴⁷⁵ Murove aptly describes the role of the *n’anga* as follows:

African traditional doctors perform their professional duties with greater sensitivity to the web of relationships with which the individual is entangled. Within this relational pattern, individuals experience themselves, and are experienced by others, as being socially and cosmologically constituted. The diagnosis and treatment of disease reflects rationality as it encompasses the invisible and the visible.⁴⁷⁶

In the same light, J.S. Mite succinctly explains the fundamental role of the *n’anga* in the following words;

*...in African societies, African traditional doctors are the greatest gift and the most useful source of help...they perform their professional duties in full consciousness of rationality that permeates the individual’s life as well as the cosmology... disease and suffering find their ultimate explanation in the realm of the symbiosis between the visible and invisible... African traditional doctors are not only concerned with the physical treatment of a patient, rather in their diagnosis of disease, they have to go beyond the physical, they view all this from a holistic point of view.*⁴⁷⁷ [Emphasis Mine]

From the above discussion, it is apparent that the *n’anga*’s diagnosis and therapeutic role is performed within a communal, holistic and relational worldview. Having noted the central

⁴⁷¹ Murove M.F. (2009) “African Bioethics: An Exploratory Discourse,”168. See also Gelfand, M. *et al.* (1985) *The Traditional Medical Practitioner in Zimbabwe*, 6.

⁴⁷² Campbell S.S. (1998) *Called to Heal* (Halfway House :Zebra), 7.

⁴⁷³ Ray B.C (1976) *African Religions: Symbol, Ritual and Community* (Prentice Hall:London)

⁴⁷⁴ Shoko T. (2007) *Karanga Indigenous Religion in Zimbabwe*, 56.

⁴⁷⁵ Shoko T. (2010) “Traditional Healing: Continuity and Change,” 90.

⁴⁷⁶ Murove M.F. (2009) “African Bioethics: An Exploratory Discourse,”168.

⁴⁷⁷ Mbiti J.S (1990) *African Religions and Philosophy* 2nd Edition (Heinemann Publishers: London).

role of the *n'anga* in the Karanga healthworlds, the following section briefly discusses the various traditional causes of illness and diseases and the usual methods identified by the Karanga for restoring health and well-being.

3.3 Traditional Causes of Illness and Diseases

Since maintaining health and well-being is a top priority for the Karanga people, identifying the causes of ill-health and any forces that diminish their well-being is of utmost importance. The Karanga traditional religious system identifies numerous and varied causes of illness and disease. Although the main role of the *n'anga* is to diagnose who or what causes illness and to provide the patient with a pertinent cure, diagnosis is not the monopoly of the *n'anga* alone. According to Shoko, “elders of a community are also consulted on the source of diseases because of their wisdom and experience. Also mothers have the ability to discern the cause of an illness in their own children. So these practitioners have a wide range of methods at their disposal. The average person knows which practitioners to approach.”⁴⁷⁸

Hence the search for healing and well-being is a communal endeavour, all members of the community work together towards preserving and securing life, health and well-being. They work as a team and each member has a role to play in the game of life. In other words, the whole community plays an active role as agents of preserving and securing life, health and well-being. Shoko argues that the Karanga identify four potential causes of illness and disease. These encompass spiritual forces, witchcraft and sorcery, socio-moral and natural causes.⁴⁷⁹ These four potential causes of illness and disease are briefly discussed below.

3.3.1 Spiritual Forces

The Karanga, like many other African traditional cultures, believe in the existence of invisible and intangible spirits that have the power to influence and affect every part of their lives. As explicated by Ray and J.S. Mbiti “the spiritual world of the Africans is densely

⁴⁷⁸ Shoko T. (2010) “Traditional Healing: Continuity and Change”, 90.

⁴⁷⁹ See Shoko T “Health and well-being: A Phenomenological Quest for the Essence of the Karanga Religion” (Unpublished DPhil Thesis, University of Zimbabwe), Shoko T (2007) “Karanga Religious Perception of Health and Well-Being” *Journal for the Study of Religion* Volume 20, No.1; Shoko ,T. (2007) *Karanga Indigenous Religion in Zimbabwe*, 43 and Dube L, Shoko T. and Hayes S. (2011) *African Initiatives in Healing Ministry*.

populated with spiritual beings, spirits and the living-dead”.⁴⁸⁰ Among the Karanga, these spirits can be distinguished between ancestral and family spirits [*midzimu/vadzimu*], angry or avenging spirits [*ngozi*], alien spirits [*mashavi/mashave*], and shadow of a dead person [*bvuri*]. These various spirits are usually identified by the Karanga as the main causal factors of illness and disease and on the other hand, some of them are regarded as possessing the power to protect and restore their living descendants’ health and well-being.⁴⁸¹

3.3.1.2 *Vadzimu* [Ancestral/ Family Spirits]

Vadzimu are the spirits of the deceased parents, grandparents and often times great grandparents drawn equally from both sides of one’s family. Like many African traditional communities, the Karanga believe that death does not represent an abrupt and total discontinuation of life. As Chitando poignantly puts it across,

Although funerals are characterized by a lot of wailing and pain, steps are taken to remind mourners that *death does not have the last word*...In many African communities a fire or light is set in the room where the body lies, this symbolizes the continuity of life...Others will sing and dance taunting death and praising life...The language employed to refer to death is also consistent with the pro-life agenda. Euphemisms are used to promote a less devastating image. Among the Shona, it is said that the deceased *wafamba* [has travelled] and will therefore return. Different African languages underscore the belief that death is only temporary. *Life, even though it might be experienced in a different form, wins the day. It is life that is acknowledged and emphasized.*⁴⁸² [Emphasis, Mine]

Other euphemisms employed by the Karanga to refer to death which show continuity of life include terms such as *watisiya* [s/he has left us] or *watungamira* [s/he has gone ahead/has led the way] implying that the deceased has not been obliterated from the community but has simply travelled ahead on the same path that all the others will subsequently follow. Another Karanga euphemism referring to death is *watogwa* [s/he has been taken] or called to join another form of existence. The overriding belief is that one would have been invited to join the ancestral realm. Charles Nyamiti emphasises that the living and the ancestors do share a common existence in this web of life.⁴⁸³ Likewise, Gelfand also argues that the African

⁴⁸⁰ See Ray B.C. (1976) *African Religions, Symbol, Ritual and Community* (Prentice Hall: New Jersey) and Mbiti J.S (1990) *African Religions and Philosophy* 2nd Edition (Heinemann Publishers: London).

⁴⁸¹ Dube L, Shoko T and Hayes S (2011) *African Initiatives in Healing Ministry* ,25 &31 See also Dahlin, O. (2001) *Zvinorwadza*: 93-95 and Shoko ,T. (2007) *Karanga Indigenous Religion in Zimbabwe* , 57-63.

⁴⁸² Chitando E. (2007a) *Living with Hope*, 48-49.

⁴⁸³ Nyamiti C. (1984) *Christ as our ancestor: Christology from an African perspective* (Mambo Press: Gweru).

community embraces the living and the departed; these two communities depend on one another for their mutual existence and cannot be separated.⁴⁸⁴ In the same light, P. Knox explicates on this matter,

The dead are believed to proceed to the world of the ancestors from where they may still have contact with the living. The dead are thought to be intimately involved in the affairs of the living and to depend on their descendants for their remembrance and continued existence. The ancestors are concerned with the well-being of their lineage and descendants. They are believed to obtain favours on behalf of their kin and, in this way, they retain authority in the family structure.⁴⁸⁵

They are believed to hold the key in preserving one's health and well-being but at the same time, they are also capable of making one vulnerable to all manner of ill-health and misfortune. This is why in most Karanga traditional contexts, if one encounters a huge misfortune such as a fatal accident, it is common to hear people saying *midzimu yadambura mbereko* [the ancestors have abandoned us]. Although protection of the descendants from illness and misfortune is a priority for the ancestors, most illnesses and diseases of a complex nature are attributed to *vadzimu*.⁴⁸⁶ M.L. Daneel concurs that while the ancestors will normally protect their descendants, their protection is primarily premised on the person's relationship with other people and the natural environment.⁴⁸⁷ Dahlin explains the dynamics of the impact of the *vadzimu* as follows:

In the traditional understanding there is a perpetual battle between the *vadzimu*, who try to defend their family, and the *varoyi* [witches] and their associates. The *vadzimu*, the protectors of human well being, may, however, also inflict illness on their dependants. The *vadzimu* can let an evil spirit into the family enclosure to do harm to members of their kin group as a means of punishing them if they feel aggravated. Reasons for doing so may be the breach of moral rules by one of the living family members or negligence concerning the conducting of commemoration rituals.⁴⁸⁸

Clearly, one is expected to maintain a sound and fulfilling relationship with the ancestors in order for them to act in your favour, failure of which, they might turn against you and expose

⁴⁸⁴ Gelfand M. *et al.* (1985) *The Traditional Medical Practitioner in Zimbabwe*.

⁴⁸⁵ Knox P (2008) *Aids, Ancestors and Salvation: Local Beliefs in Christian Ministry to the sick* (Nairobi: Paulines Publication Africa), 95.

⁴⁸⁶ Shoko T. (2007) *Karanga Indigenous Religion in Zimbabwe*, 57.

⁴⁸⁷ Daneel M.L (1993) "Healing the Earth: Traditional and Christian Initiatives in Southern Africa. Part One. *Journal for the Study of Religion* Volume 6 No1, 3-30.

⁴⁸⁸ Dahlin O. (2000) *Zvinorwadza*, 94-95.

you to all negative forces capable of causing illnesses, misfortune and even death in the event of total disobedience and disregard of the ancestors. Shoko reiterates this point,

Ancestor spirits are the basic spirits, which cause illness and disease of a complex and serious nature. Such an illness is believed to defy all treatment. However, this is not meant to kill the victim but to alert the descendants to search for the spiritual cause from the diviners. Besides their role in guarding and protecting living members of the family, ancestors can be malevolent if neglected or forgotten. This usually happens when rituals for the spirits are neglected, for example, *kurova guva*, a traditional ritual that calls back the spirit of the dead and *doro reChikaranga*, the annual traditional beer brewing in commemoration of the dead. Ancestors can cause illness and disease as means of communication, usually calling for ritual attention by the descendants.⁴⁸⁹

In some instances, the illness is interpreted as a sign of the ancestors' wish to communicate effectively with their descendants, particularly if the spirit wishes to manifest itself on a particular member of its family.

They can cause illness and disease when they want recognition by a name given to one of the family members, especially the sick one. Curing will naturally take the form of exorcism or appeasement of the spirit through sacrifice or material concessions such as beer, cloth, blankets, beasts, etc...But the ancestors can become dangerous and even cause death as a sign of complete neglect when the living relatives are unwilling to reform or continue to deny the ancestral spirit its ritual demands. So in general, ancestors are benevolent but when neglected by the descendants they become malevolent.⁴⁹⁰

Hence, failure to yield to the needs or wishes of the *vadzimu* through neglecting ritual action is to court disaster and has far reaching repercussions on the living. It is tantamount to a complete rejection of their role and importance in the family and in the community.

Ancestors depend on the recognition of their offspring for their continued authority and belonging. If they are not remembered, that is, if they are no longer respected as superiors by their descendants, they are lost. Such an attitude again endangers the well-being of the living. To deny respect to superiors undermines the very foundations of the community. It is a sacred duty to uphold the hierarchical order because it is the infrastructure of communal life. *All kinds of distress are attributed to irate ancestors who have not been given their due.*⁴⁹¹ [Emphasis, Mine]

Clearly, any breach of relations with the ancestors has negative implications on the living. It is therefore important that the living observe the appropriate rituals within specified time

⁴⁸⁹ Dube L, Shoko T and Hayes S. (2011) *African Initiatives in Healing Ministry*, 31-32.

⁴⁹⁰ Dube L, Shoko T and Hayes S. (2011) *African Initiatives in Healing Ministry*, 32.

⁴⁹¹ Nurnberger K. (2007) *The living dead and the living God: Christ and the ancestors in a changing Africa* (Pietermaritzburg: Cluster Publications), 25.

periods particularly for the immediate ancestors who would have recently passed because if they fail to do so, the ‘hovering’ spirits of the dead relatives might turn into vicious and vindictive aggrieved spirits [*ngozi*]. Once they are aggrieved, the ancestral spirits have the potential of wreaking havoc among their descendants and consequently expose their descendants to all sorts of misfortunes such as being struck by complex illnesses defying treatment, allowing negative spirits to attack the descendants [*kuvhurira mhepo*] and in some instances, causing mysterious loss of wealth or well-being among their descendants.⁴⁹²

M.F.C. Bourdillon illustrates a typical scenario among the Shona,

Someone in the family falls ill and the illness persists-or there may be some other trouble in the family which people think might be the concern of the deceased ancestors. The head of the family, usually in the company of some other members and preferably including the sick person, consults a diviner. The diviner discerns that an ancestral spirit - say, the sick person’s grandfather - wants to be appeased for some wrong done, or simply to be thanked or honoured, with an offering of millet beer.⁴⁹³

Once the cause of sickness has been identified as such, it is in the best interests of the family to promptly perform the required ritual and avert further harm befalling them. It is important that all members of the family actively participate and contribute resources required for the ritual to be performed in order for the ritual to be effective and safeguard the entire family. However, this has brought a lot of division among many Karanga families because in most families, there are some members who belong to Christian traditions which do not accept/accommodate the veneration of ancestors. In some cases, this has led to some members cutting ties with those who still hold on to such traditional beliefs but in some instances, even those who belong to churches that forbid ancestral veneration occasionally ‘put aside’ their doctrinal beliefs and participate in *doro remusha* [traditional ritual for the family] and ‘confess’ to their church afterwards. There are cases whereby members sacrifice to undergo disciplinary measures from their congregation or even to be re-baptised because they will be regarded as having ‘wandered off the path.’

In some instances, *vadzimu* might cause or allow death to occur among their descendants, the death of young people is generally regarded as something unusual and is often ascribed to the

⁴⁹² See Dahlin O. (2000) *Zvinorwadza*, 94-95 and Shoko ,T. (2007) *Karanga Indigenous Religion in Zimbabwe*, 57.

⁴⁹³ Bourdillon M.F.C. (1993) *Where Are The Ancestors?: Changing Culture in Zimbabwe* (University of Zimbabwe Publications:Harare),71.

wrath of the ancestors. Chitando explains this belief as follows; “dying young constitutes a fundamental human problem. It is a sign that relations between the dead and the living are strained. The services of a traditional healer may be sought, who may prescribe ritual action to prevent further deaths in the family.”⁴⁹⁴

Such a breach can only be effectively mended through exorcism and appropriate ritual action [*kupira midzimu*] and paying compensation to the aggrieved spirit [*kuripa mhosva*]. It is therefore apparent that within the Karanga world-view, *vadzimu* play a central role in maintaining order and security, offering protection, health and well-being to their descendants as long as the descendants fulfil their obligations. However, if the descendants are found wanting, the ancestral vengeance can prove fatal in terms of diminishing and withdrawing health and well-being. The discussion now turns to the negative impact of the ancestral spirits as a form of *ngozi* and other types and causes of *ngozi* which impact on Karanga people’s health and well-being.

3.3.1.3 *Ngozi* [Angry or Avenging Spirits]

As noted above, the Karanga believe that if the ancestral spirits are constantly spurned and neglected, they may turn into an aggrieved/vindictive spirit [*ngozi*] imposing great harm on their descendants. Generally an aggrieved/avenging spirit is one of the most dangerous and most dreaded spirits capable of inflicting harm or even death upon its victims.⁴⁹⁵ Shoko aptly defines *ngozi* [avenging spirit] as follows; “*Ngozi* [avenging spirit] is another spiritual agent, one of the most dreaded sources of illness and disease and even misfortune and death. *Ngozi* is the spirit of a person whose death came as a result of having been mistreated, which now seeks justice against the living.”⁴⁹⁶

There are various types of *ngozi* but the bottom line is that they are a spirit of someone that would have suffered an injustice and did not receive appropriate compensation during their lifetime. For instance, the Karanga believe that if a child disobeys parents, causing them so much grief, or fails to take care of parents and they die harbouring a grudge [*chigumbo/kugodora*], particularly if one’s mother dies without having received an

⁴⁹⁴ Chitando E. (2007a) *Living with Hope*, 48.

⁴⁹⁵ Dahlin O. (2000) *Zvinorwadza*, 70. See also Aschwanden (1987):38-42; Gelfand (1962):69-74 and Masango (1990), 35-45.

⁴⁹⁶ Shoko T. (2007) *Karanga Indigenous Religion in Zimbabwe*, 59.

appropriate apology, they might turn into an aggrieved spirit. This is particularly worse if the child (in most cases the son) assaulted or insulted the mother, her *ngozi* spirit can come back with such a vengeance that it causes complex illnesses and misfortunes to the child and even her grandchildren. Effective healing can be achieved only if the son performs a ritual called *kutanda botso* in which he undergoes public disgrace whereby he dresses in rags and goes around the community begging for grain and all that is required to prepare the traditional beer for appeasing the mother's spirit. As he goes around, members of the community will be chastening him and others will first hit him with *shamhu* [twigs] before offering him the donations. The haunting spirit will only stop if the son shows contrition and the appropriate ritual has been completed.⁴⁹⁷

On the other hand, the spirit of a mother who dies without having enjoyed the privilege of receiving *mombe youmai* [beast of motherhood] which is a heifer paid by the groom to his mother-in-law as part of *roora/lobola* [bride price] in appreciation particularly to the mother-in-law for bearing his wife and allowing her to marry him and bear children for him, is equally dangerous and can wreak havoc on the daughter's family. If not paid, it can cause illness, misfortune or death to the grandchildren born of that daughter.⁴⁹⁸ Mostly, among the Karanga, even if the man is so poor and struggles to raise enough *roora*, one of the first items paid by the groom is the 'beast of motherhood' and some clothing items due to the mother-in-law commonly known as *majasi* which is an important component of *roora*. It is believed that failure to give these items to her might cause her *ngozi* spirit to strike either her daughter or grandchildren with barrenness or simply withdraw her ancestral protection and expose her daughter's family to all sorts of misfortunes particularly perpetual illness or troubled marriages or sometimes the grandchildren might be so unlucky in love and fail to get married. This is most dreaded because the Karanga believe that normally the maternal spirits are more caring and are therefore harbingers of blessings, as such, they try by all possible means not to aggravate/offend them. Once it is established that the spirit of the aggrieved mother-in-law is requesting/demanding payment of what is due to her, normally prompt action is taken to pay whatever is due to her family representatives, normally her sisters, nephews or nieces, or any of her closest relative that would have been identified. Having settled the payment,

⁴⁹⁷ Dube L, Shoko T and Hayes S (2011) *African Initiatives in Healing Ministry*: 32. See also Shoko T. (2007) *Karanga Indigenous Religion in Zimbabwe*, 60.

⁴⁹⁸ Dube L, Shoko T and Hayes S (2011) *African Initiatives in Healing Ministry*: 33. See also Shoko T. (2007) *Karanga Indigenous Religion in Zimbabwe*, 60.

everything is expected to return to normalcy and her spirit will once again assume the role of protecting and cushioning her descendants against any evil, sickness or misfortune.

Another particularly dangerous *ngozi* is that of a stranger who would either have been killed by a member of the family (whether accidentally or intentionally), or if an injustice was perpetrated against a stranger and no proper compensation was paid. For instance if someone offered a lifetime of service to your family and you did not properly compensate them or if you bought/borrowed something and refused to pay what is due to the owner, this may aggravate the *ngozi* spirit to demand justice. Normally the quest for justice is manifested through the *ngozi* spirit inflicting some illness on the family of the murderer or the wrongdoer. The affliction of *ngozi* ranges from minor illness, mysterious misfortunes or even death, depending on the gravity of the situation.⁴⁹⁹ The frightening and most dreaded characteristic of *ngozi* is that normally it does not start by afflicting the offender or the murderer; in most cases, it inflicts pain or harm on someone else in the family of the guilty person. As such, it may cause several deaths before the case is settled through compensation to the victim's family.⁵⁰⁰ The anger of the *ngozi* is very difficult to placate; its vengeance gets worse particularly if its demands are disregarded and ignored as illegitimate. Failure to comply with its demands may result in the *ngozi* wiping out the whole family of the offender. This is expressed in the Karanga traditional maxim *mushonga wengozi kuripa* [the cure for an avenging spirit is payment/compensation]. This normally takes the form of a large herd of cattle and in the event that a person was killed, the payment package will also include a young girl who is meant to raise offspring on behalf of the dead. Once its demands have been met, a truce is observed and the spirit may rest in peace.⁵⁰¹

Although the ideal is to pay appropriate compensation to the *ngozi*, in the Karanga tradition some people attempt to get rid of it through a ritual of *kurasira* [driving away/casting away] the *ngozi* spirit. Shoko aptly describes this ritual as follows: "A scapegoat, usually in the form of a black goat or black fowl is taken and the illness brewed by the *ngozi* is transferred into it with the aid of a skilled practitioner. This will be a cause of illness to the family of anyone

⁴⁹⁹ See also Shoko T. (2007) *Karanga Indigenous Religion in Zimbabwe*, 59.

⁵⁰⁰ Dahlin O. (2000) *Zvinorwadza*, 70.

⁵⁰¹ Dube L, Shoko T and Hayes S (2011) *African Initiatives in Healing Ministry*, 33.

who tampers with this evil-laden animal. Members of the family would have to deal with the effects of the avenging spirit.”⁵⁰²

In some instances, the *ngozi* can be transferred onto a large sum of money, some shiny pottery or expensive jewellery which is usually left on the crossroads [*pamharadzano*] and anyone who picks up the cash, pottery or jewellery *anobatana nacho* [will take over the vengeance of the avenging spirit]. This explains why the majority of the Karanga do not have anything to do with lost items. It is the fear of the lethal diseases or misfortunes surrounding such items which normally drive away the Karanga from picking up anything whose owner or origins they are unsure of. This method of addressing the *ngozi* spirit is regarded as a temporary measure and does not offer a lasting solution as explicated by Shoko, “whilst *kurasira* is efficacious, it may only be temporary and could not guarantee well-being. After this lull, the avenging spirit will come back regenerated and will cause untold suffering through inexplicable and unyielding illnesses.”⁵⁰³

There are also cases whereby some families drive away [*kusundira*] the *ngozi* and cast it onto some of their unsuspecting relatives who will subsequently suffer from the wrath of the avenging spirit. Again this method is simply shifting the problem because in the final analysis, whoever falls victim to the *ngozi* cast upon them will subsequently seek the root cause and eventually, they would have to settle its demands in order to restore communal health and well-being. Some of the case studies presented in chapters four and five clearly illustrate how the *vadzimu* and *ngozi* spirits can negatively impact Karanga people’s health and well-being. Another type of spirit which the Karanga identify as a causal agent of either diminishing or increasing health and well-being is the *shavi* [alien spirit] to which the discussion now turns.

3.3.1.4 Mashavi/Mashave [Alien Spirits]

The Karanga identify *mashavi* spirits as lingering spirits, which, for various reasons have not found a resting spirit place; usually these are spirits of strangers who died in a foreign land

⁵⁰² Shoko T. (2007) *Karanga Indigenous Religion in Zimbabwe* , 60.

⁵⁰³ Shoko T. (2007) *Karanga Indigenous Religion in Zimbabwe* , 60.

suddenly and did not have appropriate death rituals performed for them.⁵⁰⁴ Chavunduka defines an alien spirit as follows: “A stranger or alien spirit is the spirit of a person from some other clan or tribal group who died uncared for, or perhaps was not properly buried according to custom. It is believed that the spirit of such a person may wander restlessly until it settles on someone.”⁵⁰⁵

As a result these are categorised as alien spirits because they are spirits of people who are not related to any members of the community. They therefore roam around nature and can inhabit trees, caves, anthills and some are found in strange animals or any other sacred phenomena. These spirits are therefore capable of inflicting harm on anyone who falls victim to them because they did not have any rituals performed after their death to domesticate them. Anyone who admires the object which they inhabit might attract being possessed by the *shavi* spirit. Once a *shavi* spirit identifies its host, it inflicts pain on the individual and such illness defies all treatment. The most common illnesses and diseases caused by the *shavi* spirit are menstrual problems, miscarriages and an aversion to marriage. It is only after consulting with a traditional diviner that one will discover that there is a *shavi* spirit which is seeking recognition and a home to reside in.⁵⁰⁶

The Karanga make a distinction between a positive and a negative *shavi* spirit. There are certain positive traits that the *shavi* spirit may ascribe on its host. For instance, some will endow their host with outstanding skills such as hunting, healing, dancing, singing and other traditional specialities. Normally, such positive *shavi* spirits are welcomed into the family and the intended host will perform rituals to accept and accommodate the spirit. On the other hand, the negative *shavi* spirits might cause its host to engage in activities that are anti-social, the most common ones are witchcraft, prostitution and stealing.⁵⁰⁷ Under normal circumstances, once an individual establishes that such a negative *shavi* spirit seeks to possess them, they solicit the services of a skilled practitioner to exorcise it and cast it into a fowl or a goat in the same manner with the casting of the *ngozi* spirit described above (see

⁵⁰⁴ See Dahlin O. (2001) *Zvinorwadza*: 69- 70 and Dube L, Shoko T and Hayes S (2011) *African Initiatives in Healing Ministry*,33. See also Shoko ,T. (2007) *Karanga Indigenous Religion in Zimbabwe*, 60.

⁵⁰⁵ Chavunduka G.L. (1980) “Witchcraft and the Law in Zimbabwe” *Zambezia* V111 (ii), 136.

⁵⁰⁶ Dube L, Shoko T and Hayes S. (2011) *African Initiatives in Healing Ministry*, 33.

⁵⁰⁷ Dube L, Shoko T and Hayes S. (2011) *African Initiatives in Healing Ministry*, 33-34.

3:3:1:3).⁵⁰⁸ However, it is unfortunate that there are some people who thrive in accommodating such negative *shavi* spirits and some people even set out to acquire such negative *shavi* traits for their own selfish gain. Some of the case studies presented in chapters four and five clearly illustrate how various members of the Karanga community respond to the manifestation of such positive and negative *shavi* traits.

It is therefore apparent that the Karanga attribute several illnesses and misfortunes to spirits which manifest themselves in various forms. These spirits are capable of either enhancing or diminishing health or well-being. However, besides spiritual forces, the Karanga also identify other causes of illness and misfortune and one of the most dreaded is witchcraft and sorcery. It is to this aspect that the discussion now turns.

3.3.2 Witchcraft and Sorcery

Suffice to note that under this section, some of the issues surrounding witchcraft and sorcery have been addressed under 3.2.1 and as such those issues will not be repeated here. However, because the Karanga constantly grapple with the issue of witchcraft and sorcery as a force that diminishes and threatens health and well-being, it is significant that the topic be revisited. Having discussed the way in which the Karanga attribute several illnesses and misfortunes to the spirits, it is significant to note that the Karanga also identify several illnesses as caused by malicious human beings through the practice of witchcraft and sorcery. Witchcraft is non-spiritual but is linked with spiritual entities like *zvidhoma/zvituhwani* [witch cronies/familiars].⁵⁰⁹ As noted by Bourdillon,

Witchcraft covers a variety of practices: from gruesome rituals, through the secret use of physical/or magical poisons, to bizarre behaviour that goes against the social norms of society without necessarily doing physical harm to anyone. Because witchcraft does not respect the rules of society, it is unpredictable, uncontrolled and frightening. Witchcraft can be used to explain why things go wrong.⁵¹⁰

From the above citation, it is clear that among the Karanga, witchcraft is an art which ranks quite high as a causal explanation of illness and misfortune. If a society experiences a sharp increase in cases of illness or misfortunes such as losing crops or livestock and encountering

⁵⁰⁸ See also Dube L, Shoko T and Hayes S. (2011) *African Initiatives in Healing Ministry*, 33-34.

⁵⁰⁹ Dube L, Shoko T and Hayes S. (2011) *African Initiatives in Healing Ministry*, 34.

⁵¹⁰ Bourdillon M.F.C. (1993) *Where Are The Ancestors?*, 115.

accidents, the Karanga often attribute this to a rise in witchcraft practices. Chavunduka has this to say,

Many studies have also emphasized the importance of witchcraft beliefs in explaining misfortune. The witchcraft idea is sometimes invoked as a concept for explaining the deeper or indirect causation of events which seem unnatural. Thus an individual who believes in witchcraft might attempt to understand by reference to it why for instance his child died suddenly.⁵¹¹

Most common illnesses, such as wind fever [*mamhepo*] are also regarded as manifestations of the works of witchcraft, i.e. one would have been beaten by *zvidhoma/zvituhwani* – these are regarded as very dangerous spirits of dead people raised from the graves to be used by witches as their agents. They are normally referred to as the children of witches and they wreak havoc in the lives of those under their attack. The victim of *zvidhoma/zvituhwani* convulses and, if not exorcised dies immediately. Shoko graphically presents the role of *zvidhoma/zvituhwani* in the following words; “in this complex activity of witchcraft, familiars are an intricate and indispensable cog. *Zvidhoma* are a particular force to reckon with. Regarded as the ‘children of the witches’, they are one of the key elements in the causation of illness and disease. Invisible to the ordinary eye, they are an asset to their patrons.”⁵¹²

The familiars are of unquestioning loyalty and carry out their assignments in a ruthless but logical and faithful fashion. However, if ill-treated or dissatisfied by not being fed with enough blood or human flesh, they may become hostile and attack their owners. There are numerous stories where the Karanga relate how some self-confessed witches were subsequently attacked by their agents. In some cases, witches may turn against each other ending in the death of some of their associates and eating their flesh. Stories abound on how witches magically open graves to exhume corpses so as to consume human flesh, particularly those who would have recently died. This explains why among the Karanga community in Murinye district, after the burial of a family member, the following day at dawn before many people wake up, all the elderly members of the family visit the grave site to inspect if it has not been tampered around by *varoyi*.

⁵¹¹ Chavunduka G.L. (1980) “Witchcraft and the Law in Zimbabwe” *Zambezia* V111 (ii), 135.

⁵¹² Shoko T. (2007) *Karanga Indigenous Religion in Zimbabwe*, 64.

Although the ancestors are supposed to protect their descendants from all negative forces impacting on their health and well-being, unfortunately, they are often manipulated by the witches in order to gain access to the victim. Shoko explains how this happens:

The witches' operational mode has different facets. If a witch is to succeed at all, the consent of the ancestors is a prerequisite. In cases of illness by witchcraft, therefore, the guardian and the enemy reach a compromise. Ancestors are believed to provide the green light if they are dissatisfied, and they open the doors and the enemy then has a free rein.⁵¹³

Several types of illnesses and diseases such as madness, paralysis, Down's syndrome, smallpox and epilepsy are attributed to witchcraft.⁵¹⁴ Whilst witchcraft is the domain of women, men specialize in sorcery. However, there is a very thin dividing line because women often act in concert with men and vice versa. Chavunduka compares and contrasts witchcraft and sorcery as follows;

While witchcraft is seen as something intrinsic to the person, to his soul or his personality, sorcery is intrinsic to these entities, being merely a technique or a tool employed by an individual under certain circumstances. Recourse to sorcery is always on a deliberate, conscious, voluntary basis. A sorcerer may cause illness or kill his fellows by blowing medicine towards them; by putting poison in his victim's food, drink or tobacco; or by concealing the poison or the poisonous objects on a path where the victim will pass.⁵¹⁵

According to Chavunduka, in Zimbabwe sorcery techniques fall into three broad types.

First there are those techniques which involve the use of medicines or poisons. Here the sorcerer puts medicine or poison in the victim's food, drink, tobacco pipe, and so on. Nowadays some sorcerers use arsenic cattle dip, insecticides and other poisons... The second and third types of sorcery often do psychological rather than physical harm to those who believe in sorcery. The second type is where the sorcerer plants poison or dangerous objects on a path or in the victim's home so that people coming into contact with them become sick. The third type of sorcery techniques is of those which are said to operate at a distance without actual physical contact; an example is the *gona* in Shona country, which is usually an animal's horn with medicines in it. The *gona* itself is harmless, but it is an offence to use such a charm for the purpose of injuring somebody because through fear it can cause injury to persons or property or do psychological harm to those who believe that it possesses occult powers.⁵¹⁶

⁵¹³ Shoko T. (2007) *Karanga Indigenous Religion in Zimbabwe*, 64.

⁵¹⁴ Dube L, Shoko T and Hayes S (2011) *African Initiatives in Healing Ministry*, 34.

⁵¹⁵ Chavunduka G.L. (1980) "Witchcraft and the Law in Zimbabwe" *Zambezia* V111 (ii), 132.

⁵¹⁶ Chavunduka G.L. (1980) "Witchcraft and the Law in Zimbabwe" *Zambezia* V111 (ii), 133-134.

In recognition of the effectiveness of sorcery, the craft is often bought from some corrupt *n'angas* that are in the field only for financial and material gain. Shoko aptly captures it.

Sorcerers obtain their powers from corrupt herbalists who manufacture and dispense dangerous herbs and substances. For instance, *chikwinho*, a form of herb is used by sorcerers to cause illness. This assumes the form of a landmine which is planted alongside a path and will cause physical disorder only on its intended victim. Usually targeted at the affluent members of society, *chikwinho* is meant to disturb well-being and make members of society equal.⁵¹⁷

The competitive modern society has also seen other Karanga people manipulating the work of sorcerers. For instance, “an illness called *chivhuno* [breaking] can be applied by sorcerers on prosperous farmers and on schoolmates or economic competitors. Victims of this disease suffer from joint weaknesses”.⁵¹⁸ Another common physical disorder that sorcerers specialize in is the planting of *chitsinga/chiposo* [thrown object] which tugs and paralyzes hands or legs. It is also common for a jealous neighbour, relative or associate to acquire it from corrupt *n'angas* that use evil magic and plant it onto the intended victim.⁵¹⁹

There are also illnesses and diseases that are caused by poisoning a victim through food or drink, commonly known as *kudyiswa*, [made to consume something poisonous]. Resultant diseases are stomach aches, swellings and diarrhoea and in some cases, this might end in death.⁵²⁰ In the Karanga community, a majority of poisoning incidences occur at beer parties, actually there are some men known to be notorious for this practise and some even boast about it and make a habit of it. Because traditional beer is usually drunk from the same pot and the pot is passed from one person to the other, i.e. it is consumed in a spirit of communal sharing, the Karanga relate incidences whereby the culprit sits in a strategic position so that they can stealthily administer the poison on the targeted victim. The poison can be stored in one's nails such that once they receive the beer pot, they will dip their hand to sprinkle the poison and by the time the pot is passed onto the next person, the victim will unknowingly consume the poison with the beer. There are also some women who are known to be notorious for poisoning; they can administer the poison in *sadza* [maize/corn meal made into thick porridge], water, *mahewu* [traditional beverage made of either maize/corn meal or from

⁵¹⁷ Shoko T. (2007a) *Karanga Indigenous Religion in Zimbabwe*, 65.

⁵¹⁸ Shoko T. (2007a) *Karanga Indigenous Religion in Zimbabwe*, 65.

⁵¹⁹ Dube L, Shoko T. and Hayes, S (2011) *African Initiatives in Healing Ministry*, 35.

⁵²⁰ See also Shoko, T. (2007a) *Karanga Indigenous Religion in Zimbabwe*, 66.

grains such as millet or sorghum] or they can poison a person using any other food items available in their kitchen. There are some households where children or any member of the village are warned never to accept or request for food or water from them because *mai vepo havapi unoswera* [the lady of that house is known for administering such lethal poison such that once she administers it on you, the day will not go down before you are dead].

It is therefore apparent that witchcraft and sorcery feature prominently as key factors capable of diminishing Karanga society's health and well-being. As Shoko rightly states, it is against the backdrop of the prevalence of such negative practices that "the *n'anga* is perched high up the Karanga social ladder because of his diagnostic expertise and curative ability".⁵²¹ Because the Karanga are primarily concerned with preserving health and well-being, "forces that promote death, for example witchcraft are actively resisted".⁵²² Whenever something mysterious/strange happens such as a serious misfortune or whenever a sickness defies treatment, the services of the *n'anga* will be solicited to untangle the jigsaw puzzle. In traditional Karanga culture, the *n'anga* does not only specialise in healing ailments, but also he/she is the guardian of morality. As such, the chapter now turns to a discussion of some illnesses and misfortunes believed to emanate from the community's failure to adhere to socio-moral rules and regulations.

3.3.3 Socio-Moral Causes

As has been noted thus far, traditional medicines are utilised by the Karanga in addressing most illnesses and misfortunes. However, these traditional medicines do not only cure disease, but they also promote virtuous living to those who take them.⁵²³ The Karanga traditional life involves numerous obligations towards fellow humans on the one hand and spiritual forces on the other. This entails observing the socio-moral code of behaviour as sanctioned by tradition.⁵²⁴ As such, failure to observe certain religious, social and cultural taboos and norms can provoke "spiritual forces to mete out punishments such as physical illness, drought and epidemics that affect the entire community and environment".⁵²⁵ The

⁵²¹ Shoko T. (2007a) *Karanga Indigenous Religion in Zimbabwe*, 66.

⁵²² Chitando E. (2007a) *Living with Hope*, 48.

⁵²³ Gelfand M. et al. (1985) *The Traditional Medical Practitioner in Zimbabwe*, 6.

⁵²⁴ See Chirongoma S. (2012) "Karanga-Shona rural women's agency in dressing mother earth: A contribution towards an indigenous eco-feminist theology" in Gerald West and Janet Trisk (eds) *Journal of Theology for Southern Africa: Essays in honour of Steve de Gruchy* (Volume 142, March, 2012), 120-144.

⁵²⁵ Dube L, Shoko T and Hayes S (2011) *African Initiatives in Healing Ministry*, 35.

whole community is therefore responsible for enforcing the observance of taboos and regulations since any breach of such norms is believed to have far reaching repercussions on communal health and well-being. For instance, whenever a drought, famine or pestilence befalls them, the Karanga interpret this as a sign of the ancestral vengeance for humanity's failure to observe ecological laws. This is illustrated in the Karanga proverbs *ivhu rataura* [the soil has spoken] or *vari pasi vatsamwa* [the ancestors are disgruntled].⁵²⁶ The role of *n'anga* therefore becomes crucial in terms of identifying the cause of the misfortune and guiding the community in performing appropriate rituals to rectify the problems.

Deviation from societal norms can also result in direct physical punishment on the culprit. Shoko aptly captures it as follows:

Some of the most prevalent types of diseases such as stomach aches, swollen belly etc., are perceived as a means of punishment meted out on the Karanga social deviants. The most popular medicine which is believed to safeguard fields from thieves is known by traditionalists as *rukwa*. If one eats maize or sorghum which is stolen from such a medicated field, serious illness results. The illness takes various forms; it can be a swollen stomach which will not subside until the culprit confesses to the owner of the field. Alternatively, the culprit is affected mentally and he may roam about in the field or physically stick to the item until the owner catches him.⁵²⁷

The Karanga therefore try to discourage disrespect of other people's property or possessions because stealing might result in the culprit's illness or public disgrace. Stories abound whereby after stealing and eating someone's medicated chicken the culprit will start to hear the chicken crackling or a rooster crowing in their stomach; if it is a goat, there will be a bleating sound from their stomach. Such strange and embarrassing illnesses can only be rectified if the thief owns up and pays compensation to the owner.

The Karanga also have several sex-related taboos and regulations; if sex is done at the wrong time, with the wrong person or without observing certain norms, then illness may affect well-being. There are certain diseases or conditions considered to be sex-related - most of these are meant to act as deterrents and so they discourage

⁵²⁶ Chirongoma S. (2012) "Karanga-Shona rural women's agency in dressing mother earth, 124.

⁵²⁷ Shoko T. (2007a) *Karanga Indigenous Religion in Zimbabwe*, 68.

indiscriminate sex or sexual misconduct. Some are minor illnesses depending on the type of sexual misconduct but others are complex and may result in death. Shoko succinctly summarises these sex-related complications,

If parents have sexual intercourse while the wife is still breastfeeding then the child will become ill. In the case of adultery a pregnant woman will have birth complications. At worst the baby will fail to come out until the adulterous woman confesses and the culprits are punished. If a man commits adultery he is likely to catch *runyoka*, a complex venereal disease that takes various forms. In some cases the culprits may stick together in their lovemaking nest. In other cases the man's stomach might swell up or he might even lose his genitals.⁵²⁸

These sex-related complications are much feared and act as a formidable force in social control. However, because 'to err is human,' people are often caught up in the web of transgressing these sex-related taboos and regulations and when they suffer the consequences, they may turn to the *n'anga* to address the resultant illnesses, misfortune and in some cases to avert death of the culprits.

Although the Karanga identify illness and disease to be caused by a range of factors from spiritual forces, witchcraft and sorcery as well as social and moral factors, they also regard some illnesses as emanating from natural causes. It is to this aspect that the discussion now turns.

3.3.4 Natural Causes

The Karanga believe that some illnesses are natural, i.e. they develop from nowhere and spring from the earth. These are regarded as *zvirwere zvepasi* [diseases from the earth]. Shoko clearly sums up this perspective,

In the Karanga thought-pattern, the nature of these diseases is such that no direct cause can be pin-pointed. They include diseases such as *mhizi* [scabies], *dzibwa* [colds], *zvikosoro* [coughs], etc. Their main characteristics are that they are mild and disappear with little or no medication...Of paramount importance is their conviction that at least mild illnesses have a natural cause.⁵²⁹

⁵²⁸ Dube L, Shoko T and Hayes S. (2011) *African Initiatives in Healing Ministry*, 35.

⁵²⁹ Shoko T. (2007a) *Karanga Indigenous Religion in Zimbabwe*, 70.

However, when such illnesses resist treatment and become chronic, then the Karanga search for alternative causal explanations and start questioning why: “why to this particular person and why at this time and place?”⁵³⁰ In search for answers to these questions, the traditional Karanga person normally turns to the *n’anga* who is able to identify the causes and administer healing rituals to ensure that *utano* [health and well-being] is maintained.

3.3.5 Conclusion

As has been noted above, a wide range of factors overlap in the Karanga understanding of what causes illness and misfortune. In many cases the Karanga strongly believe that illness and disease do not occur by chance but have a definite cause, which is normally diagnosed and cured by the *n’anga*. As Mbiti rightly puts it across, “Even if it is explained to a patient that he has malaria because some mosquitoes carrying malaria parasites has stung him, he will still want to know why that mosquito stung him and not another person”.⁵³¹ Hence for Africans, disease and suffering find their ultimate explanation in the realm of the symbiosis between the visible and invisible. As such, African traditional doctors are not only concerned with the physical treatment of a patient, rather in their diagnosis of disease, they have to go beyond the physical, they view all this from a holistic point of view. It is befitting to end this discussion by citing Mbiti who concludes that African traditional healers “are friends, pastors, psychiatrists and doctors of traditional African villages and communities”.⁵³² The following chapter explores religion as a health asset; it draws insights from the ARHAP framework on religious health assets and merges this with the Karanga indigenous notions on health and well-being. An exploration of the crumbling public health care system presented in chapter two provides fertile ground for exploring the Karanga understanding of religion as a health asset. It seeks to fathom the key religious and socio-cultural factors influencing Karanga people’s health-seeking behaviour, i.e. it aims to establish how health-seekers navigate the religious and medical plurality presented by the three health care systems [Modern scientific bio-medicine; Traditional healing and Faith-healing].

⁵³⁰ Bourdillon M.F.C. (1976) *The Shona peoples: An ethnography of the contemporary Shona, with special reference to their religion* (Gweru: Mambo Press), 173.

⁵³¹ Mbiti J.S. (1969) *African Religions and Philosophy* (London; Heinemann Publishers), 222.

⁵³² Mbiti J.S. (1969) *African Religions and Philosophy*, 223.

Chapter Four

Religion as a Health Asset among the Karanga: An Exploration of the Role of the Three Health-Care Systems in Murinye District, Masvingo

4.1 Introduction

The previous chapter (three) described the traditional beliefs relating to health and well-being in Zimbabwe. This chapter endeavours to explore the key religious and socio-cultural factors influencing Karanga people's health-seeking behaviour and health-care provision, i.e. it sets out to establish how health-seekers and health care providers orient themselves within the existing religious and medical plurality [Modern scientific bio-medicine; Traditional healing and Faith-healing] and how they navigate this plurality. Taking a cue from chapters two and three that foregrounded the unavailability and inaccessibility of modern bio-medicine for the majority of poor Zimbabweans, this chapter focuses on the agency and innovativeness⁵³³ of the Karanga people in their provision of and utilisation of alternative health care systems such as faith healers⁵³⁴ and traditional healers (*n'angas*)⁵³⁵ as they attempt to bridge the gap caused by the near collapse of the public health care system.

The chapter presents case-studies of health care providers specialising in the three health-care systems in Murinye District in Masvingo, highlighting how health-seekers are navigating these three systems. The case studies conducted reveal that most health-seekers utilise multiple health care providers and all the study participants expressed openness to the

⁵³³ Throughout this study, it is acknowledged that local people are active agents in responding to a crisis, hence the agency of the community in seeking/providing health care and healing is the cornerstone to understanding the core of the study. Turner E (1994:71-95) succinctly puts it this way, "No understanding of a world is valid without representation of those members' voices".

⁵³⁴ As noted in the extensive writings on Zionist Churches by Marthinus L Daneel, faith healing has been one of the most powerful and persuasive expressions of the gospel of good news. The term faith healing refers to a system whereby patients go to the 'healing prophets' or 'faith healers' who will pray for their healing, sometimes these healers administer holy water or holy oil and at times they 'extract' some objects from the patients' bodies. For more information, see Daneel M.L. (1971) *Old and New in Southern Shona Independent Churches*. Vol. 1, *Background and the Rise of the Major Movements*. The Hague: Mouton; (1974) *Old and New in Southern Shona Independent Churches*. Vol. 2, *Church Growth: Causative Factors and Recruitment Techniques*. The Hague: Mouton; (1987) *Quest for Belonging – Introduction to a Study of African Independent Churches*. Gweru: Mambo Press; (1988a) *Old and New in Southern Shona Independent Churches*. Vol. 3, *Leadership and Fission Dynamics*. Gweru: Mambo Press; (2001) Ed. *African Christian Outreach*. Vol. 1, *African Initiated Churches*. Pretoria: South African Missiological Society.

⁵³⁵ Traditional health care systems refer to the use of herbal or traditional cures either self-administered or administered by traditional healers (*n'anga*).

interchangeable use of the three health-care systems.⁵³⁶ The case studies also clearly illustrate how one's religious background and affiliation influences an individual's perception on health and well-being. Information was drawn through interviews as well as participant observation during healing rituals.⁵³⁷ During the healing rituals, information was gathered from both health seekers and health-care providers.

In order to systematise the material, I have created three clusters relating to field experiences with prophet healers, traditional healers and practitioners of biomedicine. I have summarised their responses in order to draw attention to common themes emerging from their engagement with the quest for health and well-being in Murinye. While in most instances I have allowed each of the respondents to speak for themselves, I have also left out some responses when I felt that they tended to be similar to those provided by other practitioners within the same cluster. In this regard, the responses below must be appreciated for their representativeness. I grant considerable space to a description of the call narratives as this is critical to the sacred practitioners involved.

4.2 Prophet Healers

My interaction with prophet healers confirmed their importance to the search for *utano* among the Karanga people of Murinye. In in-depth interviews and observations, prophet healers Kwangwari, Phineas, Miriam, Takunda and Patrick brought out trends and patterns in health-seeking behaviours related to their particular system. Although there were a few variations, these representatives highlighted the importance of prophet healers to the quest for health and well-being in Murinye. In the forthcoming sections, I discuss their educational background and calling, definitions of *utano*, major challenges facing their ministries and their understanding of multiple approaches to health.

⁵³⁶ Depending on the nature of the illness or at times the availability of health facilities/providers, some patients utilize all the three facilities concurrently e.g. one can first seek health care at the clinic and from there they visit either the faith-healers or traditional healers and in other cases they consult both.

⁵³⁷ The guiding questions used to conduct the interview schedule are in the appendix. The researcher was a participant observer in some of the healing rituals after having been granted by some of the healing practitioners and their clients, particularly the healing rituals performed by traditional medical practitioners or those performed by faith healers on their patients.

4.2.1 Educational Background and Calling

In this section, I summarise the educational background and calling of the five prophet healers who were my key respondents during fieldwork.

Kwangwari⁵³⁸ is a 35 years old male prophet-healer belonging to the Zviratidzo ZvaVapostori Apostolic Church and his educational level is 'O' Level. He received his calling at the early age of 20 when he was completing his secondary school education. Kwangwari described how much he tried to resist the call and even sought to run away from this ministry by enrolling to work as a miner at Renco Mine in Masvingo south. However, whilst working in the mines, he continued to receive visions instructing him to go and pray for the healing of God's people. These visions bombarded him, leaving him deeply troubled up to a point that he eventually accepted the call at the tender age of 25.

Phineas⁵³⁹ is a 73 year-old male prophet-healer belonging to the Zion Christian Church-Chikamba (ZCC-Chikamba) and his educational level is Standard 6. The ZCC-Chikamba congregation was founded in the 1950s by Saul Chikamba after whom it was named; it branched off from the Zion Christian Church founded by Bishop Samuel Mutendi.⁵⁴⁰ Phineas received his call to become a prophet-healer in 1992. On several occasions, he found himself possessed by a spirit which would reveal people's ailments and at the same time instructing him to pray for their healing. He explained that at first, these visions confused him and he feared that he was either losing his mind or was facing his death. However, with time, the denominational founder Saul Chikamba, heard about Phineas' predicament and paid him a visit. Upon observing the way Phineas behaved during the periods of possession and how he ministered to the sick, Saul Chikamba was convinced that Phineas was called by God to heal his people. Consequently, Saul Chikamba proceeded to consecrate Phineas as a prophet-healer under the ZCC-Chikamba fold.

⁵³⁸ Interviewed 10 December 2006, Murinye, Masvingo.

⁵³⁹ Interviewed 12 December 2006, Murinye, Masvingo.

⁵⁴⁰ For more information on the Zion Christian Church in Zimbabwe, see Daneel, M.L. (1974) *Old and New in Southern Shona Independent Churches: Church Growth-Causative Factors and Recruitment Techniques Volume 4 of Change and Continuity in Africa Series* (Mouton De Gruyter); (1987) *Quest for Belonging* (Mambo Press: Gweru).

Miriam⁵⁴¹ is a 45 year-old female prophet-healer who is a member of the Johani Masowe Apostolic Church. Her educational level is up to Ordinary Level, commonly referred to as 'O' Level in Zimbabwe. Miriam received her call to the prophetic-healing ministry around the age of 25 soon after she got married. Sometimes in a dream she would 'see' people battling with ailments and would hear a voice instructing her to alleviate their suffering. At times, she would feel the prompting of the spirit to fast and pray for the deliverance of members of her family from evil attacks and sometimes she would be prompted to pray for people that she had never met before, but the spirit would reveal the danger that such individuals were prone to and instruct her to intercede on their behalf. She explained how these experiences left her perplexed and deeply worried and acknowledged how she relied on emotional support from her husband and her mother-in-law who never ceased to pray with her and encouraged her not to be afraid. With time, some members of the congregation started being instructed in a dream to go to Miriam for prayers of intercession. She indicated that initially this worried her because she feared that it might put her in trouble with the elders of the church but on the other hand, she also felt obliged to minister to people who came to her requesting for prayers, especially because she realised that in most instances, these intercessory prayers were transforming people's lives.

Miriam mentioned that there were several church elders who doubted her genuineness and they were hesitant to acknowledge her ministry probably because she was the first female prophet-healer to emerge in their congregation within the whole district. These attitudes did not deter her and she continued ministering to those who came to consult her at her household and many people were being referred to her by those who had witnessed the impact of her ministry from all over Masvingo province. Within a period of two years, Miriam was ordained and officially recognised as a prophet-healer within the Johani Masowe Apostolic Church. Since then, she ministers to people both at their place of worship (*Masowe*) and also at her homestead. The days on which she is available for the healing ministry at *Masowe* are Monday, Tuesday, and Wednesday in the afternoon and on Saturday mornings. She is also available for consultation at her homestead on Tuesday and Wednesday mornings.

⁵⁴¹ Interviewed 15 December 2006, Murinye, Masvingo.

Takunda⁵⁴² is a sixty three year old male prophet healer. He has basic reading and writing skills. He is a member of the Zion Christian Church–Chikamba (ZCC Chikamba). He serves as a prophet healer, preacher, teacher and counsellor. ZCC Chikamba is an offshoot of the Zion Christian Church initially founded by Bishop Samuel Mutendi.⁵⁴³ According to Takunda, his religion is integral to his faith healing ministry. He explained that if it was not for God’s calling him to do this work, he would have been doing something completely different with his life, but because he was divinely commissioned to minister to God’s people and offer healing through the name of the trinity, he has therefore committed all his time and energy to fulfil the commission.

Takunda’s calling to the office of a healer started at an early stage in life, well before he even joined the ZCC Chikamba fold. He explained how as a young boy, he was never interested in Christianity and therefore he did not belong to any church. He was however interested in interacting with people who performed traditional ceremonies in honour of their ancestors. As such, he would gladly participate in any communal traditional rituals where people would brew beer and play drums as they observed their ancestral rituals. It was during his late grandfather’s *kurova gurova* ceremony [his grandfather’s spirit was being celebrated and being rehabilitated as well as being ushered into the ancestral fold] that it became apparent that he was destined to become a healer. Whilst he was dancing to the traditional drums and the music with the rest of the gathered members of the family and other members of the community, he found himself feeling dizzy and suddenly he fell down and started shivering and lost consciousness.

Those around him later informed him that he had been possessed by the spirit of his great ancestor who used to be a very popular traditional healer and he was being called to inherit this gift of healing. However, he was not interested in that kind of commitment and he informed his parents that he needed their support to get rid of this spirit which was intending to possess him. He was told that there was no way of escape from such an honoured responsibility and when he realised that he could not easily run away from this situation, he decided to disappear from home and travelled to Hippo Valley Sugar Estates in Masvingo

⁵⁴² Interviewed 17 December 2007, Murinye, Masvingo.

⁵⁴³ For more information about the Zion Christian Church in Zimbabwe, See Daneel M.L. (1987) *Quest for Belonging – Introduction to a Study of African Independent Churches* (Gweru: Mambo Press).

south where he worked for some years. When he started feeling unusually sick, combined with some dizziness and heaviness on his shoulders, he knew that trouble was looming and he went to seek the services of a local prophet healer who lived in the workers' compound. There, Takunda was told in no uncertain terms that if he needed relief from this sickness, he either had to accept the spirit of his great ancestor or alternatively, he could join a spirit-filled church which could help to disarm/neutralise the hold of this ancestral spirit on him. It was then that he decided to join the ZCC Chikamba church. Initially, when he joined the church, all that mattered to him was to be safe under the wings of the church and not be tormented by this ancestral spirit. After two years of membership in the church, he finally felt at peace but no sooner than he started enjoying this inner peace did he begin to encounter dreams and visions summoning him to practise as a prophet healer. He said that he again tried to resist this but the visions were so overwhelming such that some elderly members of the congregation advised him to just obey God's call. He was, therefore, ordained and anointed as a ZCC Chikamba prophet healer in 1984. Initially, he practised the healing ministry outside his working hours but the numbers of people who needed his attention kept increasing such that he eventually had to resign from his job and returned back to his rural home in Murinye where he set up his healing ministry.

Patrick⁵⁴⁴ is a fifty year-old male prophet healer who is a member of the Pentecost Apostolic Church. He is the founder of this denomination and he also serves as a prophet-healer, preacher and teacher. His academic qualification is Ordinary Level. Patrick used to work as a brewery manager in Masvingo town and was eventually forced to quit his job mainly because he kept on resisting his superior's plans of transferring him to other branches in another town which he could not easily oblige to due to the fact that he had already established a following and had set up his healing ministry in Masvingo town. When he could not withstand the pressure of having to relocate with his job, he decided to resign from his place of employment and enter into full-time ministry in his rural home Murinye.

⁵⁴⁴ Interviewed 15 December 2007, Murinye, Masvingo.

4.2.2 Understanding of *Utano* and Role in Restoring/Preserving *Utano*

Prophet healers availed valuable insights regarding their understanding of *utano*.

Kwangwari conceptualizes illness as having been caused by spiritual causes. His definition of *utano* is as follows: “well-being in all aspects of life; social, spiritual and physical.” He explained that when a patient comes to consult, his first task is to explore the spiritual harmony within the patient’s spirituality. If there is some spiritual disharmony or imbalance, then this will impact on one’s physical well-being. According to Kwangwari, most of the patients that he attends to will be either victims of spiritual attacks, witchcraft, or battling with social relations with family members or other members of the community. Others also come seeking for help to address challenges at their work place or help with securing employment or promotion at work.

The other spiritual visitations that Kwangwari’s patients encounter regularly are those of *vadzimu/madzinza* (family ancestral spirits).⁵⁴⁵ This is whereby the spirit of one’s paternal or maternal relatives wishes to take possession of one member of their family. The way in which the *mudzimu/dzinza*, (family spirit) manifests itself is usually the same as in the alien spirit explained above. Upon discovering that the family ancestral spirit wishes to possess one, mostly those who are of the Christian fold and do not subscribe to *vadzimu/madzinza* spirits will proceed to request the prophet-healer to exorcise such spirits. According to Kwangwari, it is much simpler to exorcise the alien spirits than family ancestral spirits because family spirits usually put up a huge fight, ‘refusing’ to ‘leave’ the targeted family member because they believe that they rightfully ‘belong’ and would therefore feel that they are being abandoned and in some cases they will threaten to kill the victim who has ‘rejected’ them. Sometimes the process might take years to get rid of the spirit because it will continue inflicting harm on the victim who would have to constantly consult with the prophet-healer for protection. In such cases, the patient will have to sometimes carry a *muteuro* stone on their person all the time and to keep some of the stones scattered around the household to shield them from any possible attacks. A *muteuro* stone is a small smooth pebble/stone and

⁵⁴⁵ See Shoko T. (2007) *Karanga Indigenous Religion in Zimbabwe* and Dahlin, O (2001) *Zvinorwadza: Being a Patient in the Religious and Medical Plurality of the Mberengwa District, Zimbabwe* (Universitetstryckeriet: Uppsala) for a detailed description about *vadzimu/madzinza*.

the term *muteuro*, means prayer. These *muteuro* stones are kept at the sacred shrine called *kirawa*, which is the most sacred and holy spot around the *masowe*, place of worship.

In his healing ministry, Kwangwari explained that he relies on the leading of the Holy Spirit⁵⁴⁶ to reveal the nature, cause as well as the appropriate remedy for his patients' illness. The procedure varies and is dependent on the circumstances of the patient. In some cases, the prophet-healer will ask the patient to present their request but in other cases, the prophet-healer will be prompted through a vision to minister to a patient whose impending danger/misfortune or recurrent illness will have been revealed to the prophet-healer. It could also be that the prophet-healer will discern that the patient is troubled with some spiritual or social problem and be prompted to invite them to come for prayers of intercession. Patients seeking solutions to their social problems also form a considerable number of those who regularly consult Kwangwari.

According to Phineas, the patients who visit him present a wide range of problems but the larger percentage consist of those *vanenge vachinetswa nemhepo dzokusundirana* [those who are tormented by evil spirits which are usually 'directed/sent' to them by those who hate them and wish them evil]. This could be caused by jealousy from a relative, friend, neighbour or associate who will solicit the powers of evil spirits to inflict harm on the targeted victim. In some cases it could be that the perpetrator sends these evil spirits to torment the victim as a way of revenging a wrong done by the victim or the victim's family. For instance, some people will be avenging the fact that their daughter was impregnated by a man who refused to take responsibility by failing to pay *roora* [bride-price]. If he is not interested in marrying her, he would be expected to at least pay a fine which is commonly known as 'damage', suggesting that the man who impregnated the girl damaged the dignity of the girl's family and most importantly the girl's integrity. This is so because among the Shona, once a woman falls pregnant out of wedlock and fails to get married to the man who impregnated her, it becomes very difficult for her to find another man who is prepared to marry her and even if she does, the bride-price payable for such a woman is very little because she will already be

⁵⁴⁶ Since Kwangwari is a prophet-healer who operates in the realm of the Christian tradition, the term Holy Spirit is used in the Christian sense.

regarded as ‘damaged goods’.⁵⁴⁷ Hence, impregnating a woman and failing to own up is such a great offence which could cause enmity between the man’s family and the girl’s family.

Phineas’ understanding of *utano* is as follows: “A person’s *utano* can be discerned from how they look [physical appearance]; this has a lot to say on one’s health and well-being. If a person appears physically strong and well-composed, anyone who looks at them would assume that s/he *mutano* [s/he is healthy]. Phineas went on to illustrate this point by citing the following Shona proverb; *chinosiva ivhu kuti mwana wembeva unogwara* [it is only the soil that knows that a baby rat is sick]. This proverb denotes the fact that some physical ailments may not show on the outside and therefore unless the one who is experiencing the pain speaks about it, nobody will ever know. Phineas reiterated this point using his own example. He had this to say, *Munondiona sei, mungati ndinorwara here? Asi ndinorwara nemusana muchindiona ndigere pano kudai* [how is my appearance, would you ever think that I am sick? However, I suffer from recurrent back ache but you cannot see it]. He also added that the spiritual and emotional balances within one’s faculties are significant determinants of one’s *utano*.

Miriam understanding of *utano* is expressed in the following words: “*utano* embraces all aspects of one’s existence; firstly in the spiritual realm, one should be free of all negative forces, be completely released from *mweya yepasi/yamadzinza kana minyama*, [malicious spiritual forces or misfortunes]. Second, one should enjoy *muviro wakasimba, usina zvirwere kana utachiona* [pure and fit physical health with no ailments or viruses]. Third, one should be at peace with their social and environmental surroundings, with ease of access to basic needs and enjoy meaningful social relationships. To be denied any of these diminishes/impinges on one’s *utano*.”

Takunda’s definition of *utano* is as follows: “a healthy person is one who is free from diseases, free from evil or negative spiritual attacks, has peace of mind, does not have any stress and is able to deal with life’s challenges as they present themselves.”

Patrick’s definition of *utano* is as follows: “*kudya kwemweya nemuviri kwakaringana kunopa kugadzikana mupfungwa nemumuviri* [having adequate food and enough peace of mind inculcates a positive mind and a healthy body]. *Kugara zvakana nevamwe uye kuva*

⁵⁴⁷ Using gender-sensitive lenses, such a perspective on women sounds very patronising, turning women into commodities which can be given a price-tag.

nemusha wakarongeka une zvikwaniro zvose [enjoying peaceful relations with others and having a well-organised home and family, and having the assurance that all essential household needs are catered for]. *Kusava nechirwere, muviri wakasimba usina kana marwadzo* [the absence of disease in your body, without any pain or ailment].

4.2.3 Major Challenges Encountered in the Prophetic Healing Ministry

While prophets provide a valuable service to their clients, they face many challenges. In this section, I summarise the major challenges that the prophet healers raised.

Since the issue of witchcraft dominates the cases that Kwangwari attends to, he identified this as a major challenge to his ministry, in view of the fact that the government still follows the Witchcraft Suppression Act 1899 (Chapter 73).⁵⁴⁸ Because of this act, his hands are tied and whenever he identifies witchcraft as the cause of a patient's infirmity, he can only state that it is the work of witchcraft but will not reveal the name of the witch, lest he be charged of accusing someone of witchcraft. Kwangwari also intoned that this approach safeguards against creating enmity among relatives or neighbours since in many cases, the identified witch is either a relative, friend, neighbour or associate. He, therefore, said that he usually tells the patient who is a victim of witchcraft that it is the work of *vavengi* [enemies] and will warn them that several people can be potential enemies without pointing fingers at the culprit.

The number of patients who come to consult Phineas ranges between five and ten on a daily basis. Most of his patients come from within Masvingo province; some come from Nyajena area which is about 12km away; others from Topora (15km away) and Zaka (25km away). Because of the distances that people have to travel, most of them on foot, some patients spend days on Phineas' homestead, resting before they start off on foot again. Phineas explained that his major challenge in this healing ministry is food insecurity. This is due to the fact that some of the patients come to live around his homestead for an extended period of time whilst

⁵⁴⁸ The Witchcraft Suppression Act 1899 (Chapter 73) which assumed that witchcraft does not exist was however repealed by the coming into force of the Criminal Law (Codification and Reform Act of 2006, Section 89), See http://www.chr.up.ac.za/undp/domestic/docs/legislation_57.pdf.

receiving treatment and he has to provide for their sustenance during their stay. This is problematic because Masvingo province, particularly Murinye district has suffered recurrent droughts during the past decade. Bearing in mind that people who are ill need to eat well, this presents a major predicament for him and his household. He elaborated that although they have been receiving food aid from NGOs such as CARE International, the portion that he receives only caters for the registered eligible members of his family. The unofficial regular patients who take residence in his homestead do not get an allocation. He expressed how much he wishes that the government could also allocate him food aid as they do to the local clinics and hospitals. Phineas is of the opinion that the government does not acknowledge prophet-healers as offering essential services to the community because it is only the established bio-medical institutions that receive government subsidy. For him, it implies that the government does not recognise the work done by prophet-healers to ensure healing and well-being in the community.

The major challenges that Takunda highlighted as presenting difficulties on his role as a prophet healer in this community revolve around the lack of efficient and reliable transport. He elaborated that in some cases he is invited by people needing him to travel to faraway places so as to attend to a critically ill patient or sometimes to perform certain rituals at someone's homestead and there are many times when he has failed to reach such patients at their greatest time of need due to lack of transport. He suggested that if it were possible, he could have a car donated for him so that he may be mobile and be able to quickly respond to the needs of people in different sections of the community. He also mentioned that even if he may not be accorded the luxury of a car, it would be helpful if at least the prophet healers could also be granted free transport services on all public transport just the same way in which community workers in uniformed forces such as the police and the army are accorded free transport when travelling throughout the country.

Takunda also mentioned the need to construct roads that are tarred and erecting an effective and reliable bridge where Mutirikwi River crosses over into Murinye district because the road and the bridge are a death-trap during the rainy season. He explained that small cars cannot even pass through this road particularly during the rainy season because the roads are muddy and slippery and due to the deep potholes in the roads, there will be massive pools of water in the road. Furthermore, even during times when it is dry, the roads have been so run down by

the floods such that there are deep potholes and pointed stones and rocks in the road which cause so much damage to smaller vehicles. He further explained that even bigger and stronger cars also suffer considerable damage due to the extensive wear and tear encountered on such roads. It is due to the state of the roads that very few public transport operators are prepared to risk putting their vehicles to ply such routes. As a result, there is limited transport on such a busy route. Takunda reiterated that the state of the road and the transportation system in Murinye district is a matter that needs urgent attention because it has cost so much loss of life due to accidents on the roads or due to delays in ferrying patients needing urgent medical attention. He indicated that this is a concern shared in common by health care providers across the three health care systems.

As regards the main challenges faced in undertaking their healing ministry at this centre, Patrick identified lack of decent accommodation for clients who come to board at his homestead as a major concern. He explained that since some of them travel long distances, they will need shelter whilst they rest and wait to be attended to. Some patients will be so ill such that they need to spend some time at the healing centre to receive regular care from the prophet healer. Patrick gave the example of a patient suffering from mental illness; he explained that this condition cannot be treated once off. Such a patient would need to spend a prolonged period of stay, depending on their rate of progress; some will stay for a few months, others a year or several years before they can regain sanity. It is such patients who will need decent and more comfortable accommodation, rather than for them to live in makeshift temporary shelter erected around the healing centre. Patrick also mentioned that there is a need for more toilets around the centre and a constant supply of borehole water. He explained that at the moment, his family and his assistants have to share the two Blair toilets with all the clients who come to the centre. These are inadequate because sometimes there are so many people at the centre. As for the water source, they all have to rely on running water from Mutirikwi River which is untreated and is also far away from the healing centre; hence, people have to travel a distance of about five kilometres to go and fetch water for all household needs. This is the same river where the local community wash their laundry, bath and swim; it is the same source from which where their livestock drink.

As regards solutions to these challenges, Patrick highlighted the need for the government and other local business people who can afford to please donate funds to put up the required

infrastructure so that the patients can have decent accommodation, clean water and better sanitary conditions. Patrick acknowledged that the donations and gifts offered by members of the congregation and some clients who come back to express their gratitude in the form of material gifts have been very helpful in supplying essential needs such as food and blankets for those clients who will be living at the healing centre. He also acknowledged the assistance offered by some local business people and the local chief who regularly donate some food to the centre. He appealed to more well-wishers to consider offering whatever form of assistance they can offer to sustain the healing centre.

4.2.4 Karanga People's Multiple Health-Seeking Strategies

According to Kwangwari, Karanga people's health-seeking behaviour is usually determined by three things; the nature of the ailment, accessibility and affordability. If a patient is presenting symptoms of being possessed by a spirit or has been attacked by witchcraft, the family will usually take such a patient to either the traditional healer or prophet-healer. Kwangwari also explained that the choice between a traditional healer and prophet-healer is usually influenced by the family's religious inclinations; mainly those who are Christians would prefer a prophet-healer to a traditional healer. Sometimes the nearest service provider will be the first choice, furthermore, the quality of service and the service fees charged are important factors to be taken into consideration.

Kwangwari acknowledged that there are some conditions which he cannot adequately attend to, for instance, if a person is suffering from asthma, throat infection, fractured limbs or some other conditions needing surgical procedures. In such cases, he will refer the patient to the clinic/hospital. In the event that he has diagnosed that a patient is troubled by an ancestral or alien spirit intending to possess them and they are prepared to welcome such a spirit, Kwangwari would refer them to the traditional healer who is best placed to take the patient through the process of welcoming the spirit. It is only when they wish to have such a spirit exorcised that Kwangwari can be of assistance to them. He also intoned that although there is no clear-cut working relationship between the western bio-medical system and the prophet-healers; the two are aware of the existence of the other and will informally refer patients to each other. He also utilises the services of the clinic/hospital whenever need arises and has great respect for their service. He however regrets the fact that there are times when the bio-medical practitioners fail to acknowledge that certain patients maybe tormented by some

spiritual forces which they cannot adequately heal and feels that the longer such patients stay in the hospital, the more their condition deteriorates. Kwangwari looks forward to a time when all the three systems can be officially integrated so that they can have a forum where they meet to discuss issues and create an amicable working relationship.

As regards the patients' choice of health-care providers, Phineas explained that this is usually determined by the nature of the ailment and also the family's religious traditions. For some Christian families, no matter what type of ailment confronts them, their first port of call is the clinic. However, for Phineas, whenever illness strikes in his family; the procedure is to always pray about the ailment first and through his prophetic gift, discern the cause of disease. If it is something caused by spiritual forces, he will pray over it, exorcise the spirit or cast away the evil forces. However, if it is some medical condition, for instance if a patient is suffering from asthma, cancer or any HIV related illnesses, he will advise them to visit the clinic/hospital. He has also utilised the local clinic on several occasions in relation to back ache.

In Phineas' view, there is absolutely no coordination between the three health care systems. He feels that each operates in isolation and he also mentioned that there are very few traditional healers remaining in Murinye district. He mentioned that he respects the work of bio-medical practitioners but finds it problematic that some of them want to pretend that they can cure all ailments, even some which have spiritual causes which he feels they are not best placed to address. As regards the work of traditional healers, Phineas explained that he appreciates those who work towards the healing and well-being of the community. However, he seriously criticised those who abuse their knowledge of the supernatural by practising witchcraft and evil magic and thereby inflicting harm on innocent victims.

As regards the use of three health care systems, Miriam is of the view that each one plays a significant role, depending on the nature of the patient's problem. She acknowledged that the traditional healers, particularly herbalists, play a fundamental role especially in treating snake bites, particularly at a time when the hospitals and clinics do not have any medication for

snake bites.⁵⁴⁹ She mentioned several examples of how the medical personnel at local clinics have often referred patients bitten by a snake to local herbalists and have received effective and almost instant healing. She however lamented the fact that there is no clear-cut coordination between the three health-care systems, since they all seem to be operating in isolation. Miriam feels that if the three systems could find a platform on which they make regular consultations and share ideas on how best to provide holistic care to the community, they would all achieve the best results ever.

According to Takunda, Karanga people's health-seeking behaviour is mostly determined by the nature of illness, for instance, if a patient is suffering from *chiposwa* [experiencing some numbness], then usually that person will be taken either to the traditional healer or prophet healer because it is normally regarded as a sign that an enemy would have caused a foreign object to 'enter' into the victims' body. This would therefore need an expert in these spiritual issues to extract the *chiposwa* out of the victim's body, otherwise if they go to the clinic or hospital, such an object is usually concealed from modern medicine even with the state of the art machinery such as X-rays. However, he mentioned that if a patient is suffering from a physical ailment such as cholera, malaria, measles or an eye infection, such a patient would be better off treated at the clinic or hospital than anywhere else. Takunda further explained that he does not have any problem with patients utilising two or three health care systems simultaneously, for him, what matters most is that the patients secure the healing that they will be searching for.

He elaborated that there are several times when he has had to refer patients to the clinic, for instance, if a patient has a sprained muscle or has fractured a limb, he said that he would not waste time by delaying the patient from going to the clinic, since it is the best equipped service to address such conditions. Takunda said that there is no clear-cut integration between the three health care systems; however, the three systems informally refer patients to each other. He also mentioned the fact that because he is a prophet healer and does not agree with some of the methods used by traditional healers, therefore for him, there is no way in which he would refer or encourage a patient to visit a traditional healer. Rather he works closely with the local clinic.

⁵⁴⁹ Upon further enquiry, this author established that it is only the two Medical schools, Parirenyatwa in Harare and U.B.H. in Bulawayo that sometimes have a limited supply of medication to treat snake bites.

Having summarised key themes regarding the ministries of prophet healers in the health delivery systems available for the Karanga people of Murinye, in the following section I summarise findings relating to *n'anga* (traditional healers). As with the prophet healers, I have also adopted a thematic approach.

4.3 Traditional Healers

In in-depth interviews and observations, traditional healers revealed significant insights, trends and patterns in health-seeking behaviours related to the use of indigenous healing systems. Although there were a few variations, these representatives highlighted the importance of traditional healers to the quest for health and well-being in Murinye. In the forthcoming sections, I discuss their educational background and calling, definitions of *utano*, major challenges facing their healing ministries and their understanding of multiple approaches to health.

4.3.1 The Educational Background and Calling of Traditional Healers

Raramai⁵⁵⁰ is a 64 year old male traditional healer whose educational level is up to Standard Three. He discovered his call to become a healer at the age of 30. This was established after a protracted period of illnesses which could not be properly treated by any western bio-medicine. He had grown up as a very fit person but suddenly started experiencing severe stomach pains and some dizziness whose actual cause could not be diagnosed by any medical practitioner. At that point in time, Raramai was working for Triangle Sugar Estates and therefore he had ease of access to the clinic that services Estate workers. At first he dismissed the dizziness as a sign of exhaustion due to the heavy manual work that he was doing but he realised that even on the days when he was off-duty, the same feeling persisted. The stomach-ache would also not get any better, no matter what kind of medication he received, it actually became worse to the point that he decided to return to his rural home. Raramai suspected that he could have been bewitched by some of his co-workers since there was so much competition in his line of work.

When he arrived in the village and explained the nature of his illness to his parents, they suggested that they visit a local *n'anga* to establish who was bewitching him. They also

⁵⁵⁰ Interviewed 20 December 2006, Murinye, Masvingo.

suspected that he might have been bewitched by their neighbours who were probably jealous that he was doing well at work since he had managed to build a big house which was properly roofed with metal sheets and had even sent money home to his parents to buy livestock for him. These signs of progress in a rural setting are objects of envy that might invoke witchcraft attacks from the enemy lines. As they reached the *n'anga's* homestead, the *n'anga* became possessed and without them saying a single word to her, she started talking and explaining to them that the illness that was troubling Raramai was inflicted by his great-grandfather's spirit who wished to 'possess' Raramai so that he could inherit his gift of traditional healing. When he heard this, Raramai was deeply troubled because he was still very young and adventurous and could not imagine himself sniffing traditional snuff and following all the restrictions that are to be observed by traditional healers. He therefore requested that they consult another male *n'anga* that lived further away and his parents offered to take him there. They again received the same verdict but still Raramai resisted. However, as time passed, he continued suffering spells of dizziness and bouts of stomach pains until he reached a point when he was so sick such that his family feared that he was dying. It was at that stage that Raramai finally obliged and started undergoing the initiation process and the rest is history.

Vonai⁵⁵¹ is a 53 year-old female traditional healer who has basic literacy levels. Through a series of strange dreams and bouts of allergic reactions to some types of foods and deodorants, Vonai eventually discovered that she was destined to be a traditional healer. In her early teens, Vonai started to experience strange visions and dreams revealing incidents that would happen either in her life or the life of those around her. She also constantly saw the vision of a *njuzu* [mermaid] which was inviting her into the sea to discover some healing herbs for various ailments. At first, she put this off as sheer imagination but as these dreams and visions intensified, she became concerned and started explaining her experiences to her parents. Her parents started monitoring her behaviour and it was then that they also discovered that she was becoming allergic to some bathing soaps, perfumes as well as meat from wildlife, eggs and milk. Whenever she came into contact with any of these, she could not even stand the smell and it would cause her headaches, palpitations and she would only be relieved after vomiting.

⁵⁵¹ Interviewed 21 December 2006, Murinye, Masvingo.

It was at this stage that Vonai's parents decided to take some measures into establishing the cause of such strange behaviour. Some people even suspected that she might be pregnant and they advised her parents to take her to the clinic for pregnancy tests. The pregnancy tests came out negative and the medical practitioners could not establish any medical cause for her allergies. It was in their search for her well-being that Vonai and her parents consulted a local traditional healer who informed them that she had been selected by the healing spirit of her late great grandmother to take over the skill. This revelation worried Vonai and her parents because they knew that this would not be an easy path; they all dreaded the life of self-sacrifice and commitment that this calling entailed. Wishing to verify or refute the diagnosis, they consulted several *n'angas* and prophet-healers who all confirmed the same diagnosis. They then resolved to seek a healer who could exorcise this spirit and set her free from the task of becoming a traditional healer. They were advised to consult a prominent prophet-healer from the Zviratidzo ZvaVapostori Church who assisted them to temporarily make the spirit dormant and instructed Vonai to remain a very committed and prayerful Christian because, once she started to backslide, the spirit would 'return' and overpower her. For as long as she remained in her parents' home, she remained loyal to the instructions given by the prophet-healer and she was 'free' from the visitations of this spiritual power. However, a few years down the line, Vonai got married and being overwhelmed with other responsibilities as a newly married, she started slackening in adhering to the instructions stipulated by the prophet-healer and eventually, she even stopped attending worship services. The dreams and visions started recurring and she became so sick such that her husband and her in-laws ran around consulting several healers who all identified the spirit of her great-grandmother as the source of all her woes. After much deliberation, Vonai temporarily returned to her parental home and having no other option, they organised that she goes through the initiation process. After going through all the necessary procedures, she returned to her husband and her parents-in-law who were all very supportive of her healing ministry.

Nyaradzai⁵⁵² is a fifty-five year-old female traditional healer. She has basic reading and writing skills. She possesses some healing powers and is also capable of revealing information that is hidden from the ordinary eye. Nyaradzai believes in the existence of ancestral spirits whom she describes as offering a mediatory role between the living and the Supreme Being whom she identifies as Mwari [personal name for God used by both

⁵⁵² Interviewed 14 December 2007, Murinye, Masvingo.

traditional believers and Christians], Musikavanhu [the creator] or Nyadenga [one who lives in the sky]. According to Nyaradzai, her close communication and interaction with the ancestral realm as she undertakes her role as *n'anga* defines who she is. Her whole life, e.g. what she eats, how she dresses and every facet of her life is guided by the rules and regulations that she has to adhere to as a *n'anga*. Hence her religious world view has a permanent bearing on the way she undertakes her work as a healer. There are certain food types that she is forbidden to eat, for instance, she cannot eat game meat, she is also prohibited from eating meat from any animal that has not been properly slaughtered and she cannot eat porridge prepared from sorghum. Furthermore, all her food must be prepared in an earthen clay pot i.e. no metal objects can be used in preparing her food. She is also expected to observe certain regulations, for example, she cannot enter the divining hut or handle any *hakata* [divining objects] during her menstrual period or soon after delivering a baby until such a time when she stops bleeding. She explained that these prohibitions should be observed because *vadzimu* [ancestral spirits] resent any interaction with blood since in Karanga tradition, blood is revered as sacred, therefore when a woman is menstruating or discharging blood soon after delivery, she is regarded as fragile and is not allowed to deal with any *hakata* or *mishonga* [medicines for healing ailments]. She also explained that there are times when she is required to abstain from conjugal relations with her husband, especially when she is preparing to travel to the mountains to collect some herbs and other essential plants needed for the healing ministry. There are certain periods of time when she constantly goes through *kusvikigwa/kusutswa* [being possessed by the healing/divining spirit]. It is during such times that she becomes very withdrawn and will spend most of her time in her divining hut having very limited interaction with other members of the family except her assistants who will be entering the hut and running some errands for her. She will only be focusing her time on attending to the clients who come for consultation and will not sleep in the same room with her husband.

Shingirirai⁵⁵³ is a fifty-eight year-old female traditional healer. During her early teens, she started experiencing some unusual heaviness on her shoulders and would often withdraw and spend time alone under the shade of a tree. Sometimes she would experience persistent hiccups, especially whenever she ate food with a lot of salt or a lot of cooking oil or any additives. These symptoms continued recurring and her concerned parents eventually decided

⁵⁵³ Interviewed 15 December 2007, Murinye, Masvingo.

to take her to the nearest *n'anga* to divine and ascertain the cause of all this. They suspected witchcraft and were hoping that the *n'anga* would be able to get rid of whatever witchcraft forces were causing their daughter so much misery. The moment they arrived at the local *n'anga's* homestead, the *n'anga* greeted Shingirirai with her *chidao* [praise names]⁵⁵⁴ and immediately informed her and her parents that she was not really suffering from any physical ailment nor had she been bewitched. Rather they were told that Shingirirai was being troubled by the spirit of her paternal great-grandfather who wanted the young girl to inherit his healing and divining work. The *n'anga* advised her to undergo the initiation ceremony as soon as possible because the spirit had been hovering around for many years and was getting impatient of the long wait; it needed to be 'accepted' and secure its *homwe* [dwelling place/medium] in the person of Shingirirai. The young girl could not stomach this revelation and as much as her parents tried to convince her to accept this call, she was just not ready. Eventually, she decided to elope with her childhood sweetheart in the hope that if she got married, her predicament would be resolved. However, things did not turn out as planned. No sooner had she settled with the love of her life did things start to go wrong. Whenever her spouse attempted being intimate with her, she would suddenly turn so violent such that she would start to physically attack him and sometimes her voice would change to a male voice. She would even sit up like a man and would tell the spouse to back off. This puzzled her spouse who then tried to establish the cause of such behaviour until they traced this back to the issue of her great grandfather's spirit which was still agitating to find a host in Shingirirai. After several meetings between her family and her spouses' family as well as making several consultations with some experienced *n'angas*, it was concluded that Shingirirai was destined to remain unmarried because the male spirit that had possessed her could not tolerate her being to another man. Shingirirai explained that initially this was a harsh reality to accept but gradually she came to terms with her calling and began to concentrate on the work that her great-grandfather had chosen her to perpetuate. Since then, she has committed her time and effort to this work and she feels that she offers an essential service to the community.

Mufudzi⁵⁵⁵ is a twenty seven year old male traditional healer. His academic qualification is 'O Level' and he also holds a Diploma in Accounting and a Certificate in Counselling. He

⁵⁵⁴ This is a sign of honor and respect, indicating that the *n'anga* was already treating Shingirirai with the respect that is accorded fellow *n'angas*.

⁵⁵⁵ Interviewed 16 December 2007, Murinye, Masvingo.

emphasized the fact that his work as a traditional healer is heavily embedded in his spirituality and in his relationship with *vadzimu* who act as intercessors between him and *Mwari* or *Musikavanhu*. As such, every aspect of his healing ministry is closely linked with his traditional religious beliefs and practices. His healing ministry started in 2002 when he was only eighteen years old. Mufudzi explained that from the time he was just about fifteen years old, he started to experience strange encounters whereby he would sometimes feel so overwhelmed by these sensations such that he would just withdraw from the rest of his family and friends as he felt as if he was being ‘pushed’ into spending time in solitude. It was during such times that he would also experience strange and confusing dreams and visions as he would envision himself going underneath a vast expanse of water and coming out with all sorts of medicinal herbs and roots. Such experiences worried him greatly and it took him sometime before he shared these dreams and visions with his parents. When his parents heard the news, they were deeply worried because they knew what this meant and being a Christian couple that lived and worked in an urban setting, they could not imagine their son forgoing their modern lifestyle and having to live a life of self-sacrifice as a traditional healer. As Christians belonging to the Methodist church, Mufudzi’s parents tried to persuade him to dedicate his life to being an active and prayerful Christian so that he could be cushioned from following the path of a traditional healer. However, Mufudzi was not very interested in Christianity and although he had grown up going to church with his parents, but he was basically a nominal Christian who never actively participated in any other activities that the other teenagers of his age were involved in at church.

Upon completion of his ‘O’ Level, Mufudzi’s parents encouraged him to pursue further studies which saw him attaining a Diploma in Accounting and a Certificate in Counselling. Although he was a very bright student who performed fairly well in all his studies, Mufudzi never found satisfaction in anything academic or professional because he was constantly preoccupied with the strange visions and dreams. It reached a climax in the year 2000, when together with his family they visited one of his father’s aunts who lived in their rural home. Upon their arrival, Mufudzi joined the other village boys who were going fishing and swimming at the local sacred pool which is known by the name *Chirozva* [one that swallows].⁵⁵⁶ No sooner had the boys settled by the side of the pool did they suddenly find

⁵⁵⁶ This is so because the pool is shrouded with mystery due to the fact that several people and animals have ‘gone missing’ in this pool and their remains have never been recovered. It is believed that there is a mermaid

themselves in the midst of a violent whirlwind and amidst this chaos, Mufudzi was suddenly pulled into the water by some unseen force and when the other boys regained composure to look into the water and see what was happening, they saw him being pulled by a *njuzu* [mermaid].⁵⁵⁷ It was then that after a lengthy search, deliberations and consultations that with a heavy heart, Mufudzi's family accepted the harsh reality that he had been 'taken' by the *njuzu* for training as a *n'anga*. They therefore performed the necessary rituals for his safe passage and return. Mufudzi highlighted the fact that he is not at liberty to disclose all the finer details about what transpired during the eighteen months that he spent underneath the pool. However, he reiterated the fact that when he finally came out, he had grown very long locks in his hair and had acquired the knowledge, skill and resources of practising as a traditional healer. Since then, he has never looked back and he has become a renowned traditional healer.

4.3.2 Understanding of *Utano* and Role in Preserving/Restoring *Utano*

Raramai's understanding of *utano* is as follows; *kugarisika mupfungwa* [peace of mind]; *kugarisana zvakanaka nehama neshamwari nezvese zvakakutenderedza* [enjoying right relationships with family, neighbours and all your surroundings]; *nyama dzemuviri dzakabatana uye pasina kugwadziwa kana kushushikana* [physical fitness, no body pains and no emotional stress or struggles]; *runyararo munyika* [general peace and tranquillity at a local and national level] and *kuwana chikafu chakaringana* [having adequate food/basic needs].

Vonai's understanding of *utano* is as follows: *Nyama dzemuviri dzakaringana/vurungana* [physical fitness]; *Kusafunganya nekushushikana* [free from worries and stresses]; *kuyanana nevadikanwi nevavakidzani* [peaceful co-existence with loved ones and all that surrounds you]; *kutarisira ramangwana rakajeka, rine punduso* [looking forward to a bright future, with promises of prosperity, peace and progress]; *kudya chikafu chakanaka uchiguta*

that captures 'potential candidates' to be trained as traditional healers and if their families fail to follow the proper procedural rituals to ensure their safety and subsequent return, then this person will perish and would never be seen alive again.

⁵⁵⁷ The Shona describe a *njuzu* as being half fish and half female, it is said that the upper part which is that of a female has an exceptionally beautiful face with unusually long and straight hair reaching the back. The other half has a long fish-like tail. It is believed that the *njuzu* lives underneath the deep waters and has extensive knowledge of healing such that one who would have been taken under its tutelage will come out as an extraordinarily gifted *n'anga*.

[eating well]; *kuwana zororo rakakwana* [resting well] *uye uchivata pakanaka uchirota hope dzakanaka* [and having safe, comfortable and secure accommodation and sleeping well].

Nyaradzai understands *utano* as follows: “*Ganda rakatsetseka, risina mapundu kana mavanga* [Smooth skin, no rash, and no scars]; *Muviri wakagwinya* [physical fitness]; *Kusakosora-kosora* [no recurrent coughing]; *bvudzi rakasvika kwete kutanhauka* [healthy looking hair and not weak and frail]. It also has to do with *ugaro hwakanaka* [stable and comfortable living conditions], *kuve nechekudya chakaringana chinovaka muviri* [having adequate food and maintaining a healthy and balanced diet]. It also has to do with maintaining peaceful and meaningful relations with family, friends and neighbours.”

Shingirirai understanding of *utano* is as follows, “*Muviri wakatsvinda uye wakasimba* [physical fitness and neatness]; *ganda rakaurungana kwete kukwenya-kwenya nguva dzose* [healthy and smooth skin and not to be always scratching]; *munhu ane zvinhu zvake kusanganisa pfuma yezvipfuo, jega uye dura rechikafu* [having adequate resources such as livestock, a plough and enough stock of grain]; *kuve nesimba rekuzvishandira* [having enough strength to work for yourself and be self-sustaining]; *kuva nemusha wakataridzika uye wakashambidzika* [having a well-built, secure and neat homestead] *uye kugarisana zvakanaka nevamwe munharaunda* [enjoying peaceful and amicable relations with those who surround you]. ”

Mufudzi understanding of *utano* is as follows: “*Muviri wakasimba usina zvirwere kana utachiona* [physical fitness without any ailments]; *Kuva nepfungwa dzakagadzikana nguva dzose* [having peace of mind at all times]; *Kugara zvakanaka* [living comfortably and enjoying meaningful relationships]; *Kugara wakashambidzika uye kudya uchiguta* [being clean and neat on your body and in your surroundings and having adequate food].”

4.3.3 Common Factors Diminishing or Threatening *Utano* among the Karanga

Having identified witchcraft as a factor impacting negatively on people’s general welfare and well-being, Vonai also pointed out the issue of *nzara* [food insecurity/drought]; *kushaya mvura yakanaka yekumwa* [unclean water sources]; *zvipfuwo zvinoshaya mafuro akakwana*

[limited grazing land for livestock]; *misha yaparara nechirwere cheshuramatongo*⁵⁵⁸ [families are breaking down due to the HIV epidemic]; *vana vanyamunhu vopandukirana* [general discord/discontent, kith/kin turning against each other]; *kurasha tsika dzechivanhu chedu* [general collapse of social and cultural values, particularly moral values]. According to Vonai, a combination of all these negative forces impinges on Karanga people's health and well-being, leaving them susceptible to all manner of illnesses and uneasiness.

According to Nyaradzai, the key factors influencing Karanga people's health negatively include the constant fear and threat of witchcraft; food insecurity; poverty and an insecure socio-political environment. Nyaradzai explained that the Karanga people suffered terribly during the Chimurenga war for independence such that the constant threat of an outbreak of war due to the rival political parties in Zimbabwe makes people to feel very insecure and uncertain of the future. She argued that this sense of instability robs them of their peace of mind and impacts negatively on their well-being. She also mentioned the ill-behaviour of the younger generation, most of whom are unemployed and out of frustration and desperation, they resort to stealing other people's possessions. Nyaradzai explained that this tendency of stealing from others, especially the elderly who are mostly all alone in the village after all their children have left home to seek for greener pastures out of the country, also impacts negatively on their well-being because they live in constant fear of being attacked and robbed. She expounded that these are fears and feelings that used to be common in the urban setting and were unheard of in the rural community which were once peaceful and very secure.

The major challenges that Shingirirai identified in undertaking her healing work include the prevalence of HIV and AIDS in the community; lack of proper equipment to handle terminal patients and limited food supplies to cater for patients who sometimes lodge with her. She also mentioned the challenge of having some people who come requesting malicious charms to inflict harm on others. For instance, she explained that some people are so blunt such that they will come to request if she can supply them with *muchetura* [poison] to kill someone or *muposo* [a harmful charm causing paralysis] or *mushonga wemunyama* [a harmful charm to

⁵⁵⁸ *Chirwere cheshuramatongo* is a Shona term, euphemism for the term HIV and AIDS epidemic. See also Shoko, T. (2007) *Karanga Indigenous Religion in Zimbabwe* and Chauke E. and Mashiri, P., Mawomo, K. and Tom, P. 2002. "Naming the Pandemic: Semantic and Ethical Foundations of HIV/AIDS Shona Vocabulary." *Zambezia*. 29 (ii), 229.

inflict misfortune] on other people. She explained that what is most worrisome is that sometimes people who request for such harmful objects will be intending to cause such harm on their immediate family members such as siblings turning against each other to the extent that they wish the other one dead. Shingirirai said that in such cases, she will try to counsel the one seeking for such harmful charms and explain to them that she does not deal with any harmful objects and also to try and discourage them from pursuing such vendettas. She however indicated that her major worry remains the fact that probably such culprits will not give up on their search and they might end up securing such malicious charms from other dubious sources. It therefore remains a burden in her mind, wishing she could warn some of the intended victims, particularly, if its people that she knows personally. She explained that sometimes she will find means of subtly alerting the intended victims without disclosing all the details, sometimes she will just warn them that she saw in a vision that someone is planning to harm them, but then again, that much depends on how they take it because there are some people who are so dismissive and would not want to listen to anything said by a *n'anga*, let alone, take it seriously. She also said that such attitudes are due to the fact that there are too many dubious and false *n'angas* who go around divining lies to people just so that they can attract people's attention and be paid for telling them what they wish to hear. More so, she intoned that there are some *n'angas* that are notorious for causing people some misfortune or inflicting them with illnesses so that the afflicted people may come to consult them and pay for such services.

On the challenge of HIV and AIDS in the community, she highlighted the fact that there are so many people especially the younger generation who leave their rural home to go either to the urban areas or out of the country to seek for greener pastures and when they return gravely sick with HIV or AIDS related ailments, they start to accuse some elders in the community of having bewitched them. She explained that there are several cases whereby a terminally ill patient will come to her and request to be cleansed of the works of witchcraft perpetrated upon them and they wrongfully accuse other members of the community when in actual fact, they are in denial of their HIV status. Shingirirai intoned that such denials are retrogressive and will jeopardise the chances of such patients getting any effective treatment for their condition.

As regards the major challenges encountered in undertaking his healing ministry, Mufudzi highlighted the need for more stable and secure accommodation for the patients. He explained that during the first few years, he was operating from a relative's household and found it very challenging to accommodate as many clients as was required since there was very limited space. However, at the time of the interview, he mentioned that he had been allocated his own piece of land by the village headman and was in the process of putting up structures that were necessary for accommodating the clients. The process was taking longer than he had anticipated because at that time, building materials were very expensive in Zimbabwe since they were in short supply and therefore the affordability of the essential building materials was a major hurdle for him. The other major challenge that he pointed out was the failure of people to observe the treatment procedures as instructed. He mentioned that at times people come to consult him just to 'test' him so as to establish whether he really knows what he is doing and when he diagnoses their problem and prescribes the necessary treatment, they still do not take him seriously and will not follow his instructions. The prevalence of the HIV and AIDS epidemic in the country was another key problem that he pointed out. He mentioned that at times people are so ignorant of the signs and symptoms of HIV infection such that when they come to consult him, they will be usually suspecting witchcraft. Mufudzi explained that it is in such cases when he utilises his knowledge and skills of counselling to try and enlighten the clients about the importance of testing for HIV. He said that after counselling them and encouraging them to go for HIV testing, he will offer them whatever relevant traditional medicine he has at his disposal to alleviate their suffering and will also instruct them to return to him for further assistance after undertaking the HIV test. He also highlighted the fact that there are several cases when HIV positive clients come to him going through a phase of denial and when they come to him, they will be hoping to get a different reason to explain why they are not feeling well. In such cases, Mufudzi explained that he also takes time to offer such clients some advice and counsel them to accept their status. If such clients are on ARVs, he said that he will encourage them to adhere to their treatment regimes and not to discard their ARVs due to the fact that they have received traditional medicine. He indicated that he has several useful traditional herbs that can treat HIV related illnesses such as diarrhoea, skin infections and mouth ulcers. However, he reiterated the fact that although he can treat such ailments, people should not be misled into discontinuing their ARVs in the hope that they have been completely healed.

4.3.4 Karanga People's Multiple Health-Seeking Strategies

Raramai's views regarding the issue of patients utilising the three health-care systems is that each of the three has its own relevance and speciality. He acknowledged that it's not all the conditions/ailments that he can adequately attend to and therefore, whenever the need arises for some complex medical conditions to be referred to the clinic or hospital, he will certainly do that. He has utilised the clinic mainly on behalf of his wives or children but if he has to take medication from the clinic or hospital, he would first have to go through a cleansing ritual before resuming his traditional healing roles because he would have delved into something out of line with his traditional system. However, he also reiterated that there are several minor illnesses that can be easily rectified with natural herbs without taking the trouble to travel to the clinic which is far away from his homestead and is usually out of medical supplies. He also mentioned that some people prefer to make use of the services of a prophet-healer because of their religious affiliations and also that some people usually mix the three systems although in many cases, Christians would consult him in private, for fear of being reprimanded by their fellow believers. Some Christians travel long distances further away from where they are known so that they can consult the traditional healer far from the prying eyes of fellow believers. According to Raramai, although there is no clear coordination between the three health-care systems, they are aware of each other's existence and will informally refer patients to each other.

Vonai's views regarding the patients' use of the three health-care systems is that practitioners need to be realistic and admit when they cannot adequately address some of the conditions presented by patients. She mentioned that even though she has knowledge of traditional midwifery, there are some patients that she advises to go for hospital deliveries because her divining spirit would have discerned that there would be major complications that she cannot handle. She acknowledged that she enjoys an amicable working relationship with the local clinic which sometimes supplies her with protective gloves and plastic to use during deliveries and that the nurses often advise her on how to take precautions when handling blood especially in view of the HIV and AIDS epidemic. She also explained that although there is not always a clear-cut working relationship between traditional healers and prophet-healers, probably because of competition for clients, they are aware of each other's existence and have great respect for each other's work. Vonai also noted that most people now prefer to

consult the prophet-healers rather than traditional healers because most prophet-healers offer their services for free in contrast with traditional healers who usually eke a living out of their trade. She is also of the opinion that each of the three systems has their area of specialisation and wishes if such areas of speciality could be ‘tapped’ into by the other health-care systems so that they can work together towards a more clearly integrated system of providing holistic care to the community.

As regards the issue of what influences Karanga people’s health-seeking behaviour, Nyaradzai reiterated that mostly, people’s choices are influenced by the nature of the ailment as well as the availability and accessibility of the nearest practitioner. She stated that if the patient shows signs of having been attacked by *mamhepo/mweya yetsvina* [evil/malicious spirits], the obvious choice would be either *n’anga* or *muprofita* depending on which one is nearest or which one conforms to the family’s religious convictions. However, she also mentioned that if it is a complicated physical ailment such as a fractured limb or if someone has passed out in a coma, then the patient should be rushed right away to the nearest bio-medical practitioner.

Nyaradzai intoned that she does not have any misgivings regarding people’s interchangeable use of the three health-care systems; actually she indicated that this was the norm in her community. Her major concern rather, is the fact that there are times when people insist on keeping a patient in the hospital when it is so apparent that the patient is suffering from spiritually related ailments. She explained that this is detrimental to people’s recovery; for instance, if a person has been attacked by *zvidhoma* (witchcraft familiars) and they start hallucinating, it will be pointless to put them under the care of bio-medical practitioners because these will not be able to address the root causes of the problem in its entirety. She also argued that the same case should apply to the use of traditional healers or prophet healers, elucidating that these healers should not mislead clients by claiming that they are able to cure all diseases because there are some chronic cases such as diabetes and asthma which are best addressed by a bio-medical practitioner. Nyaradzai highlighted that there is an amicable working relationship between her and the staff of the two local clinics. She mentioned that she has often been invited by the nursing staff to attend courses on basic hygienic care for terminal patients and has been enlightened on the proper use of items such as scissors and razor blades and wearing gloves when treating patients so as to guard against

passing viruses and infections from one patient to the other. She indicated that these courses have been very enlightening and very useful to her healing ministry. She also mentioned that on several occasions, they have informally referred patients to each other. However, she indicated that there is no clear-cut working relationship between traditional healers and prophet healers, stating that there are instances when there is animosity between the two, especially because some prophets look down upon traditional healers as backward, heathen and disregard any of their services. She also acknowledged that some prophet healers share mutual respect with traditional healers and would even refer some patients to them, for instance, if a patient is troubled by an ancestral spirit which wishes to find a host in them. The prophet healers are only capable of exorcising the spirit, but in the event that the patient wishes to accommodate and welcome the spirit, they would refer such a patient to the traditional healer who will then assist the patient to go through the necessary procedure.

Asked about the key factors influencing Karanga people's choice of a health-care provider in the event of illness, Shingirirai said that this is usually dependent upon the nature of the ailment and also the family's religious convictions. She said that for her family, if it is an ordinary ailment which can be treated by locally available herbs, she usually administers herbs to them. However, if it keeps getting worse and they fail to respond to the herbs, then she will advise them to visit the local hospital. She further explained that if it is any condition related to *mhepo dzepasi* (malicious nature spirits), then she will focus on exorcising such spirits and relieving the patient of the negative spiritual attacks. If such a condition persists, she said that she would refer the patient to other renowned traditional healers. Shingirirai explained that she does not see any problem with patients utilising all the three health-care systems. Her standpoint is that each of the systems has their specialities and patients should use their discernment to decide which system will be most suitable for a particular condition. Shingirirai reiterated that all the three systems should do their best to maintain and restore people's health and well-being. She bemoaned the antagonism that sometimes pertains among the practitioners of the three systems and intoned that there is a need for more centralised coordination and integration of the three systems rather than continue to operate with some air of suspicion and prejudice against each other.

Mufudzi's response to the question on what factors influence Karanga people's health-seeking behaviour was that usually, this is determined by people's cultural and religious

standpoints. He highlighted the fact that there are some families that strictly believe in the use of clinics or hospitals only. Hence even if it might be a condition which cannot be properly treated through medical science, such people will not shift from their stance. On the other hand, he noted that there are some families that mix the services of the three health-care systems. For him, all the three health-care systems can be used concurrently because he believes that “all healing comes from *Mwari*, the creator, the giver and taker of life”. He feels that it is unfortunate that there are people who look down upon traditional healers and prophet-healers and that such attitude sometimes deny patients the opportunity to utilise such services when it is possible that their healing might come from there. He argued that there are some conditions that are best addressed by either *muporofita* or *n’anga*, for instance *runyoka* [this is a complicated condition whereby a person suddenly starts to have their stomach swelling as a punishment for breaking a taboo such as engaging in sex with a man or woman whose spouse has just died and has not yet gone through the necessary cleansing ritual]. Mufudzi explained how such a condition would actually get worse if a patient is taken to the clinic or hospital because it can only be rectified by performing the necessary rituals to release them from the curse. He also mentioned that sicknesses that are related to being called to the healing ministry as *muporofita* or *n’anga* also require the services of people who are familiar with such calling procedures, otherwise medical science will only worsen the situation. However, he acknowledged that several physical ailments such as cholera, asthma, tuberculosis and other cases that require sophisticated surgical procedures should be taken to the clinic or hospital. Mufudzi indicated that although there might not be a clearly laid out and coordinated working relationship between the three health-care systems, he feels that there is mutual respect shared among the different health practitioners. He also suggested the need for considering the use of other well known and effective traditional remedies in clinics especially in view of the perennial shortage of drugs in the Zimbabwean public health-care system.

Having interacted with traditional healers in this section, the following section focuses on representatives of Western bio-medicine.

4.4 Western Bio-medicine

The previous sections have highlighted responses from prophet healers and traditional healers. In this section, I dwell on the responses of study participants representing the

Western bio-medical system. I retain the same approach of summarising their key reactions to topical themes and present their responses in a representative capacity.

4.4.1 Educational Background and Calling of Practitioners of Western Bio-medicine

Moline⁵⁵⁹ is a female nurse aged forty-four and is a Christian belonging to the African Apostolic Church. She holds the following qualifications: State Registered Nurse, State Certified Maternity Nurse, and Operating Theatre Nurse. At the time of the interview, Moline was enrolled in the undergraduate programme studying towards a Bachelor of Nursing Science with the Zimbabwe Open University.

Monica⁵⁶⁰ is a thirty-five year-old female State Certified Nurse working at Mashenjere Clinic. The clinic was established in 1954 and it is owned by Masvingo rural district council. She is a Christian who belongs to the Roman Catholic Church. Monica explained that her motivation and interest to join the medical field was ignited by her mother who served as a Community Health Worker (CHW), commonly known as Mbuya *Utsanana*⁵⁶¹ in the early 80s when Monica was still very young. She described how excited and fascinated she was whenever she saw her mum smartly dressed in her CHW uniform and would be riding the bicycle distributing medication and disseminating information on nutrition, sanitation and preventive health throughout the surrounding villages. It was from this early age that Monica committed herself to working hard at school so as to attain good grades that would enable her to secure entry into the School of Nursing. Upon completion of her 'O Levels' in 1990, Monica enrolled as a nurse aide at Masvingo General Hospital. She served as a nurse aide until 1994 when she finally secured the long awaited opportunity at Parirenyatwa School of Nursing, where she graduated with the qualification of a State Certified Nurse. Monica had been working at Mashenjere clinic since 2003. Her role as a nurse in the clinic is to attend to patients who present with various ailments, flu, headache, stomach-ache and malaria. As a Christian, Monica considers her role in the health-care profession as being influenced by the Christian central message of healing and restoring humanity's wholeness and well-being. She considers herself as God's instrument in ministering to the sick.

⁵⁵⁹ Interviewed 5 December 2006, Shonganiso Clinic, Murinye, Masvingo.

⁵⁶⁰ Interviewed 7 December 2006, Mashenjere Clinic, Murinye, Masvingo.

⁵⁶¹ The CHWs were instituted by the Ministry of Health during the first decade of independence in Zimbabwe and played a fundamental role in general community health awareness especially in terms of sanitation and nutrition as well as educating communities about Family Planning and distributing Contraceptives in the community. Reference to the CHWs is also made in chapters two and five.

Violet⁵⁶² is a female aged twenty- eight and is employed at Mashenjere clinic as a nurse-aide. She is a Christian belonging to the Seventh Day Adventist (SDA) Church. Her academic qualification is ‘O’ Level. According to Violet, her Christian religion has a great influence on her role as a nurse aide. Her upbringing in the SDA Church and in an SDA family inculcated an interest in taking up a career in care-work. She explained that the teachings and writings of Ellen G. White on Christ’s healing ministry that she received from an early stage in life motivated her to devote her life towards care-giving. Violet’s main role in the clinic is to assist the nurses in various tasks such as dressing the patients’ wounds, dispensing medication prescribed by the nurses and in some instances when the clinic is under-staffed, she assists with prescribing as well as administering medication. She also offers educational awareness campaigns on hygiene and nutrition especially to nursing mothers when they bring their children for regular check-ups and immunisation, an exercise commonly known as ‘baby-clinic.’

Patricia⁵⁶³ is a forty year-old female nurse working at Shonganiso clinic. She is a member of the African Apostolic Church of Zimbabwe, which is also known as Chibarigwe. Her academic qualification is Ordinary Level and her professional qualification is that of a State Certified Nurse. She is the Sister-in-charge at this clinic that means she oversees all the activities at this station, including the duties and responsibilities for other members of staff and the treatment of patients. Patricia explained that her religious grounding has a fundamental influence on her work as a nurse. She considers her care-work as a Christian duty and calling, and the act of relieving pain and suffering on fellow human beings gives her a sense of satisfaction. The clinic was established in 1980; its establishment was spear-headed by the late Reverend J.M. Zvobgo who is also the founder of the African Apostolic Church of Zimbabwe (Chibarigwe). Since the clinic is run by a Christian denomination, the work ethic for staff is also greatly influenced by Christian principles of love, hospitality and tender care for the sick.

Richard⁵⁶⁴ is a thirty-five year-old male nurse working at Shonganiso clinic. He is a member of the African Apostolic Church of Zimbabwe (Chibarigwe). His academic qualification is

⁵⁶² Interviewed 8 December 2006, Mashenjere Clinic, Murinye, Masvingo.

⁵⁶³ Interviewed 9 December 2006, Shonganiso Clinic, Murinye, Masvingo.

⁵⁶⁴ Interviewed 9 December 2006, Shonganiso Clinic, Murinye, Masvingo.

Ordinary Level and he holds a Nursing Diploma from United Bulawayo Hospitals (UBH). Richard serves as an assistant to the nurse in charge and is responsible for attending to patients and administering medication. He is also responsible for travelling regularly between the clinic and the suppliers of essential drugs and utensils in Masvingo town where he collects orders for the clinic. Richard explained that although working in the care-giving industry is a professional duty for him, he also regards it as some kind of a Christian ministry. He highlighted that he draws a sense of fulfilment from serving his community through his professional responsibility.

Shonganiso clinic services a population of approximately fourteen thousand patients (14 000) and the total number of patients attended to daily is approximately one hundred (100). The furthest distance that patients travel in order to access the clinic is approximately twenty-five (25) kilometres. The staff complement at this clinic consists of three nurses, two nurse aides, one general worker and two security guards. The common ailments that patients usually present with include malaria, flu, headache, stomach ache, diarrhoea, measles, acute respiratory infections and fever.

4.4.2 Understanding of *Utano*

Monica's understanding of *utano* is as follows: "it is the well-being of a person physically and mentally, i.e. one should not be suffering from any bodily ailments and one should be enjoying complete peace of mind, without any stress or worry about their socio-economic needs."

Violet's understanding of *utano* is as follows: "It is the well-being of a person physically, mentally and emotionally. It is being at peace with one's surroundings, living in a clean and peaceful environment, maintaining good relations with family, friends and neighbours. It also incurs being content with one's circumstances such as having the assurance that there is enough food for the household, having one's livestock and crop produce flourishing."

Patricia understands *utano* in the following words: "for a person to be described as *mutano* [being healthy], they have to be in a state of well-being physically, mentally and emotionally. There is need for an equal balance in all these sectors of one's existence; an attack on one of

the three causes disequilibrium in one's well-being and impacts negatively on their *utano*. Hence, one should endeavour to maintain a reasonable balance on all spheres of their existence to ensure some stability in their *utano*.”

Moline's understanding of *utano* is as follows: “for a person to be regarded as *mutano*, this has to encompass health and well-being physically, mentally and spiritually. Physically, one should be free from any ailments or pains. Mentally, one should not be battling with any psychological problems. Spiritually, your soul is whole and you are at peace with all your surroundings.”

Richard understands the term *utano* as follows: “It is a state of wellness, when one enjoys good physical health, having the assurance of peaceful and meaningful relations, enjoying abundant harvests and having enough fodder for your livestock, and above all having somewhere comfortable to live. Any lack in one of these diminishes one's standard of *utano*.”

4.4.3 Role in Preserving/Restoring *Utano*: Major Challenges Encountered by Western Bio-Medical Practitioners

Morgenster hospital is the major provincial referral centre and attends to all referral cases from all over the province. Moline is the matron of the maternity ward in the hospital. She monitors all the main activities in the maternity ward and is responsible for all the critical cases related to pregnant mothers during delivery in the ward. She attends to most of the complications related to maternity deliveries and will only solicit the services of a medical doctor in the event of major complications usually those cases requiring a caesarean section. In all her work, Moline's spirituality spurs her on, especially in view of the numerous challenges encountered in their service delivery. The hospital has suffered massive brain drain, severe shortages in resources and equipment and all this impacts negatively on their work load and service delivery. Shortages of essential drugs, staff and equipment sometimes makes the work practically impossible to be accomplished. Moline expressed how frustrating it has been to sometimes helplessly watch expectant mothers lose their lives simply because there were no qualified medical personnel present to undertake a caesarean operation. This sort of crisis usually occurs during weekends; the doctors are only available during the course of the week therefore if need arises for an emergency caesarean section, it would have to wait

till the weekend is over. These are very trying times for Moline and in most cases she can only hope, trust and pray for and with the patient that they can endure till such a time when they can be operated on. However, it is not all the patients who make it through the weekend, and some have died in the process.⁵⁶⁵

Moline appreciates and is grateful for various donor organisations who have been supplying the hospital with much required resources to keep it going but she highlighted the need for improved salaries and conditions of service for medical personnel so that the hospital can retain and attract qualified and experienced personnel. She also expressed the need for the government to increase subsidies for church-related medical centres in order to improve their quality of service. She explained how the hospital has struggled to provide patients with balanced and nutritious meals especially in times when the province is food insecure and the country's economy is down on its knees with runaway inflation. In times like these, government subsidies would really come in handy. Moline also identified the issue of distance as a major challenge for many patients. Since this is a provincial referral centre, some patients have to travel for hundreds of kilometres to access the service. This is a challenge for those who have limited financial resources because securing transport money is an uphill task and in most cases, the first time pregnant mothers who would have been referred to the hospital will need to be accompanied by another female relative who has to care for them during their waiting period. This means that they have to secure transport money for the accompanying relative also. More so, this accompanying relative would have to camp outside the hospital in what is commonly known as *matumba*,⁵⁶⁶ literally temporary shelter, and they have to cater for their own food. Coming from an already food insecure and financially struggling background, this becomes really problematic. Worse still, many of the accompanying relatives camping in these temporary shelters go through immense pressure because there will be others who have better resources and they will be preparing all sorts of special meals, showing off to those who have less.

⁵⁶⁵ For more information regarding the challenges of accessing healthcare in Zimbabwe, see Chirongoma S. 2006 "Women's and Children's Rights in the time of HIV and AIDS in Zimbabwe: An Analysis of Gender Inequalities and its impact on people's health" in *Journal of Theology for Southern Africa* Volume 2 No.126, November (2006), 48-65.

⁵⁶⁶ Hansson G. (1996) *Mwana ndiMai*: 166-168 discusses this practice also common in Mberengwa district. The term *Machacha* is used to refer to these temporary shelters in Mberengwa.

In view of these numerous challenges, Moline suggested that if there could be an adequate and more experienced staff complement, it would be better to have some of the hospital staff occasionally visiting the district clinics to offer a mobile service regularly. This would reduce the pressure on many patients who will not have to struggle with transport costs and other added expenses to cater for accompanying relatives. She also suggested that with time, it would be of great help if some of the district clinics were upgraded to enable them to house a medical doctor and be equipped with some equipment to undertake procedures such as tooth extraction, care for fractured patients and with time even having caesarean sections. However, Moline acknowledges that all this can only be possible if there are adequate resources, qualified and experienced personnel, all of which were severely lacking at the moment.

According to Monica, the total population that is serviced by Mashenjere Clinic is approximately fourteen thousand (14 000) people. The furthest distance that patients travel from in order to access the clinic is about eighteen (18) kilometres. There are eight people employed at the clinic; three nurses, one nurse-aide, one maintenance worker, two security guards and one extension health technician. The total number of patients who visit the clinic daily is approximately sixty people and they are generally afflicted by common ailments but their biggest challenge at this health facility is malaria and diarrhoea. Patients who present with malaria attacks pose a real predicament to the staff because they do not always have the required medication to relieve patients from this disease. The other major challenges encountered at this clinic include lack of adequate medication, broken down equipment and non-existence of in-patient services. Monica reiterated the need for a facility whereby patients can be admitted if need be. She highlighted that on several occasions, patients are brought to the clinic in a critical condition that would need constant monitoring and supervision from qualified medical personnel but due to the fact that the clinic only offers out-patient services, they are not in a position to admit such patients. This is particularly critical in view of maternity patients; some pregnant women will be needing urgent caesarean section or to be induced for labour but because the clinic does not have qualified personnel nor relevant equipment to offer such services, they are often forced to refer such patients to the nearest referral provincial hospitals, Morgenster Mission Hospital or Masvingo General Hospital, which are far away (70km and 80km respectively). There is no regular public transport plying the route to the two referral hospitals. All the transport leaves early in the

morning going in the direction of these two hospitals and if a patient falls ill during the day or in the afternoon, it becomes problematic to reach the hospital as soon as possible unless they hire a car, which is very expensive and cannot be afforded by the majority of the rural population. As a result, some patients end up suffering unnecessarily for many hours and others die prematurely, since in many instances they have to wait until the following morning when they can get onto the next bus. The same challenge pertains to HIV positive patients; they have to regularly travel to the referral hospitals to replenish supplies of their medication. Some people cannot afford transport costs and they end up defaulting on their treatment.

As regards the way forward in addressing these challenges, Monica suggested the need to have an ambulance on stand-by such that whenever there is an urgent need to transfer a patient, the ambulance can ferry the patient within the shortest time possible. She also suggested that some donor organisations should be approached to solicit for funds to repair or replace broken down equipment and also to donate essential drugs needed for the patients' daily needs. Monica also reiterated the need for construction of an in-patient ward since the need for admitting patients arises in several instances. She also explained that in times of drought and food shortages, patients present with symptoms of malnutrition and suggested the need for donor organisations to offer feeding schemes for needy families, especially children in primary school and also nursing mothers.

Violet highlighted the shortage of resources as a key challenge that they encounter in their care-giving work. She mentioned that since the year 2000 when the socio-economic situation took a downward turn, on several occasions they have run out of essential medical supplies. The unavailability of qualified personnel is another major challenge. She explained that usually, the newly qualified nurses are deployed to the clinic but these have been coming and going as soon as they complete the stipulated term of office as required by the Medical Council of Zimbabwe. As a result, there have been episodes when the clinic has had to rely on skeleton staff. She highlighted that all these challenges are intensified by the many number of HIV positive patients who constantly come to be treated for HIV related symptoms.

As regards the suggestions on how to rectify such challenges, Violet was quick to mention that the shortage of essential medical supplies could be resolved through the concerted efforts of the local community and the Ministry of Health and Child Welfare in soliciting donor organisations to donate the essential medical supplies and also to put in place a system whereby there is transparency and accountability in distributing and utilising the donated supplies so as to gain the trust of the donor community and ensure constant supply of the required resources. She also noted that the main reason that discourages most qualified personnel from settling in at this clinic is the very low standard of living offered at the clinic. Violet explained that the accommodation offered at the clinic is not up to standard, nurses with families have to share houses and this infringes on their privacy. She suggested that the council should construct decent accommodation for the nurses to ensure that they may live comfortably. She also mentioned that although the nurses working in the rural areas receive an allowance to compensate for the not-so-comfortable circumstances they live and work under, this amount is very little and she suggested that if the amount could be increased to a substantial figure, probably this could attract other qualified personnel to settle in the rural areas.

The major challenges that Patricia identified as an impediment to their care-giving work at Shonganiso clinic include shortage of staff, lack of resources such as essential drugs and relevant equipment, particularly their inability to offer services for HIV Testing and Counselling in an era of a national outbreak of the HIV epidemic. She explained that many times they identify a need for their patients to be tested for HIV; however, because they do not have qualified personnel and relevant equipment to offer HIV Testing and Counselling at the clinic, they are forced to refer their patients to the nearest referral centres, Morgenster Mission Hospital or Masvingo General Hospital which are far away (65km and 75km respectively). She identified this as presenting a major predicament to their work because in many cases, the patients cannot afford transportation fees to travel to these referral centres and sometimes even when the patients scrounge around for transportation fees to go for testing and in the event that they test positive for HIV, it becomes financially and physically strenuous for patients to travel on a monthly basis to replenish their supplies for ARVs and other relevant check-ups. She further explained that these two referral centres are also reeling with large numbers of patients requiring HIV Testing and Counselling as well as ARVs, such that there is massive backlog in rolling out ARVs to those in urgent need of the drugs.

Patricia highlighted that the HIV epidemic is presenting a huge challenge in their work because in many cases, the patients who come to consult will be presenting with HIV related symptoms and it becomes very problematic because some of these patients are defaulting on their ART. According to Patricia, there is a huge communication deficit between the local clinics and the two referral centres such that it jeopardises their chances of providing services to patients who would have been to the provincial hospitals. She acknowledged that staff in these referral centres are also under severe pressure with their heavy workloads such that they cannot afford time to give the relevant feedback on the patients' progress to the clinics that would have referred them.

Patricia suggested several solutions to the challenges that she noted above. As regards the lack of equipment and personnel for HIV Testing and Counselling, she suggested that there is an urgent need for the Ministry of Health and Child Welfare to partner with donor agencies that are working on HIV Testing and Counselling such that they can set up centres at various local clinics to offer such services and also to employ experienced personnel who will focus on the HIV epidemic. She went on to argue that there cannot be effective progress in efforts to turn the tide of the HIV epidemic in rural areas if centres for HIV Testing and Counselling and ART centres remain to be concentrated in the urban areas which are largely inaccessible to the majority of the rural poor. She also noted the need for a regular and consistent supply of all the essential drugs for treating common ailments to enable an effective and smooth-running clinic. In addition, Patricia highlighted the need for constantly replenishing staff at both local clinics and referral centres because shortage of staff impacts negatively on service delivery. For her, the key in retaining and attracting staff members lies in the conditions of service. She explained that as long as the conditions of service are poor and unattractive, then both local clinics and referral centres will continue to offer poor service to their patients because the few staff compliment that will be available would not cope with the amount of work expected to be accomplished by one individual.

The major challenges that Richard identified as infringing on their work at this station include lack of resources, erratic supplies of essential equipment, utensils and drugs and seasonal blockage of the road which is the only route to the nearest provincial hospital. Richard explained that although the clinic is well placed, being located along the road that leads to the nearest referral centre as well as the nearest town, in times of heavy rains, the nearby

Mutirikwi River which flows across the road leading to Morgenster Mission Hospital (it is the same road that proceeds to Masvingo General Hospital) sometimes gets flooded, making it impossible for any movement across the river. This is because the bridge that was constructed across that river is very low and narrow such that whenever there is a downpour of rain, the bridge gets over flooded and in many instances, it is completely swept off, leaving patients who stay across the river cut off and stranded, with no means of crossing over to access the clinic. This inaccessibility also impacts heavily on members of staff because it becomes very difficult to access transport to source for essential supplies.

Richard suggested that the first major solution to the issue of inaccessibility to the clinic caused by over-flooding would be the construction of a much higher and wider bridge linking the clinic with Mutirikwi River. Such a bridge should be erected using durable and effective building material, and not continue to use materials of low quality which is easily swept off whenever heavy rains occur. He also highlighted the need for constructing a tarred road along the route that links the clinic with the main referral centres because the road is muddy and slippery in times of heavy rains, making it very dangerous and sometimes impossible to ferry patients who will be critically ill. He also suggested that people who live along Mutirikwi River should be properly educated about the dangers and side-effects of stream-bank cultivation because this prevalent practise is impacting heavily on the bridge and the drainage system which is already of low standard.

4.4.4 Karanga People's Multiple Health-Seeking Strategies

Although Moline is a Christian, a trained and practising western bio-medical health practitioner, she also revealed that she had solicited the services of a traditional healer (*n'anga*) for about four years (2000-2004). Moline described how she suspected that her teenage daughter Rumbidzai was being attacked by witchcraft in the following words: “*mwana aiita seane mamhepo, achida kubuda panze usiku*; [the child was behaving as if haunted by evil spirits and was hallucinating and sleep-walking].” Her daughter's behaviour made her suspect that the condition was related to attacks from evil spirits because sometimes she would start screaming around 11pm at night and would be rushing to get out of the house. Fortunately, because the doors were securely locked, they would manage to restrain her and by the time she came to her senses, Rumbidzai seemed to be totally unaware of what was happening around her. They then took her to the traditional healer who administered some

medicine in the form of *mvura yekufuka*, [water that she had to inhale whilst covered with a blanket]. This process continued for four years until eventually one night Rumbidzai dreamt of a prophet-healer of the African Apostolic Church, Ernest Paul Mwazha, instructing her to kneel down so that he could pray for her. She knelt down in the dream and Mwazha questioned her, *Unorwara ka iwe?* [You are ill, isn't it?] To which Rumbidzai answered 'yes' and then Mwazha prayed for her healing in the dream. The following morning, Rumbidzai related her dream to her mother and when her mother asked her if she believed she was healed, she answered 'yes'. Since then, Rumbidzai never suffered from the past attacks and hallucinations. This experience that Rumbidzai went through convinced Moline and her whole family to join the African Apostolic Church, to which they have become active members.

Moline explained that for her and her family, they visit the prophet-healer within their African Apostolic Church occasionally whenever they go to church for worship so that they can be prayed for and be protected from any impending dangers, be it spiritual, emotional or physical. The prophet-healer prays for them in the name of Jesus, with laying on of hands and giving them Holy water to drink or to take home to either sprinkle in the house/around the homestead or mix it with their household meals or sometimes mix it with their bath water.

For Moline, whenever illness strikes in her family, she turns to the *muporofita* first. This is because she believes that whatever form of healing one might receive, it comes from God, who dispenses it through the prophet-healer. Therefore, Moline and her family will consult the *muporofita* first and after having been prayed for, if need be, then they will go to the clinic later. In Moline's view, the three health-care systems are usually utilised concurrently by the health seekers, depending on the nature of ailment. For instance, if a patient presents with *mamhepo* [attacks from evil spiritual forces], the family will usually take such a patient either to the *muporofita* or *n'anga* right away so that the evil forces may be exorcised. If one is being troubled by *munyama* [misfortune], the first port of call for most Karanga people would be either *muporofita* or *n'anga*. However, some conditions such as cerebral malaria or a condition requiring a surgical procedure or if one suspects HIV or rather if it is some HIV related illnesses, such conditions are best attended to at the clinic or hospital. Moline also acknowledged that some HIV related illnesses such as diarrhoea, skin infections and headache can also be alleviated by some medicinal herbs administered by traditional herbalists.

Being a practising medical practitioner, who also has first hand interaction with the traditional healers and faith-healers, Moline was quick to mention that there is no clear-cut integration between the three health-care systems. She explained that although each of the three systems is cognisant of the existence of the other two, rarely do they make an intentional effort to consult with the other and find ways of mutually cooperating with the other. However, she acknowledged that some bio-medical practitioners in hospitals and clinics will advise their patients to seek help from *muporofita* or *n'anga* especially in cases where some unusual conditions keep recurring, e.g. if a patient continues coming for a surgical operation on the same part of the body whereas no clear medical cause can be discerned. Such conditions might be suspected to be spiritually related and although this might not be recorded on their medical record, in confidence the bio-medical practitioner might suggest the use of a *muporofita* or *n'anga* to the patient. According to Moline, there are also cases in which the *muporofita* or *n'anga* will advise their patient to visit the hospital or clinic, e.g. if a patient is anaemic so that they get blood transfusion or in cases where the patient is presenting some HIV-related symptoms but have not yet established their status. Most of the contemporary *vaporofita* or *n'angas* are now very familiar with the signs and symptoms of HIV and they will therefore refer their patients to seek for proper medical check-ups.

4.4.5 Factors Impacting upon Karanga People's *Utano*

The key factors that Monica identified as influencing Karanga people's health negatively are food insecurity, especially in times of drought or flooding, poverty which is also closely related to crop failure, and a sense of despair caused by the prevailing political and economic instability at a national level. Monica's response on the issue of patients' health-seeking behaviour was that people turn to the clinic first because they receive free services. Although Monica did not specifically spell out the existence of a clearly defined integrated co-operation between the clinic's health personnel and the local *n'angas*, she was however quick to mention that the *n'angas* often refer patients who have malarial symptoms to the clinic because *n'angas* do not have the required medication to treat malaria. She did not mention anything about prophet healers; her standpoint is that she is a Roman Catholic who does not believe in utilising the services of prophet-healers, and therefore, she is not well-informed about how prophet-healers operate and how they relate to the clinic or the local *n'angas*.

However, upon further probing from the researcher, Monica indicated that there is a possibility that their patients utilise the three health-care providers concurrently because there are times when patients make reference to having consulted either a traditional healer or a prophet-healer before coming to the clinic. She also mentioned that there is a likelihood that some patients who would have consulted either the traditional healer or a prophet-healer before coming to the clinic decide to withhold such information from the clinic staff either out of fear of being ridiculed or being reprimanded by conservative staff members who regard such efforts as an unnecessary delay for seeking proper and effective health-care.

In response to the question on what are the main factors that influence Karanga people's health negatively or positively, Violet mentioned poverty, drought, excessive rains, particularly the recurring cyclones in the past few years, and malnutrition. She explained that in many instances, the destructive cyclones wreck havoc on people's livelihoods, destroying homes, crops, livestock, roads and sometimes schools and even shopping centres. This has far reaching repercussions on a community which is already struggling to make ends meet, especially considering the fact that this is a rural community depending on subsistence farming.

According to Violet, Karanga people's health-seeking behaviour is generally influenced by the availability and accessibility of the nearest facility. She explained that for her and her family, whenever disease befalls one of them, they always go to the clinic or the hospital, depending on the gravity of the illness. Being a member of the SDA church, she does not subscribe to the use of either traditional medicine or faith healing from the prophet healers. However, Violet acknowledged that some, or rather most of their patients, make use of either traditional medicine or faith healing or both before coming to the clinic, and some even continue to utilise these services even after they have been treated at the clinic. Although Violet was very clear about her standpoint of not using either traditional medicine or faith healing, she was however very liberal in her approach towards those who mix the three systems. She explained that she does not have a problem with those patients who, due to their socio-religious orientation, find satisfaction in seeking the services of other health-care providers. She however reiterated the fact that whenever patients decide to mix the two or three health-care providers, they should be careful not to default on the treatment which they would have received from the clinic because this could jeopardise their chances of gaining a

complete recovery.⁵⁶⁷ In her opinion, Violet intoned that most of the clinic staff look down upon the role played by traditional healers and prophet-healers in the community. She explained that although there is no clear-cut working relationship between the three systems, practitioners informally refer patients to each other. One example of the informal referring that she mentioned was the case of patients suffering from snake bites who if they come to the clinic will be advised to seek the services of a local herbalist who has knowledge of special herbs that can instantly cure anyone who could have been attacked by the most poisonous venom.⁵⁶⁸ Violet is of the view that although these three health-care systems are not clearly integrated, they are also not openly antagonistic to each other, i.e. she feels that the three systems co-exist amicably although some clinic staff might have some misgivings regarding their patients defaulting on medication due to the influence of the other health-care systems. She however highlighted that some prophet-healers view modern medicine as unholy and defiling and they therefore discourage their patients from mixing such medicine with their holy water or holy oil that would have been prayed over by the prophet-healers. She reiterated that it is in such extreme cases that the patients' mixing of the healing systems becomes problematic.

According to Patricia, the main factors influencing Karanga people's health negatively include food insecurity, financial constraints, socio-political instability and lack of infrastructure. She highlighted that whenever the community is going through a period of food insecurity, the number of patients succumbing to ill-health increases drastically. Furthermore, the perennial socio-political downturn also impacts negatively on people's peace of mind and triggers all sorts of ailments among people who would be generally fit under normal circumstances.

As regards Karanga people's health-seeking behaviour, Patricia is of the view that in many cases, people turn to the nearest and most accessible service provider whenever the need arises. However, she explained that for her family, whenever someone falls ill, they turn to the clinic or hospital first. She also mentioned that in many cases, being a member of the African Apostolic Church of Zimbabwe (Chibarigwe), they also consult their prophet-healers

⁵⁶⁷ Violet further elaborated that this is especially the case when a patient has been given a course of anti-biotic medication that need to be completed.

⁵⁶⁸ This is mainly because the Zimbabwean medical system is running low on drugs to treat snake bites such that most of the health facilities do not have any of such medication at their disposal. Reference to this issue is also made in chapter five of this work.

for prayers of healing and anointing of the sick. She indicated that for most members of her church they usually make use of modern medicine and faith-healing concurrently and for her, there is no inherent problem with that. As regards the use of traditional healers and traditional medicine, Patricia explained that her church teaching does not believe in the work of traditional healers and therefore, from her faith perspective, she does not make use of such services and would not encourage any member of her family to utilise them. However, as regards traditional medicine such as medicinal herbs that are self-administered, she explained that she has always used some of these herbs since time immemorial and therefore she does not see any problem with their use.

On the question regarding the possibility of one health-care system being better placed to heal specific cases or diseases, Patricia gave the example of patients presenting with spirit-related conditions such as one who would have been attacked by *zvidhoma* [witchcraft familiars] and she explained that such cases will be more appropriately addressed either by the prophet-healers or traditional healers since the clinic is mainly equipped to address the physical ailments and not spiritual issues. She also argued that the prophet-healers or traditional healers do not have adequate resources and know-how to treat patients suffering from some conditions such as malaria or acute respiratory infections and suggested that such conditions would be best addressed at the clinic or hospital because these service providers are better equipped in this regard.

According to Richard, Karanga people's health-seeking behaviour is mostly influenced by the availability and accessibility of the care giver and also the religious standpoint of the patient or their family. He explained that in many cases, those who believe in the efficacy of the traditional healer or the prophet healer will consult these practitioners first before visiting the clinic, or if they decide to visit the clinic first, they will then visit the traditional healer or the prophet healer afterwards. For him and his family, their choice of the health practitioner will be determined by the nature of the illness. He explained that if a person is suffering from symptoms of having been attacked by witchcraft or if they appear as if they have been possessed by an ancestral or alien spirit, then such a patient would be put in the care of a prophet healer from within their denomination so that they can be prayed for and be anointed for the exorcism of such spiritual attacks. However, if the patient is suffering from any other common ailments such as malaria, cholera, flu or chest pains, then such a patient would be

put in the care of the modern bio-medical practitioners in the form of a clinic or a hospital. Richard explained that it is common practice for most people in the community to mix all the three health-care systems concurrently or at least two of the three health-care systems and he indicated that he did not find this problematic at all. However, his major concern was that sometimes people who are HIV positive or those who would have been advised to go for HIV Testing and Counselling tend to hide behind the banner of witchcraft and fail to seek proper help in good time since they will be going from one traditional healer or from one prophet healer to the other such that by the time they go for testing, it might be too late for them to be put on ART. He also has major concerns with those traditional healers or prophet healers who claim to have the cure for HIV or AIDS who then discourage their clients from continuing with their ARV treatment regimes. His standpoint is that the traditional healers or prophet healers can be put to good use even by those who are HIV positive, but whatever assistance or medication they offer the patients who are already on ART, it should not interfere with the patients' compliance and adherence to ART, but rather to encourage their clients to live more positively and being more optimistic about the future whilst they continue with their ART.

As regards the question of whether the three health-care systems are integrated or not, Richard was quick to mention that there is no clearly coordinated integration between the three, although there are instances when the practitioners within the three health-care systems will informally refer patients to each other. He acknowledged that some of the prophet healers within his denomination will advise some of their clients to seek the services of the clinic whenever they feel that the clients' condition would be best treated at the clinic rather than with anointed water or holy oil. He gave the example of times when there was a cholera outbreak in the community in 1992 or in times when there are outbreaks of malaria or fever. Richard explained that such conditions will need to be immediately put in the care of trained bio-medical practitioners.

4.5 An Analysis of the Main Themes Emerging from the Health-Care Providers' Experiences

Several common themes emerged from analysing the views and experiences of the study participants within the three categories of health-care provision. Below an effort is made to discuss the main common themes prevalent among the fifteen key informants.

4.5.1 Calling

The theme of receiving a calling at a very young age into the healing ministry runs through all the five prophet-healers interviewed. For Kwangwari and Takunda, their first inclination was to resist the call and focus on other career pursuits but the calling kept pursuing them until they gave in. In Phineas' case, initially he was confused and could not make sense of what was happening to him and with the support of those around him; he was encouraged to accept the call. Patrick tried to combine the two, i.e. practising as a prophet-healer on a part-time basis and pursuing his career on a full-time basis, but the two could not co-exist until he eventually resigned from his job.

Miriam's case was a bit different; probably due to her being female, the elders in her church were initially sceptical about her being genuinely called as a prophet-healer but as they continued to observe her and seeing that she was going through the same processes as other male prophet-healers who had also received their calls within the congregation and noting the positive impact that her ministry was having on the congregation, they were finally convinced and they accepted her as the first female prophet-healer within the whole district.

All the five prophet-healers view their role as a calling, not something they chose to do out of their own interest but they all found themselves divinely commissioned to undertake the work of healing people through prayers and intercession.

There are some similarities between the prophet-healers' response to the call and the traditional healers. Raramai and Mufudzi also received the call for traditional healing at a very young age. Their attempts to resist and escape into the world of academia and employment were futile. Likewise, Vonai tried to run away from becoming a traditional healer through joining the church but no sooner had she gotten married did the calling resurface and she had to accept it. Shingirirai tried to find an escape route through eloping with the man she loved but unfortunately, marriage could not save her because her grandfather's spirit pursued her and made it impossible for her to remain married. Reluctantly, she accepted her calling and gave up her married life. Nyaradzai was also called at a very young age and she was initiated through assisting her grandmother who was a

traditional healer. After her grandmother passed on, she took over the role of traditional healing.

All the five traditional healers view their work as an essential service to the community. They all expressed that it is not a responsibility that can be taken lightly because there are so many sacrifices that one has to make and there are various challenges that one has to contend with as they commit their lives to serving their community through works of healing and preserving lives.

When it comes to the five western biomedical practitioners who were interviewed, the issue of calling does not come out as strongly as it did with the earlier two groups (prophet-healers and traditional healers). Only one out of the five biomedical practitioners (Monica) expressed that her interest to become a nurse aide was ignited at a young age by her mother who also worked as a Community Health Worker. The other four did not give much background information pertaining to what motivated them to join this profession. However, what runs through all the five bio-medical practitioners' experiences as well as the prophet-healers and traditional healers is that their main role is to provide care, preserve lives and they all expressed their commitment and passion for their work.

4.5.2 Disease/ Illness as Conceptualised in the Spiritual Realm: Witchcraft and Evil Spirits

The five prophet-healers emphasized the role of spiritual attacks as causing some of the sicknesses. According to Kwangwari, most of his patients are "either victims of spiritual attacks or witchcraft". Another prophet-healer, Phineas also identified spiritual attacks, particularly those who are tormented by evil spirits or avenging spirits as a major problem that makes Karanga people to come and consult him. Top on the list of the problems that Miriam attends to on a daily basis are "those who are troubled by malicious spiritual forces, family ancestral spirits or alien spirits". Takunda also noted that several of his patients are those "who will be seeking help to get rid of evil spirits such as the spirit of witchcraft which they would have acquired or seeking protection against acts of witchcraft". Patrick also identified his key role as "praying for those who are tormented by evil/malicious spirits".

All the five traditional healers identified the Karanga constant fear of witchcraft as a major problem that diminishes Karanga people's health and well-being. Raramai noted that he is "regularly consulted to either protect/shield individuals or families against witchcraft attacks and also to heal those who have been bewitched". Vonai also noted that she "assists in the cleansing of those who are struggling with the spirit of bad luck". Likewise, Nyaradzai mentioned that "she attends to those who wish to be cleansed of the spirit of bad luck or evil/malicious spirits." Shingirirai also indicated that she "attends to people tormented by the spirit of witchcraft, alien spirits and those bedevilled by the spirit of misfortune". Mufudzi highlighted that most of his clients "suffer from witchcraft attacks; some are tormented by goblins/witchcraft familiars or works of sorcery."

The issue of witchcraft and evil spirits as impacting negatively on Karanga people's health also features among western bio-medical practitioners. Moline, a practising nurse revealed that she had consulted a traditional healer on behalf of her teenage daughter who was showing signs of having been "attacked by witchcraft". She also mentioned that she constantly seeks the services of a prophet-healer within their congregation "so that they can be prayed for and be protected from any impending dangers, be it spiritual, emotional or physical". Patricia too made reference to the fact that witchcraft is an existential reality among the Karanga, therefore those "attacked by *zvidhoma* (witchcraft familiars)" should either be referred to the traditional healers or the prophet healers. Similarly, Richard made the following statement: "if a patient is suffering from symptoms of having been attacked by witchcraft or if they appear as if they have been possessed by an ancestral or alien spirit, then such a patient would be put in the care of a prophet healer..."

4.5.3 Negative Impact of the Socio-Economic and Political Environment on Karanga People's Health

Poverty and food insecurity features constantly among the factors listed by the health-care providers within all the three systems as having a negative impact on Karanga people's health. Three out of the five prophet-healers interviewed pointed out these inter-related factors. Phineas bemoaned the negative effects of food insecurity on the community's health as well as among his household, particularly in view of those patients who come to live in his home for longer periods whilst receiving treatment and he has to provide for their sustenance. He highlighted that this presents a challenge because sick people need to eat well. Miriam

identified “poverty and food insecurity and the harsh economic climate” as factors that impact heavily on Karanga people’s health and well-being. She noted how sometimes “out of desperation, some people solicit the services of evil powers to ‘get rich quick’ with far-reaching repercussions on the whole clan.”⁵⁶⁹ Takunda identified “poverty and food insecurity as factors that impact heavily on Karanga people’s health.” He added that this is worsened by the in-fighting between supporters of opposition parties who destroy their opponents’ “crops, livestock and homes, posing a huge strain on food security and people’s sense of security and well-being”. Similarly, Patrick explained that “poverty which is mainly caused by crop failure in times of drought or flooding makes people so stressed out such that they become ill.”

The five traditional healers cited poverty and food insecurity as main factors impacting negatively on Karanga people’s health and well-being. Raramai highlighted “extreme poverty, extreme heat, and drought and water shortage” as negative factors affecting Karanga people’s health and well-being. Vonai also pointed out that “food insecurity/drought, unclean water sources and limited grazing land for livestock” are factors that impinge on Karanga people’s health and well-being, leaving them susceptible to various stresses and diseases. Nyaradzai pointed out that the issue of poverty is a heavy burden which has ripple effects on people’s health. She noted that it is sometimes due to poverty that out of desperation for survival or for food items, some people resort to stealing “other people’s possessions.” This anti-social behaviour robs the community their peace of mind and impacts heavily on their health and well-being. In the same light, Shingirirai noted that “poverty and food insecurity diminish Karanga people’s health and well-being.” She highlighted how such factors usually force people to “engage in risky behaviour and lifestyles such as commoditising their bodies, poaching wildlife, illegal gold panning and selling illegal drugs and minerals.” Shingirirai further explained that all these activities “have far reaching repercussions on people’s well-being” as this is done “at the risk of losing their lives in the process.” Top on the list of factors listed by Mufudzi as affecting Karanga people’s health negatively is the issue of food insecurity.

⁵⁶⁹ This comment was made in connection with those who acquire *zvikwambo* to enrich themselves unaware of the long term negative effects of such an acquisition.

All the five western bio-medical practitioners cited poverty and food insecurity as factors that impact negatively on Karanga people's health and well-being. Moline mentioned poverty and food insecurity as taking centre stage. She expressed it in the following words: "poor people are generally food insecure and food insecurity impacts negatively on nutrition which will eventually impact on people's immune systems." In the same light, Monica put it this way: "food insecurity, especially in times of drought or flooding and poverty which is closely related to crop failure and a sense of despair caused by the prevailing political and economic instability at a national level are factors that impact negatively on Karanga people's health and well-being." Violet also listed "poverty, drought, excessive rains particularly the recurring cyclones in the past few years and malnutrition" as factors impacting negatively on people's health "especially considering that this is a rural community depending on subsistence farming." Similarly, Patricia put it this way: "food insecurity, financial constraints, socio-political instability and lack of infrastructure are factors that impact negatively on people's well-being, triggering various ailments among people who would be generally fit under normal circumstances." In the same way, Richard identified "poverty, food insecurity and the unstable socio-economic and political situation as having ripple effects on Karanga people's health."

4.5.4 Karanga People's Multiple Health Seeking Behaviour

All the study participants in the fifteen case studies revealed that Karanga people utilise at least two or three health-care providers sometimes interchangeably and often times, concurrently.

All the five prophet-healers displayed some openness to the utilization of different health care systems depending on the nature of the ailment, accessibility and affordability of the health-care providers. Kwangwari indicated that usually Karanga people consult either a prophet-healer or a traditional healer for all conditions that have some spiritual symptoms. He explained that "the choice between a traditional healer and a prophet-healer is mostly influenced by the family's religious affiliation, for instance, Christians would prefer a prophet-healer to a traditional healer." As a prophet-healer, Kwangwari acknowledged that there are some medical conditions which he cannot adequately deal with and for such cases, he refers the patients to the western bio-medical system. In the same light, Phineas also noted that "the patients' choice of health-care providers is usually determined by the nature of the

ailment and the family's religious traditions." He added that for some Christian families, for instance in his case as a prophet-healer, whenever illness strikes in his family, the first step is to pray about the ailment. Through his prophetic gift, he can discern the cause of the disease and be guided on whether to pursue western bio-medicine if it is a medical condition or to focus on prophetic healing if it is a spiritual condition. Miriam is of the view that all the three health-care systems play a fundamental role in Karanga people's lives and they are utilised according to the nature of the patient's problem. Although she is a prophet-healer who specialises in exorcising harmful spiritual forces, she also highlighted that some traditional healers, particularly herbalists, offer an essential service especially in treating snake bites in view of the scarcity of such medication within the western bio-medical system. She cited incidents on which medical personnel have referred patients bitten by snakes to the traditional healers and noted how such patients were effectively healed with traditional herbs. Takunda also noted that the Karanga people usually utilize the two or three health-care systems depending on the nature of the illness. He explained that there are some medical conditions which require specialist western bio-medicine but there are also some spiritual conditions that require the services of an expert in addressing spiritual matters. Patrick is also of the view that Karanga people make use of the two or three health-care systems depending on the nature of the ailment. However, he personally has some reservations regarding any use of traditional healers because he believes that this is in contradiction to God's word as he feels that the methods used by traditional healers are not in line with the Christian faith.

All the five traditional healers acknowledged the fact that most patients make use of the two or three health-care systems and noted that this is usually determined by the nature of the disease or the rate at which the patient is responding to a particular health-care system. Raramai noted that each of the three health-care systems has its own relevance and speciality. He further explained that whenever a patient consults him with a complex medical condition that he cannot address, he will immediately refer such a patient to the clinic or hospital. He also mentioned that he has personally utilized western bio-medicine as well as his children and his wives whenever the need arises. However, he highlighted that for common ailments that can be easily treated with natural herbs, his family will depend on traditional medicine to avoid the trouble of visiting the clinic which is so far away and is almost always out of medical supplies. Vonai emphasized the need for practitioners within the three health-care-systems to be forthright and admit that they cannot adequately address some of the

conditions. Although she has some knowledge of traditional midwifery, she mentioned that there are some patients that she advises to go for hospital deliveries because her divining spirit would have revealed that the patient might encounter some complications which she is not qualified to deal with.

Nyaradzai also noted that most patients' choices of which health-care system to use are influenced by the nature of the ailment as well as the availability and accessibility of the nearest practitioner. She also indicated that if a patient is suffering from a spiritual condition, then the family's religious convictions will automatically determine whether they will consult a traditional healer or a prophet-healer. However, if it is a complex physical ailment, she emphasized that "the patient should be rushed to the nearest bio-medical practitioner". Similarly, Shingirirai also noted that most patients make use of all the three health care systems depending on the nature of the ailment and the family's religious beliefs. She explained that for her family, if it is an ordinary ailment which can be easily managed, she will administer traditional herbs to them. However, if it is a complicated medical condition, she will advise them to visit the hospital. On the other hand, if it is a spiritual condition needing major exorcism, she would refer the patient to other renowned traditional healers. Mufudzi is also of the opinion that most patients mix the services of the three health-care systems depending on the nature of the diseases as well as the patient's cultural and religious standpoints. He feels that each of the three systems have their own areas of specialisation and people must use their common sense to decide on which facility to use and when, although some use all the three concurrently.

All the five western bio-medical practitioners mentioned that most patients make use of the three health care systems and noted that in some cases, the patients might not disclose that they had consulted either a traditional healer or a prophet healer before coming to the clinic or hospital. It is interesting to note that one of the bio-medical practitioners, Moline, openly shared how she once consulted a traditional healer on behalf of her daughter who was suspected to have been attacked by evil spirits. Moline also revealed that since her conversion to the African Apostolic Church, whenever illness strikes in her family, she turns to the prophet-healer first because she believes that all healing comes from God. She indicated that even if there might be need to go to the clinic later on, her family prioritises the services of the prophet-healer who is able to see even what might be hidden from the ordinary eyes of

bio-medical practitioners. Although Monica noted that due to her religious convictions she does not have any knowledge about how prophet-healers or traditional healers operate, she acknowledged that some of their patients also utilise the services of traditional healers and prophet-healers. She also indicated that there are some instances when bio-medical practitioners refer their patients to a traditional healer and vice versa. Violet indicated that due to her religious tradition, she does not subscribe to the use of either traditional medicine or prophet healers. However, she acknowledged that most of their patients make use of the three health care systems interchangeably. Patricia noted that patients usually “turn to the nearest and most accessible service provider whenever the need arises”. In her case, most members of her family “usually make use of modern medicine and faith-healing concurrently”. Richard is also of the view that patients usually alternate the use of the three health care systems depending on the nature of the illness, availability and accessibility of the care giver as well as the religious standpoint of the patient.

4.5.5 Disintegration of Social Values and the HIV Epidemic

The negative effects of the disintegration of social values, particularly a disregard of taboos and regulations surrounding sexual relations, are some of the reasons given by the study participants as the main drivers of the HIV epidemic which is decimating the country’s population and impacting heavily on the health of the nation.

Two prophet healers elaborated on this issue. Miriam bemoaned the general breakdown in social values, putting it this way: “the general disintegration in the country’s social fabric forces some people into risky survival strategies, putting their lives and the lives of their loved ones on the line.” Patrick also spoke at length on the problem of some married couples engaging in extra-marital affairs and some unmarried youth failing to adhere to sexual taboos and regulations, and as a result they engage in risky sexual behaviour exposing themselves and their partners to HIV infection.

Three traditional healers also noted the negative impact of the disintegration of social values. Nyaradzai mentioned how some unemployed youth, out of frustration and desperation, resort to a life of crime, sexual immorality and abusing drugs and alcohol. She added that this kind of behaviour makes them vulnerable to HIV infection, impacting negatively on their health

and the health of their care-givers who are usually their parents or grandparents after they have succumbed to AIDS. Shingirirai critiqued the degeneration in moral values ushered in by the “condom generation”. She nostalgically explained how the Karanga community used to “enforce a tradition of abstaining from sex until marriage whilst married couples maintained absolute fidelity to their partners.” She further explained that all this is now a thing of the past as some of the elders who used to be custodians of morality have turned into “monsters preying on children young enough to be their own offspring whom they have turned into sexual toys”. Mufudzi also mentioned the prevalence of casual unprotected sex and marital infidelity as key factors affecting Karanga people’s health negatively especially in the era of the HIV epidemic.

All the five bio-medical practitioners highlighted the high rates of the HIV epidemic as impacting negatively on Karanga people’s health. Moline mentioned that although most of the patients that they attend to at the clinic suffer from HIV related symptoms, some of them are in denial and they prefer to focus on accusations of witchcraft rather than address the real cause of their illness. She explained that such an attitude is detrimental to the community’s health because some of the infected patients would have lost their spouses due to HIV related complications, but in their denial, they will go on and engage in unprotected sex with other people and as a result continue to spread the epidemic. Richard expressed exactly the same concerns with Moline and he added that he is particularly worried about some bogus traditional healers or prophet-healers who claim to have a cure for HIV. He explained that these bogus practitioners are taking advantage of the desperate situation of those trying to come to terms with an HIV diagnosis.⁵⁷⁰ Richard emphasized the fact that all practitioners should adhere to the Shona cultural values and do their best to preserve and improve people’s lives and not to exploit them in their desperate time of need.

Monica highlighted the fact that most of their patients who suffer from chronic conditions such as HIV are often referred to the major hospitals for specialised treatment due to the fact that their clinic does not have adequate equipment and personnel to cater for such patients. She explained that the HIV epidemic imposes a huge burden on the health of the community because some people cannot afford to pay for services at most referral centres and even if

⁵⁷⁰ These comments were made in view of the fact that some bogus prophet-healers and traditional healers exploit their female patients by sexually abusing them or advising their male clients to rape virgins in order to be cured of HIV.

they go there, these referral hospitals are also over-burdened by vast numbers of patients such that at times they do not receive enough care and some end up dying from neglect. Similarly, Patricia mentioned that due to the challenge of inadequate resources “such as essential drugs, relevant equipment and their inability to offer HIV Testing and Counselling in an era of a national outbreak of the HIV epidemic, they are forced to refer most of their patients to major hospitals.” She expressed that this is a major impediment to their care-giving work particularly due to the fact that there is very poor communication between the rural clinics and major hospitals. She also added that this is especially frustrating because some patients become despondent and others begin to feel as if the public health-care system does not really care about them. Violet expressed the challenges compounded by the effects of the HIV epidemic on their care-giving work. She added that sometimes the community’s attitude of stigmatising and discriminating those infected or affected by HIV is a complete departure from the traditional African values of empathy and solidarity with those in difficult circumstances.

4.5.6 Collaboration and Integration among the Three Health-Care Systems

An analysis of the views presented by the fifteen study participants reveals that there were mixed responses to the issue of collaboration and integration between the three health care systems in their care-giving work.

Some prophet-healers expressed openness to collaboration with both the western bio-medical system and the traditional healers whereas others expressed some hesitancy in accepting the work of the traditional healers due to the ambivalence of the role of some traditional healers. Kwangwari indicated that there are some chronic or complex physical conditions that he immediately refers to the clinic/hospital. He indicated that although there is no clearly set out working relationship between the western bio-medical system and the prophet-healers, the two are aware of each other’s existence and will informally refer patients to each other. He also expressed concern about the fact that some western bio-medical practitioners tend to deny the reality that some patients will be suffering from spiritually related conditions which need to be addressed from the spiritual context. Kwangwari also mentioned that in the event that he establishes that a client is battling with a spirit which intends to ‘come out/possess’ them, if the client wishes to welcome/accept the spirit, then he would refer them to a traditional healer who can assist them in welcoming the spirit. However, if the patient wishes

to exorcise such a spirit, then he would assist them to get rid of it. Phineas is of the view that there is absolutely no coordination between the three health-care systems. He feels that the three systems operate in isolation. He, however, expressed that he has so much respect for the western bio-medical practitioners although he is concerned that some western bio-medical practitioners tend to claim to have the knowledge of treating all ailments, even some spiritual conditions which they know nothing about.

As regards the role of traditional healers, Phineas indicated that he appreciates those who add value to people's lives but he also expressed some serious reservations about those who abuse their knowledge and skills by inflicting harm on innocent victims. Miriam also expressed the view that there is a lack of clear coordination between the three health-care systems. She is of the opinion that the three usually operate in isolation although she noted that some western bio-medical practitioners usually refer patients who fall victim to snake bites to traditional herbalists who have specialised herbs for treating snake bites. Patrick mentioned that there are some instances when practitioners within the three health-care systems refer patients to each other depending on the nature of the ailment. However, he emphasized that whatever illness the patient is suffering from, they must believe that God can heal them "because without faith, there will be no complete healing". He also highlighted that their healing centre collaborates with the local clinic through sharing information and referring patients to each other whenever necessary. He does not have any interaction or collaboration with traditional healers because he believes that some of their methods are not in line with God's word.

All the five traditional healers share the same view that there is some collaboration particularly between the western bio-medical practitioners and traditional healers. However, they tended to sense some animosity between prophet healers and traditional healers. Raramai mentioned that he often refers patients to the clinic and even members of his family sometimes utilise western bio-medicine. Vonai mentioned that she enjoys an amicable working relationship with the local clinic and has often been assisted with protective gloves and plastic for use in her work as a traditional midwife. She is of the opinion that there is a sense of competition for clients between traditional healers and prophet-healers, making it virtually difficult for these two systems to have any meaningful collaboration. Nyaradzai indicated that she has a very good working relationship with the local clinic personnel, referring patients to each other whenever necessary. She added that she had attended various

training sessions from the clinic on how to deal with terminally ill patients as well as the safe and proper use of sharp instruments. However, she feels that there are some underlying tensions between prophet-healers and traditional healers, chiefly because some prophet-healers disregard the authenticity of traditional healers, sometimes accusing them of being backward, heathen and demonic. Nyaradzai also acknowledged that there are some rare instances when some prophet-healers refer patients to traditional healers especially in the event that a patient expresses an interest in being initiated as a spirit-medium or a traditional healer. Shingirirai bemoaned the antagonism that sometimes pertains among practitioners of the three health-care systems. She intoned that there is need for more centralised coordination and integration of the three health-care systems rather than operating with an “air of suspicion and prejudice against each other”. Mufudzi indicated that although there might not be a clearly laid out and coordinated working relationship between the three health-care systems, he feels that the three share some mutual respect. He also suggested that it would be helpful if considerable effort was made towards integrating the use of well known and effective traditional remedies in the clinics especially in the wake of “perennial shortages of drugs in the Zimbabwean public health-care system.”

All the five western bio-medical practitioners reiterated the apparent need for collaboration and integration between the three health-care systems especially in view of the outbreak of the HIV epidemic and other communicable diseases. Moline mentioned that there had been initiatives taken by western bio-medical practitioners to acquaint both traditional healers and prophet-healers with knowledge and providing them with protective equipment to reduce the risk of exposing patients to several communicable diseases. Monica also noted that there is some kind of collaboration between the western bio-medical practitioners and local traditional healers whereby they informally refer patients to each other. Violet intoned that although most of the clinic personnel look down upon the role played by traditional healers and prophet-healers in the community, nevertheless, practitioners within the three health-care systems occasionally and informally refer patients to each other. Patricia also made reference to the fact that each of the three health-care systems specialises in certain conditions and although the collaboration is not clearly defined but one way or the other, the reality of the situation is that practitioners often refer patients to each other. Likewise, Richard also indicated that although there is no clearly coordinated integration between the three health-care systems, however, practitioners often informally refer patients to each other.

4.5.7 Health Provider's Understanding of *Utano* in the Physical, Spiritual and Emotional Realms

All the fifteen study participants tended to define *utano* from a multiplicity of angles, i.e. physical, spiritual and emotional. Since the prophet-healers mostly deal with clients suffering from spiritual attacks, most of their definitions of *utano* emphasized aspects of spiritual and emotional well-being. They also indicated that the physical aspect is important but almost always they highlighted that the physical cannot be separated from other aspects. Kwangwari conceptualises *utano* as “well-being in all aspects of life; social, spiritual and physical”. He explained that if there is spiritual disharmony or imbalance in a patient's life, this will certainly impact on one's physical well-being. Phineas also defined *utano* from a physical and spiritual perspective. He emphasized that although sometimes it cannot be easily detected that a person is sick from the outside, deep inside they might be physically, spiritually and emotionally unwell. Likewise, Miriam defined *utano* as embracing the physical, spiritual and emotional entities. In the same light, Takunda defined *utano* as “being free from diseases, free from evil or negative spiritual attacks” and enjoying peace of mind. Patrick also defined *utano* as enjoying peace of mind (emotionally and spiritually), having adequate food which makes your body physically fit and being free from any bodily ailments/diseases.

All the five prophet-healers also understand *utano* as embracing the physical, spiritual and emotional aspects. Raramai understands *utano* as having peace of mind, enjoying right relationships, physical fitness without any bodily or emotional pains and having adequate needs. Likewise, Vonai understands *utano* as physical fitness, being free from any worries and stresses, enjoying peaceful relations and being able to eat and rest well. Nyaradzai also regards *utano* as physical fitness, smooth skin, healthy body, stable and comfortable living conditions and enjoying a healthy and stable diet. Similarly, Shingirirai considers *utano* as physical fitness and neatness, healthy and smooth skin, having adequate resources, having a safe, secure and neat homestead and enjoying peaceful and amicable relations. In the same manner, Mufudzi views *utano* as physical fitness, having peace of mind, living comfortably, enjoying meaningful relationships, having adequate food, and always maintaining cleanliness and neatness.

All the five western bio-medical practitioners view *utano* as multi-dimensional, highlighting the physical, mental and emotional aspects. For Moline, *utano* encompasses health and well-being in all aspects of life. This includes the physical, i.e. being free from any ailments or pains; mentally, one should not be battling with any psychological problems, and; spiritually, one's soul must be whole and being at "peace with all your surroundings." In the same light, Violet defines *utano* as "being at peace with one's surroundings, living in a clean and peaceful environment, maintaining good relations with family, friends and neighbours. It also incurs being content with one's circumstances such as having the assurance that there is enough food for the household, having one's livestock and crop produce flourishing". Similarly, Patricia defines *utano* as maintaining a balanced "state of well-being physically, mentally and emotionally...an attack on any one of the three causes disequilibrium in one's well-being and impacts negatively on their *utano*". For Monica *utano* encompasses "the well-being of a person physically and mentally, i.e. one should not be suffering from any bodily ailments and one should be enjoying complete peace of mind, without any stress or worry about their socio-economic needs". Likewise, for Richard *utano* means "a state of wellness, when one enjoys good physical health, having the assurance of peaceful and meaningful relations, enjoying abundant harvests and having enough fodder for your livestock, and above all having somewhere comfortable to live. Any lack in one of these diminishes one's standard of *utano*."

4.6 Conclusion

Capturing the results of fieldwork, this chapter has outlined the responses of key providers of health services to the Karanga people of Murinye. The chapter presented findings relating to the views of prophet healers, traditional healers and practitioners of Western biomedicine. It highlighted their concern with ensuring that their clients achieve health and well-being.⁵⁷¹ The chapter captured their calling and educational background, understanding of *utano*, perceptions relating to the challenges in their ministries and interpretations of multiple health-seeking behaviours. The chapter also provided a comparative analysis of the three health

⁵⁷¹ For further discussion on multiple therapeutic systems see, Nondo S.J. ed. (1991) *Multifaith Issues and Approaches in Religious Education with Special Reference to Zimbabwe* (Utrecht: Rijkuniversiteit); Landman, C. (2007) *Doing Narrative Counselling in the context of Township Spiritualities* (DTh, Practical Theology University of South Africa, Pretoria) and Landman, C. (2009) *Township Spiritualities and Counselling* (Unisa Press: Pretoria).

delivery systems. In the following chapter, the study will explore the views of the health-seekers within the three health care systems and how these health-seekers navigate the three health delivery systems.

Chapter Five

Karanga People's Agency in Securing and Preserving *Utano*

5.1 Introduction

Chapter four explored the case studies of the Karanga health-care providers in Murinye District, Masvingo. It was noted that for the three health care systems [Modern scientific bio-medicine; Traditional healing and Faith-healing], although not systematically integrated, their key task and vision is to work towards provision of *utano* (health and well-being) in its fullness. Proceeding from chapter four, the present chapter focuses on the case studies of health-seekers. The main purpose of this chapter is to explore the agency of Karanga health-seekers in their constant search and quest for *utano*. It seeks to fathom the key religious and socio-cultural factors influencing Karanga people's health-seeking behaviour, i.e. it aims to establish how health-seekers navigate the religious and medical plurality presented by the three health care systems [Modern scientific bio-medicine; Traditional healing and Faith-healing]. Using interviews and participant observation during some of the healing rituals, information was acquired from key informants in Murinye District, Masvingo.⁵⁷² During the healing rituals, information was gathered from both health seekers and health-care providers.

5.2 Patients at a Prophet Healer

In this section, I discuss the information of the patients at the prophet healers, exploring their health-seeking behaviour. The thematic approach used in chapter four will also be utilized in this chapter; hence in the forthcoming sections I discuss their biographical information, medical history, definitions of *utano*, major challenges in accessing health care, and their views regarding the Karanga multiple approaches to health. Finally, the common themes emerging from all the patients will be explored towards the end of the chapter. In the same manner that chapter four outlined representative responses from the health-care providers, the same format will be followed in this chapter.

⁵⁷² The guiding questions used to conduct the interview schedule are in the appendix.

5.2.1 Biographical Information and Medical History

Ingrid⁵⁷³ is a 43 year-old female and is a Christian belonging to the Johani Masowe Apostolic Church. She holds a Masters degree in Media and Communication Skills and is a secondary school teacher. Ingrid described the current ailment/problem that had brought her to the prophet-healer as follows; *kurohwa nezvidhoma, kutambudzwa nemweya yepasi/mweya yakaiipa*, [being physically attacked by witchcraft and being deeply troubled by evil spirits.] She mentioned that the other ailments that she has been regularly treated for at the local clinic are; *kupera simba/kuneta muviri*, [physical body weakness], *chitemo/kutemwa nemusoro*, [headache] and *kurwadziwa padivi*, [side pains.] Ingrid explained that she had consulted several prophet-healers in the past especially to seek for spiritual intervention in settling major domestic problems with her husband. She had also consulted many other prophet-healers seeking for God's blessings to bring peace into her home but had not received the anticipated results. She eventually stopped consulting all these other prophet-healers because she was now affiliated to the Johani Masowe Apostolic church and the faith does not allow its members to consult other *vaporofita* [prophets] who are not members of the same faith. However, it allows members to seek medical treatment from the clinics or hospitals, hence, her regular visits to the local clinic for other physical ailments.

Mbuya (Grandma) Esther⁵⁷⁴ is 75 years-old and is a member of the Zviratidzo ZveVapostori Church. She has basic literacy and is able to read and understand the Bible, and that is the only document she is interested in reading. At the time of the interview, Mbuya Esther was battling with cervical cancer. She mentioned that she had tried all sorts of bio-medical practitioners but had now come to accept that medical science cannot do much to alleviate her condition. She had now resorted to the prophet-healer, trusting God for a miracle to restore her to full health.

Mbuya Esther mentioned that she had consulted several *n'angas* in the past years especially during her early years in marriage because three of her first children all died during their infancy. At a later stage in life, she also consulted *n'angas* on behalf of her daughter who was struggling to conceive. This problem led them to visit various *n'angas* seeking for *uchiko*

⁵⁷³ Interviewed 12 November 2005, Murinye, Masvingo.

⁵⁷⁴ Interviewed 13 December 2006, Murinye, Masvingo.

[ability to conceive]. She explained that her attitude towards *n'anga* shifted drastically in the past few years, and the turning point was in 1990 when she lost her eldest son who left ten young children behind. After the son's death, she was persuaded by the in-laws [relatives to her son's wife] to consult a prophet-healer from the Zviratidzo ZveVapostori Church who was known to them (in-laws) in order to seek guidance on how to care for the ten orphaned children. Although she was not comfortable about it (she belonged to the Roman Catholic Church then), she felt obliged to go and consult this prophet as a sign of respect and politeness to the in-laws. The manner in which the prophet handled their predicament and the practical advice that she offered them for free made Mbuya Esther to conclude that this prophet was the anointed of God sent to deliver people from all their life's struggles. Since then, she puts all her faith for healing in the prophets or in western bio-medicine. She also believes in the power of intercessory prayer and being a member of the women's guild in the Zviratidzo ZveVapostori Church, she often solicits for prayers from fellow prayer warriors in the women's guild.

Samson⁵⁷⁵ is a 47 year-old male and is a member of the Johane Masowe WeChishanu Apostolic Church (hereinafter JMWAC). He is an Aircraft Technician Journeyman. Samson's major health problems are gastro-intestinal disorders and a weak chest. He has been battling with these problems for more than two decades and alternates between the services of a prophet-healer and the clinic/hospital.

Wellington⁵⁷⁶ is a sixty year-old male whose educational qualification is Standard One. He is a member of Zviratidzo ZvaVapostori and the main reason that had brought him to the prophet-healer is that he had come to consult on behalf of his son who was battling to find employment. His son had been out of employment for almost three years and as a concerned parent, he had come to consult so that whatever *munyama* [bad luck/misfortune] was hindering his son from finding a job would be cleansed and open the door for him to secure employment. He also mentioned that he had been coming to consult this prophet-healer on other matters; for instance whenever he is sick or whenever a member of his family falls sick. According to Wellington, one experience that stood out for him was a few years ago when his son had *dambudziko rekurutsa chose chaadya* [his son was experiencing problems with

⁵⁷⁵ Interviewed 15 December 2006, Murinye, Masvingo.

⁵⁷⁶ Interviewed 16 December 2006, Murinye, Masvingo.

stomach pains and could not hold any food, he would vomit whatever he ate]. He explained that they had tried bio-medicine but it had failed to bring any lasting solution to his son's condition; worse still, they could not establish the actual cause of his vomiting. However, when they brought him to this prophet-healer; he was made to drink a concoction of raw eggs mixed with milk, salt, holy water and anointed oil. After drinking and vomiting this concoction, the prophet-healer extracted some objects from his stomach which looked like teeth belonging to a wild animal. He was then informed that these objects had been inserted into his stomach by an enemy who wanted him dead and they were therefore causing his stomach to be upset whenever he ate some food. The prophet-healer then assured him that from then onwards, he would never be troubled by these unexplainable bouts of vomiting and since then, the problem has never recurred. It is for this reason that Wellington and his family have immense faith in the effectiveness of the prophet-healer's ministrations.

Terrence⁵⁷⁷ is a sixty-two year-old male and is a member of the Zion Christian Church-Chikamba. His academic qualification is Standard Three. The main reason that brought him to this prophet-healer is because he was experiencing unbearable pain around his right knee and sometimes the pain would spread across the whole right side of his body. He mentioned that he had visited several bio-medical practitioners and had even tried *n'angas* but had not seen an end to this pain and discomfort. The pain had been recurring and sometimes he would feel so numb such that he could hardly walk and when he did walk, he would be literally limping with a walking stick for balance and support. However, he indicated that since he started to consult this prophet-healer who administered an injection on him and facilitated his undergoing *kudzurwa kwezvinhu zviru mumuviri* [extraction of harmful objects from his body], he began to feel some relief and sometimes the pain would completely disappear. He explained that he always comes to this prophet-healer whenever he feels sick and sometimes he even comes just for prayers of protection so as to guard against enemy/evil attacks on him and his family. His religious interpretation of sickness is that most of the ailments are caused by the *mweya yepasi* [work of evil spirits] or *varoyi* [witchcraft]. He also acknowledged the fact that some common ailments such as flu, minor headaches and stomach ache can be *zvirwere zvinobva pasi* [natural ailments, not caused by any external forces].

⁵⁷⁷ Interviewed 17 December 2006, Murinye, Masvingo.

5.2.2 Understanding of *Utano*

Ingrid's understanding of *utano* is as follows: "physical fitness, well-being, mental stability and freedom from stress." Mbuya Esther's definition of *utano* is as follows: "*Chimiro nekufamba* [physical fitness and one's posture], if one walks slowly and shows physical frailty, then their *utano* is questionable. But if one moves with strength and vigour and their physical stature is well built and composed, then that person has *utano* in all its fullness. *Ganda kusvava kana kupfumbira* [skin texture], one's skin texture has a lot to say on the state of their *utano*. It reveals whether the person is healthy or not and if it's a child, one can tell whether the child is well-fed or malnourished. *Pfungwa dzemunhu* [one's mental state], this has to do with one's actions, revealing whether one is happy, sad or troubled, whatever one's actions impacts negatively or positively on a person's *utano*. If one incessantly goes out on drinking sprees, this could be a sign that they are having a problem that they are failing to cope with or if someone who is generally friendly and chatty suddenly withdraws and stops interacting with their friends, this could also send some warning signals on their troubled *utano*."

Samson's understanding of *utano* is as follows: "*utano* entails physical fitness with all parts of the body functioning normally, without any bodily pains. One's general appearance should be presentable and satisfactory; one should be overall smart in their physique and their surroundings. They should also enjoy mental and spiritual stability. Hence for one to be regarded as *mutano*, all faculties of one's existence should be considered; that is, the physical, mental and spiritual components."

As regards his understanding of *utano*, Wellington began by reiterating the fact that nowadays it is very difficult to ascertain who is sick and who is healthy by mere physical appearance because some people who are HIV positive are taking ARVs and therefore on the outside, they will be appearing very healthy when inside *rinenge riri zumbu rakapinda nyoka* [one will be appearing strong and healthy on the outside when deep inside there is a terminal illness infesting]. He went on to explain that usually a healthy person will show through the texture and appearance of their skin. If one's skin is unusually pale/dark and full of rash and scars, then that person's *utano* is questionable. On the other hand, if a person has vibrant skin which is full of life and has nice complexion colour, then that person has *utano hwakabatana*

[good health and fullness of life]. He also mentioned that one's mental state has an enormous bearing on one's *utano*; for instance, if a person is stressed or worried about something, their countenance may reflect some sadness which infringes on one's *utano* in its fullness. He also pointed out that *panogara munhu* [one's surroundings] also reflects whether one is healthy or not; for instance, if a person's surroundings are always filthy and their clothes are always dirty then that means one's *utano* is challenged and under threat of completely diminishing.

Terrence's understanding of *utano* is as follows: "One should be physically fit *akasimba/akafuta*, [with a well-built body] *uye akatsvinda* [their appearance should be presentable, neat and tidy]. They should also enjoy peace of mind, having adequate food and proper shelter."

5.2.3 Factors Impacting upon Karanga People's *Utano*

Ingrid singled out the persistent droughts in the region as a major factor affecting Karanga people's health negatively. These were impacting negatively on food production and consequently making the province perennially food insecure. She also highlighted endemic poverty as an impediment to procuring food, resulting in malnutrition or sometimes forcing people into risky survival strategies which have far-reaching repercussions on their health.

Ingrid pointed out that whenever illness strikes her or a close relative of hers, her first inclination is to suspect witchcraft. She explained that witchcraft usually attacks a person when the victim's close relatives open the way for the enemy [*kuvhurira mhepo*] for the witches to tamper with the victim's health and well-being. This can happen in instances where for example if the victim's parents or relatives are unhappy about their child neglecting them; or in other cases they might be simply jealous with the progress that the victim is making in their life. As a result, they will go around saying negative things about the child or simply wishing them evil. This would 'open the way' for an enemy to enter and inflict harm on the victim because it is believed that by sheer wishing them evil, they would have withdrawn their spiritual protection from the victim. Ingrid acknowledged that it is possible to fall ill with minor ailments such as flu without it having been caused by external forces like witchcraft. However, she maintained that whenever an illness persists, it means *papinda uroyi*, [witchcraft would have set in]. She strongly believes that God does not punish people

through illness; rather she attributes most major illnesses to *mhepo* or *varoyi* [evil spirits or witchcraft].

Ingrid explained that she visits *vaporofita* within the fold of her church regularly. This is common practise among members of this church - almost every move or decision made in one's life should be brought forward to the prophet of God to discern if all will go well. For instance, a pregnant woman will go to the prophet of God to be prayed for and to be anointed for a safe delivery before she goes to the hospital for the actual delivery. She also indicated that she often visits *vaporofita* whenever things are not going well between her and her husband at home or if she is facing problems at work, problems with neighbours or relatives and when ill. Whenever she is planning to undertake a journey, she seeks God's blessing by consulting a *muporofita* [prophet] to safeguard travel mercies.

As regards the distance that one needs to travel to utilise this service, Ingrid explained that this varies; for her, she lives about five kilometres away from where the prophet-healer lives but for others, they live just a few houses away from the prophet-healers' house. However, others have to travel hundreds or thousands of kilometres from other parts of the country to come and consult with the prophet-healer.

5.2.4 Challenges Encountered in Accessing Health-Care

Asked about the challenges encountered in utilising this service, Ingrid highlighted the fact that the prophet-healer is not available on all the days of the week and expressed how she wished if the service could be available on a daily basis. The prophet-healer is only operational on Monday, Tuesday, and Wednesday starting from 3:00p.m. until all the people gathered have been attended to, and sometimes this stretches up to about 9:00p.m. On Saturdays, the operational hours are from 6:00a.m till 9:00a.m. The main challenge this presents is the fact that there are no healing services on Thursday, Friday and Sunday; so if people have an emergency during these days, then they have to wait for some days before they can consult the prophet. She highlighted that in cases where someone has been attacked by *zvidhoma* [witchcraft familiars], this is really problematic because it is a real emergency that needs immediate attention. If these evil spirits are not exorcised, the victim might be severely injured to the point of being maimed or even losing their life.

Although she has so much faith in the power of western bio-medicine, Mbuya Esther highlighted that there are major difficulties in accessing the clinics especially due to the long distances that most people have to travel. She mentioned that other people can spend up to half a day or more walking to the clinic. Some who are old or too weak to walk to the clinic have to be driven in a wheelbarrow or scotch-cart. This is because the transport system is not so efficient in the area and there are some places where there are no established roads. As such, public transport does not reach such places.⁵⁷⁸ Hence if one needs to use a car in times of illness, they have to hire one, which is very expensive. She bemoaned how sometimes patients die on the way to the clinic or hospital due to the unreliable and unsafe mode of transport as well as the persistent lack of medication at most of the district and provincial medical centres.⁵⁷⁹ She also mentioned problems of favouritism at some medical facilities, alleging that some medical personnel reserve medication for those who have money who can pay a handsome amount of money as bribe. These allegations have been coming out in almost all corners of the country and they are more rampant especially in places where ARVs are being rolled out.⁵⁸⁰

Mbuya Esther suggested that there is need for more transparency in dispensing medication, especially for those who are chronically ill because there are so many who are denied access to medication simply because they cannot afford to bribe the officials who are responsible for dispensing the drugs. She also suggested the need for a more reliable and efficient road system that will make public transport available to all members of the community and most of all she emphasized the need for building more clinics. She also nostalgically recalled how soon after independence there were Community Health Workers (CHWs) visiting the villages on their bicycles distributing essential medication including contraceptives. They were mainly female, popularly known as ‘Mbuya *Utano*/Mbuya *Utsanana*’, literally ‘Grandma Wellness and well-being or Grandma cleanliness/smartness’. She intoned how reinstating

⁵⁷⁸ See Chirongoma S. (2006) “Women, Poverty and HIV in Zimbabwe: An Exploration of Inequalities in Health Care” in Phiri I.A and Nadar S (eds) *Women, Religion and Health: Essays in Honour of Mercy Amba Ewudziwa Oduyoye* (Orbis Books: Maryknoll, New York):173-182 for an exploration of some of these challenges.

⁵⁷⁹ These issues were also raised by health care providers in Chapter four.

⁵⁸⁰ The local media has constantly reported on such incidents. See Saharo T (2009) Massive misuse of state AIDS levy negates years of progress <http://www.thezimbabwean.co/comment/24113/massive-misuse-of-state-aids-levy-negates-years-of-progress.html> (20 March, 2009).

these CHWs would make such a whole world of difference to the health and well-being of the society. The major challenges that Samson identified regarding patients accessing the services of the prophet-healer include occasional closures of the healing centres. He went on to elaborate that there are certain time-periods when all the prophet-healers from the JMWAC receive a prophecy instructing them to close down the *kirawa* [healing centres] and this is usually the time when they are all supposed to be travelling to a particular part of the country to observe moments of prayer and fasting. He mentioned that this can take several weeks and if there arises a need to consult the prophet-healer during such times, it presents a real predicament to the patient because there will be no one to fill in for the prophet-healer. He indicated that some people out of desperation might end up consulting traditional healers even if this is against the JMWAC rules and regulations. The other challenge that he noted is the fact that often times, the prophet-healers that are highly gifted in responding to complex issues might not always be available at the *kirawa* to attend to the people needing them. He explained that this is due to the fact that these prophet-healers do not charge any consultation or service fees; they offer all their services free of charge and as such most of them are self-employed and therefore they often need to travel away from the *kirawa* in order to pursue their personal business ventures. He acknowledged that although it is understandable that the prophet-healers need to make a living and attend to their personal business matters, the clients are left unattended and some of them might need urgent attention from the prophet-healer. The third challenge that Samson highlighted has to do with the set-up of the *kirawa*; although it is located within the prophet-healer's homestead, the *kirawa* is in the open where patients are exposed to all weather elements. Sometimes they have to endure scorching heat, rainstorms, extremely cold or windy conditions.

Samson suggested that provision should be made so that at all times there is a prophet-healer on duty at the *kirawa* and therefore patients do not get stranded when they need to consult. This could be arranged in such a way that they alternate the days or times that they offer their services at the *kirawa*. As regards the exposure of clients to weather elements due to the open-air structure, Samson suggested that some shelter should be constructed to shield the clients from the open air otherwise some people's condition might end up deteriorating due to long hours of exposure whilst they will be waiting in the queue.

The main challenge that Wellington identified regarding utilising this service is the fact that the prophet-healer is not always available at the healing centre due to the fact that sometimes he is invited to travel to some faraway places to attend to patients there or to perform some rituals at some clients' households. As a result, the patients have to either wait for him for days or return to their homes and come back to consult him upon his return. Wellington explained that this can be problematic especially when it is a critical case, particularly those who would have been attacked by *zvivanda* [witchcraft familiars] because these can be so vicious such that if the afflicted person does not get help within the shortest period of time, they might suffer permanent mental damage or become paralysed and worse still, some might lose their lives. He indicated that it is in times such as these that some people out of desperation will go to consult a traditional healer, a practice which is against their Christian religious traditions. However, because there will be no prophet-healer to attend to the crisis at hand, they will be forced to break the church's traditional teaching in a bid to save a life under threat rather than to adhere to the rules and watch a person dying. In view of this challenge, Wellington suggested the need for prophet-healers to alternate their shifts so that whenever they are away from the healing centre, there would be another prophet-healer on 'stand-by' to attend to clients so that they are not stranded during their greatest times of need.

The main challenge that Terrence identified in terms of utilising this service provider is the fact that there is no available public transport to ferry people from where he lives into the direction where the prophet-healer is located. He explained that the only mode of transport available which passes through his village every morning will be moving from the opposite direction going into town and will only return towards the end of the day. As such, if one needs to access the prophet-healer in the morning, they have to walk on foot or if they are too sick to walk, they would have to hire a car which most people cannot afford; therefore usually patients are carried in a scotch-cart in order to get to the prophet-healer. Sometimes people have to get onto the bus in the evening and sleep over at the prophet-healer's homestead so that they may be able to consult the following morning. That means they would have to spend another night there and will only be able to catch the morning bus on the following day after their consultation. If not, then the other option is to make an arrangement with the prophet-healer to travel to the patients' homestead. However, he explained that this option is more expensive because once the prophet-healer is made to leave his homestead and travel to offer their services to the patient, then the fees charged will be much higher than

when a patient comes on their own accord to consult. The other challenge closely related to the transportation issue has to do with the issue of having to cross Mutirikwi River in order to reach the prophet-healer.⁵⁸¹ This becomes problematic during the rainy season when the bridge is sometimes covered by water such that it becomes impossible to cross over. In view of these challenges, Terrence suggested that the transportation dilemma can be resolved by ensuring that the roads are properly repaired such that more transport operators can ply the route, this would open up opportunities whereby the transport system is more flexible so as to allow other buses to move from the direction of Masvingo town towards Murinye in the morning rather than to remain with just one way transport only. He also emphasized the need for a stronger and more enduring bridge across Mutirikwi River for ease passage during the rainy season.

5.2.5 Patients' Choice of Health-Care System: Multiple Health-Seeking Strategies

Ingrid's views on patients' utilising the three health-care systems are as follows: for her, visiting the *muporofita* is her first priority whenever a need for guidance, healing and wholeness arises because she is always assured of receiving a blessing from the prophet of God in the form of *muteuro* stone. Asked what she likes best about the service offered by the prophet-healer, Ingrid pointed out the fact that it is offered free of charge without any discrimination or favouritism that is sometimes encountered at the local clinics. According to Ingrid, this service is open to all members of the community; even those who are not members of the faith receive it for free. She explained that she turns to the *muporofita* first whenever they suspect witchcraft or when they encounter abnormal illnesses. However, if a patient has got a fractured bone or needs an urgent surgical procedure, they rush the patient to the hospital first and then someone can go and consult the prophet-healer on the patient's behalf to pray for God's intercession during the patient's stay in hospital. As soon as the patient is able to visit the prophet-healer, they will go and be prayed for. She explained that if someone has a spiritual ailment, such as *kurohwa nezvidhoma* [being physically attacked by witchcraft], they will go straight to the *muporofita* because the prophet-healer has the appropriate knowledge and skills to deal with such attacks.

⁵⁸¹ This challenge was also made reference to in chapter four whereby Richard, a nurse from Shonganiso clinic raised the same concerns regarding their patient's struggles in accessing the clinic during the rainy season.

In Ingrid's view; the three health-care systems are usually utilised simultaneously by the patients even though the practitioners might not always acknowledge it. The patients usually use them interchangeably, visiting the *n'anga*, *muporofita* and western bio-medicine. However, there are some patients who only go for western bio-medicine and do not believe in *vaporofita* or *n'anga*. From her personal experience, there is no clear integration between the three health-care systems, although there are some instances when the *muporofita* of Johani Masowe will refer a patient to the hospital when need arises; however, hospitals rarely refer patients to the *muporofita* for treatment. On the other hand, the *n'angas* will rarely refer patients to *vaporofita*, although in some instances the *n'angas* would refer patients to the hospital.

Mbuya Esther strongly defies the power of witchcraft. In her opinion, if someone falls ill, she does not blame it on witchcraft, rather she views it as God's punishment on humanity. She mentioned that whenever she feels really struck down by disease and pain, she cries out to God, pleading *Mwari mandimesera, ndisunungureiwo* [Lord, please do not forsake me; the pain/burden is too heavy, please release me from this yoke]. She believes that God can grant her healing either through western bio-medicine or through the prophet-healers or through intercessory prayer from the women's guild prayer group. In her experience, she has also learnt that there are some prophet-healers who mix both traditional medicine with holy waters and prayers and that some of the prayers are offered both to God and the ancestral spirits to intercede in the healing process.⁵⁸² She also noted that some experienced doctors are aware of the existence of some powerful and reliable traditional healers and they often advise patients to seek the services of some of these reputable traditional healers. She mentioned how in Masvingo town there are some well known traditional healers registered with Zimbabwe Traditional Healers Association (ZINATHA) who are specialists in several aspects of healing and divining and it is to such healers that some medical doctors refer their patients to. Mbuya Esther bemoaned how the modern day western bio-medical system has been so infiltrated with *chioko muhomwe* [corruption and bribery] such that *ane mari ndiye mukuru* [s/he who has money has the greatest influence and power], i.e. it is money that speaks, hence your

⁵⁸² See Shoko T. (2007) *Karanga Indigenous Religion in Zimbabwe: Health and Well-Being* (Ashgate: Ashgate Publishing Limited); Dahlin O. (2001) *Zvinorwadza: Being a Patient in the Religious and Medical Plurality of the Mberengwa District, Zimbabwe* (Universitetsstryckeriet: Uppsala) and Daneel M.L. (1971) *Old and New in Southern Shona Independent Churches*. Vol. 1, *Background and the Rise of the Major Movements*. The Hague: Mouton.

dollar power will enable you to receive special care and treatment in most of the public health care facilities.

Being an active member of the JMWAC, Samson explained that for him the procedure to be followed upon being confronted with an ailment is to consult the prophet-healer first. This is mainly because of the dominant belief in witchcraft as the major cause of illness. He explained that in many cases “witchcraft or *mweya yamadzinza inosimudza mhepo neurwere*” [malicious family spirits inflict forces that cause disease and ill-health]. Upon consultation with the prophet-healer, s/he will advise the patient whether it is necessary to go to the clinic/hospital or not, depending on the nature of the ailment. According to Samson, often times spiritual healing is enough to address the problem at hand. He also highlighted that on several occasions, paying regular visits to the prophet-healer for routine check-ups safeguards oneself from pending evil and spiritual attacks. This is because the prophet-healer is able to foretell the future and may alert you to impending dangers of witchcraft or some form of misfortune and then offer spiritual protection against these negative forces. Hence, the figure of the prophet-healer is central to the well-being of the faith community and their services are also open for use to non-members. Their services are solicited in times of trouble and also in times of peace and tranquillity just to ensure that the relative balance on well-being is maintained.

The prophet-healer offers the patient prayers in the name of the trinity. If one is under the attack of witchcraft forces [*kurohwa nezvidhoma*], or *kugarwa nemudzimu/dzinza/shavi* [being possessed by ancestral or alien spirits], the prophet-healer will minister to the patient by casting away these evil forces and cleansing the patient through prayer and offering them the *muteuro* stone as a protective measure against witchcraft. Even when the patient is suffering from a physical condition, for instance severe stomach pains or having fractured a limb, the prophet-healer will offer intercessory prayers and give them a *muteuro* stone that they can continue using even when they have been admitted in hospital. Samson explained that the prayers and the *muteuro* stone assist *kuti nyama dzemurwere dzidavirane nemishonga yekuchipatara pakurwisa urwere* [their function is to act as a catalyst in assisting the patient to respond positively to the medicine administered in the hospital and enable the patient to fight off the disease].

As regards the distance that patients have to travel in order to access the prophet-healer, Samson explained that this depends on where the patient is coming from. For instance, some people travel from very far away parts of the country as far as 500kms away to come and consult this prophet-healer. However, some of the patients are local members of the community who live just a few kilometres away from the prophet-healers' homestead.

As regards Karanga people's health-seeking behaviour, Samson explained that for him and his family, the nature of the ailment determines their first choice. For instance, if a person is suffering from *mamhepo* [attacks from evil spirits] or *kuvhumuka* [hysteria/hallucinations], these and other spiritual cases will require spiritual healing, and therefore, such a patient will be taken to the prophet-healer straight away. However, if a person has suffered a physical injury or has a fracture, then certainly such a person would be taken to the clinic or hospital immediately. However, he was quick to add that such a patient will still need to visit the *kirawa* in order to be prayed for so that the treatment received at the clinic or hospital may work properly.

Samson is of the opinion that the three health care systems are integrated. He went on to explain that some medical practitioners will refer the patient to *muporofita* or *n'anga* whenever they suspect that the condition might have spiritual origins. He pointed out that this is usually the case if after running tests, conducting x-rays and taking scans they still fail to establish the root cause of a patient's ailment or discomfort, then they might advise the patient to consult *muporofita* or *n'anga* who can divine the actual spiritual cause of the problem. He also noted that sometimes *vaporofita* or *n'anga* will also refer patients to the medical practitioners in the event that they realise a need for specialist medical attention.

As regards the issue of whether there are some cases which are best treated by one health care system and not the other, Samson explained that this needs in-depth discernment and a flexible approach to the problem at hand. He elaborated that there are some people who are so 'set in their ways' such that even when it is so apparent that the patient needs immediate medical attention, they would still not opt for it. He gave the example of one family hailing from the same village as him; they are members of an apostolic church which is totally against the use of bio-medicine due to the fact that they regard it as unclean and defiling. One

of the daughters from this family experienced some complications during the delivery of her first child under the care of their denominational mid-wives. The baby died and the mother started bleeding profusely. Samson painfully described how other members of the village advised and even begged her family to rush the lady to the hospital but they adamantly refused. They kept her in their home and would invite the prophet-healers from their church to come and pray for her and offer her healing water. The lady was in excruciating pain for two weeks and eventually died. He went on to explain how such rigidity might end up in unnecessary and painful loss of life which could have been avoided if people could be able to draw a line between what professional medical practitioners can achieve and what *muporofita* or *n'anga* can achieve.

Conversely, Samson argued that taking a person *akarohwa nezvivanda/zvidhoma* [afflicted or attacked by witchcraft familiars] to the clinic or hospital might delay the whole healing process and could even result in death. However, if such a patient is taken to *muporofita* or *n'anga*, and if they get timely and appropriate exorcism, they can receive immediate release and complete healing. He also highlighted the fact that some prophet-healers and *n'angas* mislead patients with their false claims of being able to cure HIV. He explained how this can mislead people and disturb or delay their process of seeking proper life-sustaining and life-enhancing ARVs.

Wellington's conception of disease is that it is something that comes from God, probably to test one's faith. However, he also highlighted that sometimes it puzzles and worries him that he seems to be the only one encountering suffering and tribulations in terms of diseases and other life's trials. All this makes him to wonder if there are no outside sources such as witchcraft, inflicting harm on him and his family. Whenever he is faced with a problem in his household, he first consults this prophet-healer and even if it is a medical problem that needs to be attended to by bio-medical practitioners, he still believes that the prophet-healer's intercessory prayers will assist the patient to respond quickly to bio-medicine. He explained that the prophet-healer makes use of holy water, holy oil, eggs, salt and a sanctified injection which he administers to the patients. Wellington said that he prefers consulting this prophet-healer because he is very helpful and friendly to all the clients; furthermore, his services are affordable because he charges a very small consultation fee and even if one does not have cash, they can pay in kind. More so, even if the client does not have anything to pay for

consultation fees, they will not be turned away, rather, he will attend to them and they can come back to pay their dues whenever they can. Wellington also mentioned that this prophet-healer is so popular such that people travel from as far as 300 kilometres away to come and consult with him.

As regards the factors that influence Karanga people's health-seeking behaviour, Wellington pointed out that in many cases, the nature of the ailment guides people on who to consult first. He however reiterated that for him and his family, they always turn to the prophet-healer first and then after consulting him, they can then be guided on whether they still need to visit the clinic/hospital or not. He explained that there are cases in which the prophet-healer will minister to the patient and assure them that there will be no need for proceeding to the clinic. However, in other cases, the prophet-healer will reiterate the need for seeking bio-medical help. Wellington was very forthright about his views on *n'anga* as medical practitioners. He argued that he does not believe in the work of *n'anga* and does not believe in anything positive coming out of their practise. Wellington even went on to allege that some *n'angas* are as detrimental to people's health as witches and sorcerers because they can actually dispense harmful medicine that can be used to injure, maim or even kill people.

Wellington is of the view that the three health-care systems are not clearly integrated in terms of their health-care provision mainly because their practices are not founded on the same principles. However, he acknowledged that the prophet-healer whom he consults regularly is someone who is very open to the use of bio-medicine such that whenever there is a need, he will refer the patient to the clinic/hospital. He also made reference to some bio-medical practitioners who on several occasions have referred their patients to some specialists in herbal medicines and sometimes they even refer them to the prophet-healers, depending on the condition that the patient will be suffering from. He is also of the opinion that there are specific cases that can be appropriately attended to by certain practitioners than would be achieved by another. For instance, he noted that if a patient is suffering from *kurohwa nezvikara* [having been attacked by witchcraft familiars] or *kushungurudzwa nemweya wengozi* [being tormented by an avenging spirit], such cases will be effectively addressed by *muporofita* and not by bio-medical practitioners. On the other hand, he indicated that some common physical ailments such as asthma, malaria and tuberculosis will be best addressed by bio-medical practitioners and not by the prophet-healer.

Terrence highlighted that he prefers this service provider because it is nearer for him to access (4kms from his home) than going to the clinic (8kms away) and also the fact that unlike the clinic which often runs out of medication, the prophet-healer does not run out of the few essential items needed to undertake his work. On the other hand, he also complained that the clinics/hospitals are often flawed with favouritism, segregation and poor quality care. In his own words, he put it as follows: '*kuchipatara kuGehena*', [going to the hospital is just as good as going to hell], implying that the hospitals are the worst places for one to go when ill. For him, it is as good as condemning yourself to hell. In contrast, he noted that the prophet-healer offers holistic and compassionate care; everyone is treated equally, with dignity and respect.

Terrence explained that this prophet-healer offers a wide range of services. Besides praying for and healing the sick, he also offers prayers of intercession for protection against all malicious forces. For instance, if one is planning to go on a journey, they will come to the prophet of God who will offer prayers of intercession for journey mercies. He also added that the prophet-healer also serves as a diviner who can figure out information which is hidden from the ordinary eye and he can also foretell what will happen in the future. Terrence explained how in some instances, this prophet has forewarned people of an impending disaster. For instance, he will alert someone that they will be involved in a car accident and sometimes he can intercede and manage to completely avert the accident from happening. But in some cases, even though he cannot stop the incident from happening, at least he can intercede that when it happens and it will not be as fatal as taking people's lives, or maiming people. He also prays for those who will be seeking for good luck in their endeavours; for instance, when seeking for employment or when looking for the right person to marry and in other cases for couples who will be trying for a child.

As regards the key factors influencing Karanga people's health-seeking behaviour, Terrence highlighted that their choice is usually guided by the nature of the illness and also by their religious perspective. For him and his family, they usually turn to the prophet-healer first and if need be, then they go to the clinic/hospital. However, in cases where they realise that it is a real medical emergency, they will go to the clinic first. On the issue of people using the three health-care systems interchangeably, Terrence indicated that this is usually the norm in the

community. He explained that most people are flexible such that they try two or all the three systems depending on the condition that the patient will be suffering from. However, he elaborated that there are some cases that can be especially addressed in one system and not the other. He gave the example of *kupotswa/kutsingwa* [a patient having been harmed by sorcery causing them to be paralysed or having an object magically inserted in their body]. He argued that such a condition is best addressed by either *muporofita/n'anga* since no amount of bio-medical treatment can resolve such a case. He also mentioned that other medical cases such as those requiring surgical procedures should not delay by spending time at the *muporofita/n'anga* but they should rather seek urgent medical attention.

On the issue of whether the three health-care systems work together or not, Terrence's response was that these three systems are integrated to a very limited extent, in view of the fact that they occasionally refer patients to each other. He also made reference to some instances when the local traditional healers were being invited at the local clinic to attend some courses to enlighten them on the proper use of some objects such as razors, scissors and injections so that they can guard against spreading viruses and infections onto their patients. He also suggested that such knowledge should also be passed on to the prophet-healers because some of them also use these same objects and if they are not properly informed, they might continue to expose their patients to the danger of infection. Terrence also noted that there are some prophet-healers or traditional healers who are completely in conflict with the use of bio-medicine and would therefore discourage their clients from using it. On the other hand, he also mentioned that some bio-medical practitioners are totally opposed to the use of prophet-healers or traditional healers whom they accuse of claiming to heal people when instead they are dubious practitioners.

5.3 Patients at Traditional Healers

Having interacted with research participants who were seeking the services of prophet healers, I also sought to understand the experiences of those who sought the services of traditional healers. I present the material in the following sections.

5.3.1 Biographical Information and Medical History

Andrew⁵⁸³ is a 42 year-old male who holds a PhD and is a member of the Zion Christian Church (ZCC). He described the ailment that brought him to this healer as *muposo* [a mysterious swelling of the foot accompanied with sharp stabbing pains]. He had suffered from this condition for a period of five years. He explained that he had been treated at the local clinics and at Masvingo General Hospital. He had also consulted several general practitioners and medical specialists at privately owned medical facilities throughout the country but had given up on bio-medical service because it just could not cure his ailment.

Andrew explained that what made him to suspect witchcraft is the fact that whenever he consulted medical practitioners at the different facilities that he had visited, on several occasions they could not diagnose the cause of his swollen foot and the sharp stabbing pains that he was experiencing. He mentioned that he had gone through several medical examinations and X-rays of his foot had been taken many times and all that the medical practitioners could ascertain was the swelling of the foot; however, they could not establish the reason behind the swelling and the cause of the pains. It was mainly because of their failure to fathom the mystery behind the ailment and the swelling of his foot that led Andrew to visit the traditional doctor [*n'anga*]. It was through the use of *hakata* [divining bones] that the traditional doctor managed to diagnose the cause of his sickness as *muposo*, an ailment that is usually associated with witchcraft. Andrew acknowledged that his religion does not approve treatment from African traditional doctors because they are usually suspected to be agents of the devil. He further explained that he had sought this treatment secretly knowing that if the Church came to know about it, he would be definitely excommunicated.

Edwin⁵⁸⁴ is a sixty-one year-old male and is a member of the Reformed Church in Zimbabwe. His educational level is Standard Six. The main reason that led him to consult the traditional healer is because he had been suffering from recurring headaches which had failed to respond to western bio-medicine. He also highlighted that his livestock had been perishing mysteriously over a certain period of time such that he had been forced to suspect that there are works of witchcraft behind these misfortunes. According to Edwin, although his church does not openly acknowledge the existence of witchcraft and the religious leaders go out of

⁵⁸³ Interviewed 19 December 2005, Murinye, Masvingo.

⁵⁸⁴ Interviewed 21 December 2006, Murinye, Masvingo.

their way to discourage members from consulting traditional healers, he feels that there are times when he senses a pertinent need to consult a traditional healer. His vantage point is that there is a certain pattern in which events occur which reveal some affinities to the works of witchcraft and for him to just sit at home and rely on prayers for protection is not enough. He also charged that some of the church leaders who are in the forefront of denouncing the practice of consulting traditional healers have sometimes been seen consulting some traditional healers in the thick of the night. He even went on to insinuate that some leaders are so power-hungry such that they even go to the extent of consulting traditional healers to solicit favours so that they can be re-elected into leadership positions whenever there is going to be a selection of church leaders in their congregation.

Takwana⁵⁸⁵ is a seventeen year-old male who is a member of the Christian Assemblies of God church. His educational qualification is 'O' Level and he was in the process of searching for either employment or tertiary education at vocational training institutions. The main reason why Takwana visited this traditional healer is because he was constantly suffering from an ear infection which did not seem to respond to any conventional medicines. He explained that this problem started when he was still in primary school. He had visited the local clinic several times and had even been referred to the provincial hospital (Morgenster Hospital) but the problem subsided just for a short while and tended to resurface whenever he was preparing for his major examinations at school. Takwana explained that this had impacted heavily on his academic performance because sometimes he could not even hear what the teachers were teaching in class even though he always sat in the front row of the classroom and always paid special attention to what the teachers were saying. His hearing was severely impaired and although he used to be a brilliant and cheerful student at school, his social and academic life had been negatively affected by this ear problem. His parents, who are also members of the Christian Assemblies of God church, had tried as much as possible to resist the temptation of taking their son to a traditional healer since this was against their religious beliefs, but noting how much pain and suffering their son had endured, they decided to give it a try.

⁵⁸⁵ Interviewed 22 December 2006, Murinye, Masvingo.

Laina⁵⁸⁶ is a nineteen year-old female and is a member of the Johane Masowe weChishanu Apostolic church. Her educational qualification is A' Level and she was busy with her undergraduate studies at the University of Zimbabwe. The main problem that had brought her to the traditional healer is that she was constantly suffering from tonsillitis and ear-infections to the point that she would sometimes totally lose her sense of hearing. Laina's parents explained that she had suffered from tonsillitis since she was an infant and this problem had continued into her teenage years. The ear infections started when she was around seven years old and this had also continued to be a recurring problem. She had been to several bio-medical practitioners and prophet-healers within her congregation but these two ailments never seemed to receive total healing. She would sometimes briefly respond to western medication or the prayers for healing but every now and again, the same ailments tended to resurface.

Runyararo⁵⁸⁷ is a thirty-five year-old female and is a member of the United Methodist Church. Her educational qualification is 'O' Level and she is a stay-at-home mother. The main reason that had led her to visit this traditional healer is because she was feeling weak and the whole body was in pain [*kurwara muviri wose*]. In other words, she could not pinpoint what she was suffering from exactly because nothing seemed to feel alright, and she was experiencing pain all over her body. This condition had been recurring for the past four years and the doctors were failing to diagnose the real cause of this malfunction. She explained that she had consulted various bio-medical practitioners but they had all been baffled by her condition because it was not clear what was exactly wrong with her. She had also consulted various prophet-healers, some of whom had told her that there was an avenging spirit hovering around her but they had all felt that this spirit was so angry and so determined to cling onto her such that any of their attempts to exorcise it might result either in it striking the prophet-healer dead or striking Runyararo dead, and so they had advised her to seek the services of a very powerful traditional healer who knows how to deal with such cases.

⁵⁸⁶ Interviewed 23 December 2006, Murinye, Masvingo.

⁵⁸⁷ Interviewed 24 December 2006, Murinye, Masvingo.

5.3.2 Understanding of *Utano*

Andrew's understanding of *utano* is as follows: "*utano* means the physical and spiritual well-being of a person. A person is understood as a holistic being and their health-care needs can only be fulfilled when they are treated holistically. *Utano* does not only imply individual well-being qua individual, but it also implies the well-being of the whole community. This is shown in the concern which each individual expresses towards the well-being of everybody else in the community. The first greeting among Karanga people demonstrates this truism when they say – *hwakadini upenyu?* [How are you faring in life?] In response to such a greeting the Karanga will normally say, *tinorarama hedu kana muchiraramawo* [we are faring if you are faring i.e. we are well if you're also well]. In other words, *utano* is a state of well-being that should be shared by everybody. It is not an individual privilege but a communal good (inter-relatedness/inter-dependence). *Utano* is also related to harmonious relationships that exist between the living and their ancestors. Ancestors promote *utano* among their descendants. The prevalence of *utano* in the community or family signifies *utano* and amicable co-existence among the living and their ancestors."

Edwin's understanding of *utano* is as follows, "*Chimiro chemunhu, kana muviri wakagwinya zvinotaridza kuti munhu ane utano hwakanaka* [appearance, if the body appears strong and fit, it shows that one is healthy]. *Asi kana muviri wakakatara, zvinotaridza kuti utano hwemunhu hauna kumira zvakanaka* [if the appearance is in shambles, it shows that one's health is not in a good condition]. *Chigarisano nevamwe zvakanaka, kana munhu achigara akafara achisekedzana nevamwe, zvinotaridza kuti akagarisika mupfungwa, kazhinji ukaona munhu achigaroparana nevamwe, zvinoreva kuti haana kugarisika zvakanaka mupfungwa, panenge pane zviru kumunetsa* [social interactions, if a person relates well with others, it means that s/he is at peace but if they are constantly in conflict with other people surrounding them, it means that they have a problem and they are not at peace].

Takwana's understanding of *utano* embraces the physical [*chimiro chemunhu*] and emotional realms [*pfungwa dzemunhu*]. He explained that if a person's physical countenance appears to be in tatters, that also impacts on one's emotional state and as a result, it means that the person's *utano* has been diminished. He went on to explain that *kana ukaona munhu akawondoroka, uye achingogara ane tsvina asina kana hanya nekutaridzika zvakanaka,*

zvinoreva kuti pamwe pfungwa dzake hadzisi kushanda zvakanaka kana kuti pamwe nyama dzemuviri dziri kurwadziwa nechirwere chiri kutanhaura muviri [if someone appears frail and unkempt, it either means that the person's mental attitude is not functioning well or they are suffering from an ailment that is eating them up]. For Takwana, someone who has *utano* in fullness has a good physical appearance and is well-balanced emotionally and spiritually.

Laina views *utano* as follows: *kusimba kwemuviri* [physical fitness], *pfungwa dzakagarisika* [peace of mind], *kusava nechirwere kana marwadzo panyama dzako* [free from diseases and pain] *uye kuva nechikafu chakaringana* [having access to a balanced and nutritious diet].

Laina's view about sickness is twofold; on one hand, she believes that there are some common ailments that are due to natural causes, for instance, if one is exposed to excessive cold and does not have proper attire to keep warm, they might come down with flu. Or if one is exposed to too much heat and becomes dehydrated, they might come down with a headache or feel some dizziness. On the other hand, she believes that some sicknesses are as a result of the work of witchcraft, especially strange conditions which cannot be explained through any natural or bio-medical terms. Laina does not view any sickness as having been caused by God's punishing people; rather she is of the opinion that the work of the evil one causes pain, disease and suffering, but not God. Runyararo's definition of *utano* is as follows: *ruvara rweganda, kana ukaona ganda rocheneruka kana kuita mapundu asingahwisiki uye kusviba kuti tsvaa, zvinoreva kuti utano hwatarangana* [skin texture and complexion, if one's skin suddenly becomes pale and develops ugly skin rashes or if one suddenly becomes very dark in complexion, it means that their health is diminished]. *Chete kuti utano hwemazuvano hwonetsa kuona nokuti kune vamwe vari pachirongwa saka miviri yavo yakasimba zvekuti haungambofungiri kuti vane chirwere, kunyangwe ganda racho rinenge rakatsetseka richipenya zvekuti unoti hechino chigagaigwa izvo muviri wemapiritsi chete* [it has become very difficult to judge with a naked eye when it comes to one's health status because there are some people who are on anti-retroviral drugs and their skin texture appears so healthy such that you would think they are the healthiest people around and yet it's just chronic medication that keeps them going].

5.3.3 Factors Impacting upon Karanga People's *Utano*

In Edwin's view, the key factors that influence Karanga people's health negatively include food shortages, droughts that put a heavy toll on their livestock and rendering them poor, lack of clean water for household use and limited space of fertile land to grow their crops and vegetable gardens, graze their livestock and not having enough land to pass on to their children who are starting their own families. He emphasized the problem of families being scattered in faraway places due to the fact that they could not find enough farming land within their parents' villages and as a result young men are forced to move further away from their ancestral homes in search of greener pastures. According to Edwin, this is very problematic because at the end of the day, elderly parents are left behind when their grown children have to relocate and live in *kuminda mirefu* [resettlement areas] or to occupy some farms which were previously owned by white commercial farmers that were removed during the code-named *hondo yeminda* [the battle for land]. He explained that this has resulted in disintegration of families, tearing the family fibre apart. His major concern is that children are supposed to build their homes nearby their ageing parents so that they can offer each other support in times of need but usually this is no longer the case as the younger generation is pushed out of their original villages due to either lack of land or only infertile land being available for them to possess and therefore, they are forced to relocate.

The other major concern that Edwin raised is the syndrome of *kuenda kunze kwenyika* [going out of the country]. Edwin explained that due to the high levels of unemployment in Zimbabwe and the harsh economic climate even in the wake of the dollarization of the economy, the younger generation has resorted to migratory labour. Particularly hordes of them are going into South Africa and Botswana to seek for employment or engage in cross-border trading activities. In Edwin's view, this has also had far reaching repercussions on the health of many, particularly the young families because spouses are separated for very long periods of time and when the young men spend extenuated periods of absence from their wives, they are often tempted to engage in sexual relationships wherever they will be working, exposing them to *chirwere chomukondombera* [HIV&AIDS] which they will subsequently pass on to their spouses. He explained that the HIV epidemic has spread like wildfire in the rural communities, leaving orphans under the care of grandparents or

sometimes leaving orphans to care for themselves in the absence of grandparents or other members of the extended family.

When asked about what he considers as the key factors influencing Karanga people's health negatively, Takwana mentioned that this mainly has to do with the challenge of food insecurity. He explained that the recurring poor harvests and droughts were impacting many households such that some children were suffering from malnourishment. He also indicated that unfaithfulness in many marriages was causing the spread of the HIV epidemic to sweep families like veldt fire. He further explained that lack of most rural communities' understanding of the nature of the HIV epidemic and the issue of denials for those infected and affected was a major problem which was causing them to delay seeking help or adhering to proper medication regimes. The use of unsafe sources of water is another major challenge that he emphasized. He indicated that most of the villages relied on water from the river for domestic use and this caused constant outbreaks of diseases.

As regards the key factors impacting on Karanga people's health negatively, Laina noted three of them, namely poverty, food insecurity and limited knowledge surrounding chronic conditions, particularly HIV and AIDS. Laina explained that due to poverty, some people are forced into risky sexual practices, exposing them to the risk of contracting HIV. Furthermore, she highlighted that some people have very limited knowledge regarding the nature and spread of the HIV epidemic such that in many cases, they focus on accusations of witchcraft and delay seeking proper treatment. By the time they get an accurate diagnosis, it might be too late and in most cases, they would have passed on the infection to their partners. She explained that in some cases, when couples who are HIV positive give birth to children who are also HIV positive, such children will be sickly and instead of facing the harsh reality of life and get tested, they waste time accusing other people of bewitching them and their newly born babies. She gave an example of how some young couples she knows have fallen into this trap, to the extent that they keep trying for a second and third baby who will all die in their infancy without them making any effort to be tested for HIV. She also mentioned that the problem of food insecurity has far-reaching repercussions on people's health because lack of nutritious food makes people vulnerable to so many diseases. Even those who have accepted their HIV status, if they do not have adequate food it becomes very difficult to

adhere to the treatment regime because they need to eat well in order to respond to the medication.

5.3.4 Multiple Health-Seeking Strategies among the Karanga

In Andrew's view, endemic poverty, combined with the many and varied understandings of health and healing as well as the new eating habits and lifestyles ushered in by the modernisation process, impact negatively on Karanga people's health. For him and his family, they always turn to the *n'anga* first whenever they are confronted by sickness because that is where they get holistic medical care - that is, medical care which incorporates and addresses the material and the spiritual. He also regularly consults the prophet-healers within his ZCC fold and if either the prophet-healer or the traditional healer advises him to consider the use of bio-medicine, he does not object to such advice. He also mentioned that usually, people are guided by the nature of the ailment in deciding which of the three health-care practitioners to consult first. Andrew is of the opinion that people should be flexible to utilise all three healthcare systems and that they must be able to choose the one that they are most satisfied with. If need be, they should be flexible enough to use the three systems interchangeably, depending on the nature of one's illness or their circumstances. For him, the main goal for any health care should be to provide healing in its fullness and what matters most for him is to receive complete healing, no matter where that healing comes from.

Andrew indicated that he always visits the traditional doctor whenever he feels there is need to seek help for physical healing or guidance especially when undertaking major life decisions. What he appreciates most about the services offered by the traditional doctor is that all fundamental aspects relating to the traditional African holistic perspective on life, sicknesses, misfortunes and all other struggles of life are embraced in the diagnosis and treatment.

One major reason that makes Andrew for preferring the service offered by the traditional healer is that whereas one has to travel for a distance of approximately 15 kilometres to reach the nearest clinic, for the healing-prophet or the traditional doctor they do not need to travel that much because these practitioners are members of the community and they live among their people in the village. Another reason that makes Andrew to appreciate the role of the

traditional healers is that they are always readily available, whereas the medical doctors and nurses are not always available. For instance, the local clinic is closed during weekends and on all public holidays such that if there is an emergency, it becomes very problematic. Moreover, the service fees charged at most of the hospitals are very high and one is expected to pay cash in hard currency, which is very scarce especially for civil servants (of whom Andrew is one of them) because they earn meagre salaries. What makes it even worse is that more often than not, the prescribed medication is not available in the clinics and the hospitals, and buying from the privately owned pharmacies makes it even more expensive. This is also because most of the pharmacies have to individually import most of their supplies from the nearby countries, particularly from South Africa and Botswana. As such, they incur major expenses which they pass on to the client in the form of charging exorbitant prices.

One of the key solutions to the current health-care crisis that Andrew suggested is the need for integrating African traditional medicine in the public health care system, particularly the local clinics and also hospitals. His argument is that there is abundant knowledge around the African community on herbal and other traditional healing remedies which have been utilised by Africans since time immemorial, well before the introduction of western bio-medicine in Africa. He suggested that these effective remedies could be patented and preserved so that they are made available for use to all members of the community. He noted that there are several people who are very knowledgeable about various remedies but are very secretive about it such that there is a danger that the older generation might die with their knowledge, not having had the opportunity to pass on this precious knowledge to the younger generation. He also explained that the modernisation process has created a huge cultural vacuum within the traditional African family set up; as such, the younger generation growing in the urban community very far away from their rural home (or sometimes in other parts of Africa or even overseas due to migratory labour) has lost touch with most of the older generation. Whereas, in the past, grandparents, parents, aunts and uncles would pass on their wisdom and knowledge or traditional healing remedies to the younger generation, the current situation has created a huge gap, making it almost impossible to maintain the generational link. In view of these challenges, Andrew is of the opinion that this knowledge and these remedies should be preserved and information about them must be circulated in written form so that it may continue to be passed on to the oncoming generations.

Andrew's perspective is that these three health-care systems are usually portrayed as antagonistic to each other and this portrayal of antagonism is usually exaggerated. He was also quick to mention that other religious belief systems condemn the African traditional doctor as a witch or wizard, but he also acknowledged that this attitude was much stronger in the early days when Christianity and bio-medicine were still being introduced to Africa. However; because of the stigma attached to traditional medicine, many people will hide their profession lest they be condemned or those who are supposed to get help from them end up consulting them in the thick of the night for fear of being singled out as heathen. In this regard, Andrew suggested that there is a major challenge for policy makers to find an amicable way of integrating these health-care systems so that there can be a holistic health-care system in the country.

Andrew went further to explore other possible reasons for conflict and antagonism within the three health-care systems by tracing their historical backgrounds. He noted that on one hand, Western oriented health-care tends to view African traditional health-care as pagan, heathen and barbaric. Furthermore, 'Born again Christians' (mainly mainline evangelical, charismatic and Pentecostal Christians) despise and demonise everything that is traditional in African society. On the other hand, African traditional doctors strongly feel that they are not appreciated by their western trained counterparts. Western trained healthcare practitioners insist that a healthcare practice that depends so much on the spiritual world cannot be trusted. Christian health-care (mainly modern bio-medical practise introduced by missionaries) is usually accused of using medicine with the aim of demonstrating the power of Christ to the Africans with the main purpose of undermining traditional medicine and traditional belief systems. Western oriented healthcare practitioners are usually accused by African traditional doctors of being arrogant for insisting that all medication should be subjected to scientific observation and verification. Within such a situation there is a general lack of trust that usually arises from mutual suspicion, making meaningful collaboration a far cry from reality. In view of all these complex realities, Andrew therefore propounds for a program to re-educate these healthcare practitioners on the importance of developing a healthcare outlook that is based on holistic healing.

As regards factors influencing Karanga people's health-seeking behaviour, Edwin noted that this is mainly determined by either the nature of the problem or the availability of the

practitioners. He explained that for his family, they usually alternate the use of bio-medicine and the services of the traditional healer. For instance, if a person is experiencing some illness which they regard as a purely physical and ordinary ailment such as a headache or continuous coughing, they will take the patient to the nearest clinic. However, if they feel that even after seeking treatment from the clinic, the problem seems not to be improving, they might consider going to consult the traditional healer to establish if there are no other extenuating causes. On the other hand, he mentioned that in the event that a patient is suffering from convulsions or is hallucinating, their first inclination is to suspect witchcraft such that they will immediately take the patient to the traditional healer.

In Edwin's opinion, most people utilise the three health-care-systems concurrently, even though some might not want to readily admit it, particularly those who belong to churches that restrict them from utilising either traditional medicine or prophet-healers. He highlighted that from his experience, the three health-care systems are not clearly integrated because they seem to operate from different principles but on the other hand, he feels that they are not antagonistic towards each other especially in view of the fact that often times, their local clinic has limited supply of medication to relieve people's suffering. As such, the nurses at the local clinic will not be in a position to discourage their patients from accessing other services if they cannot even provide the basic medicines for common ailments. Edwin is of the view that people should have the freedom to decide which service to utilise, even those who profess to be Christians; they should not be restricted from utilising alternative health-care services if they feel that is where their problems will be adequately addressed.

When asked about how their religion influences their response to sickness, Takwana and his parents explained that they believe that God created people to live life to the fullest without any pain or suffering and their interpretation of illness was that there was an outside force causing ill-health, either humanity's failure to live according to God's natural laws or the evil one would have interfered with the well-being of humanity. They explained that they had patiently prayed and faithfully waited for God's healing touch to restore Takwana's health but they had come to the realisation that they needed to seek the services of the traditional healer to ascertain the real cause for the persisting problem in their son's health. Probed further to explain why they thought it necessary to consult the traditional healer, Takwana's parents highlighted the fact that in the Karanga traditional cultural beliefs, a recurring ear

problem is a sign of the presence of either *mashavi* [foreign/alien spirits] or *midzimu* [family spirits] intending to possess the affected host. As such, they found it pertinent that they consult the traditional healer to get to the bottom of the problem and resolve it. They indicated that this was their first time to consult this traditional healer and the main reason they had chosen this particular service provider is because she was someone renowned within the community. Furthermore, they only had to travel a short distance of about four kilometres from their homestead in Masunda village to reach the healer in Chineka village, hence, the issue of accessibility and reliability of this healer was an added advantage for them.

As regards his views on the issue of people utilising the three health care systems, Takwana's response was that personally, he prefers the use of western bio-medicine and only resorts to alternative healing systems when all else in the bio-medical system has failed. However, he was also quick to add that other people alternate the three systems concurrently and that he does not have a problem with that, as long as people consult genuine traditional healers or prophet healers whose main goal is to preserve health and well-being. He said that the problem with most traditional healers and prophet-healers is that they always accuse either close relatives or neighbours of witchcraft and this often causes rifts in many families. He mentioned that even some people suffering from HIV related symptoms always blame it on the work of witchcraft and in the process; their health will continue to deteriorate.

Takwana feels that there is almost no integration between the three health-care systems mainly because their methods of diagnosing and treating patients are different. He mentioned that often times, he senses some tension and competition for clients between the three different health practices and he feels that in most cases, most bio-medical practitioners look down upon the other two.

When asked about her views regarding the key factors influencing Karanga people's health-seeking behaviour, Laina explained that this is usually determined by the nature of the ailment as well as how well the patient is responding to a particular health-care system. For instance, she indicated that in her case, she usually visits the clinic or hospital or private doctor whenever she comes down with tonsillitis because she believes that western bio-medicine is better placed in dealing with such a condition. However, when it comes to the

issue of severe earache resulting in totally losing her hearing senses - which usually coincides with the times when she is preparing for major exams, - her family ascribe this to works of witchcraft perpetrated by those who are envious of her academic excellence. As a result, she has often resorted to consulting the prophet-healers from her church to protect her from the malicious witches and then afterwards, she goes to the clinic to seek pain relief for the earache.

Laina is of the view that the three health-care systems complement each other, particularly because in her case, she utilises all the three systems concurrently. She believes that there are conditions that can be best addressed by western bio-medicine, for example, if someone has a bruise or is suffering from some common or physical ailments. However, she feels that it can only do so much and if there are other forces at work such as witchcraft and spiritual forces, then it becomes imperative to combine either the two, i.e. western bio-medicine and the prophet-healers, or all the three, i.e. western bio-medicine, prophet-healers and traditional medicine. In her case, she had now resorted to traditional medicine because she felt that she had exhausted the other two which had failed to reach the bottom of the cause of her recurring ailments. Laina noted that whenever she visited the clinic, the bio-medical practitioners would always find a clinical cause for her condition but their treatment had not managed to protect her from suffering from the same ailment again and they had never suggested that she try alternative health-care systems. On the other hand, whenever she visited the prophet-healers, they would give her lengthy explanations about the malicious works of witchcraft which were causing her all this suffering and they would try to cast away these forces of witchcraft and then advise her to seek help from the clinic so as to address the physical pain. She mentioned that there are some traditional healers and prophet-healers who totally discourage their patients from mixing their healing remedies with those from the western bio-medical system and by the same token, some western bio-medical practitioners are very antagonistic to their patients' utilising alternative health-care systems. Laina emphasized that she found such an attitude very problematic and suggested that all the three health-care systems should work towards resolving their conflicts and focus on caring for and restoring people's health in all its fullness, rather than focusing on fame and amassing wealth through cashing in on other people's miseries.

According to Runyararo, several factors influence Karanga people's health-seeking behaviour. In her case, she is mostly guided by the nature of the ailment which will determine whether she goes to the bio-medical practitioner first or to the prophet-healer first because she usually makes use of these two interchangeably. She said that in the event that she is suffering from an ordinary ailment such as a minor headache or stomach-ache, she will go to the clinic first. Only if it persists and she suspects that the ailment might be caused by other external forces, then she will consult the prophet-healer. However, if the condition is spirit-related, such as *kurwara pfungwa* [mental disturbances] or *pfari* [convulsions/fit], then she would consider taking such a patient to the prophet-healer first, and only after the prophet healer has cast off the evil spell will she take the patient for bio-medical observation. She noted that there are some people who prefer utilising the traditional healer first and for her, as long as the condition warrants the attention of such a practitioner, she does not have any problems with it. However, her major concern is when people delay seeking proper bio-medical help only to take the patient to the hospital at the point of death. For her, this is problematic because sometimes people die from a condition that could have been easily managed if only the patient received proper treatment from the beginning.

According to Runyararo, the three health-care systems are not properly integrated when it comes to the issue of care-giving. She feels that most of the times, they operate separately and are often antagonistic to each other. She also alleged that in many instances, most public health care systems have lost the caring and supportive environment that they used to offer to patients in the past. She argued that some people prefer to spend their dying moments at home under the care of their loved ones because they feel that the public hospitals tend to neglect any critically ill patients. She added that people often regard public health institutions as death-traps because some personnel do not properly care for the patients and they are quick to dismiss any patients whom they perceive as being poor with nothing to offer them as a bribe for preferential treatment. In this regard, Runyararo feels that to a large extent, prophet-healers and traditional healers are less discriminatory and they treat all patients with utmost care and respect. She suggested that the three health-care systems need to work together in providing and preserving people's well-being and they need to be aware of what services each has to offer so that they can make informed decisions when referring patients to each other.

5.4 Patients at a Clinic (Western Bio-Medicine)

Having examined the responses of study participants who were interacting with prophet healers and traditional healers in the preceding sections, in this section I bring together reactions from patients who were accessing health care at Mashenjere and Shonganiso clinics in Murinye.

5.4.1 Biographical Information and Medical Histories

Believe⁵⁸⁸ is a twenty-five year old male who is a member of the Seventh Day Adventist (SDA) Church. His educational qualification is 'O' Level and he is self-employed. He does carpentry and metal-work for local people, a trade that he inherited from his late father. The main reason that made him to visit the clinic on this particular day is that he was responding to a campaign on flu vaccination and had come along with his younger brother and sister to be vaccinated. Believe mentioned that he is an orphan who is raising his two siblings after they lost both their parents at a very young age. Having watched his parents suffer and having cared for them through their illness, he is wary of any signs of illness among his remaining family members and therefore he makes all the effort to seek medical care whenever a need arises.

Pauros⁵⁸⁹ is a thirty-six year old male and is a member of the Seventh Day Adventist (SDA) Church. His educational qualification is 'O' Level and he works as a security guard at Mashenjere shopping centre. On this occasion, he was visiting the clinic in order to be vaccinated against influenza. He mentioned that he visits this clinic regularly, especially to be treated for a recurring headache. Pauros highlighted that when it comes to the problem of suffering from constant headaches, he prefers to make use of the clinic services because the clinic is very near to where he lives (approximately 3kms away) and also because his place of employment is located around the same place with the clinic. However, he also mentioned that although he regularly receives some pain-relieving medication for the headaches, unfortunately, it has not brought a lasting solution to his pain and suffering.

⁵⁸⁸ Interviewed 28 December 2006, Mashenjere Clinic, Murinye, Masvingo.

⁵⁸⁹ Interviewed 28 December 2006, Mashenjere Clinic, Murinye, Masvingo.

Milton⁵⁹⁰ is a forty year-old male and is a member of the Seventh Day Adventist (SDA) Church. His educational qualification is 'O' Level and he holds a teaching diploma, being a teacher by profession. Milton is an asthma patient, therefore he regularly visits the clinic for a medical review (at least twice monthly) and to collect his monthly supply of asthma medication. He highlighted that for his asthma condition, he relies solely on bio-medicine because he feels that it is the best health-care system to address this condition. However, he mentioned that at some point when he was suffering from an unusual stomach ailment, he resorted to consulting a prophet-healer because bio-medicine seemed to have failed to treat the ailment. He explained that he had visited the clinic and when he did not get any better, he was referred to the provincial hospital, and still the hospital could not detect the actual cause of his stomach problem. He even consulted a private doctor and spent a huge amount of money trying to seek relief for this condition.

Milton indicated that it was after he had exhausted all the avenues within the bio-medical system that out of desperation, he resolved to consult a prophet-healer because several people had been advising him to try faith healing. Being a member of the SDA Church, Milton had some reservations regarding the use of prophet-healers since his church teaching heavily attacks such practices. However, he explained that on several occasions, some of his relatives had warned him of the possibility that his sickness was emanating from the work of witchcraft. They advised him to consult a renowned prophet-healer who could use his divining power to detect the cause of his stomach pains and relieve him from the unbearable pain. With a heavy heart, Milton went to consult the prophet-healer who was able to 'extract' some foreign objects from his stomach and ended his misery. He also related how this cost him his position at church as a deacon, because when the church board discovered that he had 'wandered off the path' through consulting a prophet-healer, they censured him and stripped him of the office of a deacon. Milton explained that this was very humiliating but he accepted his lot because he knew that he had transgressed against the church's doctrine. After humbly observing the disciplinary measures, Milton eventually rededicated his life to following the SDA doctrine and began to participate actively in the church leadership structure.

⁵⁹⁰ Interviewed 29 December 2006, Shonganiso Clinic, Murinye, Masvingo.

Jennifer⁵⁹¹ is a thirty-two year-old female and is a member of the Seventh Day Adventist (SDA) Church. Her academic qualification is O' Level and she is actively involved in small-scale vegetable farming for household use and also for selling to the local community. The reason why she had visited the clinic on this particular day is because she was suffering from severe headache which had persisted for a full week. Jennifer indicated that she visits the clinic regularly, whenever an illness strikes in her family. Sometimes she brings her two children to the clinic for immunisation or for treatment when they are sick. She lives approximately four kilometres away from the clinic and finds it readily accessible because she can easily walk to and from the clinic. Jennifer indicated that she prefers utilising Shonganiso clinic because it is a church-related institution and its basic principles are anchored on Christian values. She highlighted that even some of the teachings offered to nursing mothers when they bring their babies for immunisation usually resonates with the basic health laws offered in her SDA Church's health reform message.

Rutendo⁵⁹² is a fifty-eight year-old female and is a member of the SDA Church. Her educational level is Standard Four. Her reason for visiting the clinic on this particular day is that she was suffering from *nyon'go* [gastritis]. She mentioned that she visits this clinic regularly, sometimes to be treated for chest pains, asthma or gastritis. The other health care services that she has utilised in the past include Zvishavane Clinic, a prophet healer in Zvishavane town and another prophet healer in Gaviro village. Rutendo was quick to acknowledge that although consulting prophet-healers is not accepted within the SDA Church doctrine, she however justified her actions by arguing that she was desperate for healing after having exhausted the bio-medical route with no end in sight for her asthma condition. She mentioned that the prophet-healer from Gaviro village healed her asthma about ten years ago and since then, she has never suffered from any attacks and has not found any reason for consulting the prophet healer again. Rutendo emphasized the fact that whenever she went to consult the prophet healers, she did it secretly so that none of the members from her congregation would detect her, lest she be censured for that. Luckily, for her, nobody ever caught her and she has therefore escaped the disciplinary measures. Rutendo charged that even some members in the top church leadership such as deacons/deaconesses or church

⁵⁹¹ Interviewed 29 December 2006, Shonganiso Clinic, Murinye, Masvingo.

⁵⁹² Interviewed 29 December 2006, Shonganiso Clinic, Murinye, Masvingo.

elders also nicodemously go to consult some prophet healers; paradoxically, when they find that an ordinary member has done the same thing, all hell breaks loose.

5.4.2 Understanding of *Utano*

Believe understands *utano* as follows: “*Chimiro uye kutaridzika kweganda remuviri* [One’s physical appearance and also skin texture] *muviru wakasimba, uye ganda rakatsetseka kwete kugara uchingokwenya-kwenya* [healthy and fit physical appearance, one should not be always scratching their skin]. *Muviri wakasimba kwete kungokosora-kosora* [free from all sorts of ailments, one should not be constantly coughing].

Pauros understands *utano* in the following words: “*Chimiro chemunhu chinotiudza zvakwanda zvakavanzika* [one's appearance reveals a lot, even if the person does not wish to reveal that they are sick]. *Kukosora nekugara munhu achingokwenya-kwenya muviru zvinotaridza kuti urwere hwapinda mumuviri* [recurrent coughing and persistently scratching show that illness has set in]. *Munhu ane utano anoonekwa nemuviri wakasimba, ganda rakatsetseka risina mavanga uye anogara akafaranuka* [a healthy person has a strong body, well-built physically, good quality skin texture without scars all over and they are always jovial]. *Ukaona munhu anogara akasuruvara achingokurumidza kutsamwa kana kukonana nevamwe, zvinoreva kuti pane zviri kunetsa muupenyu hwake* [if a person is always unhappy or if they easily get upset and are forever picking up fights, it is a sign that there is something very wrong in their life].”

According to Milton, he views *Utano* is as follows: “Someone who is not sickly, *ane muviru wakagwinya* [with a strong and healthy physical outlook]. *Ganda rakaurungana uye muviru wakashambidzika* [Smooth skin and neat outlook/appearance]. *Pfungwa dzakagadzitsikana uye kugarisana zvakanaka nevamwe nekuva nechekudya chakaringana* [One should have peace of mind and maintain amicable relations with those surrounding you. They should also enjoy abundance in terms of food security].”

Milton's conception of illness is that it is God's way of chastening humanity and reminding them of his almighty power to heal the sick and to take away life. He also intoned that some unusual illnesses are not from God but rather are the work of the evil one who plots against

God's people to inflict pain and misery in their lives. He bemoaned that some people are involved in acts of witchcraft and sorcery just for the sake of causing other innocent people to endure unbearable pain. Jennifer defined *utano* in the following words: “*munhu ane muviri unotaridza kuti wakasimba uye anogona kuzvishandira mabasa ose epamusha* [one with a healthy looking body and is fit and strong enough to work and support themselves].”

Jennifer's perspective on illness is that it is a normal physical process that happens to people for a reason. She believes that God is in charge of humanity's well-being and that if people adhere to God's natural laws, observing all the dietary stipulations and adhering to basic health and hygienic rules, this will certainly reduce incidences of illness.

5.4.3 Factors Impacting upon Karanga People's *Utano*

As regards the key factors negatively affecting Karanga people's health, Believe highlighted some prevalent practises such as partaking of alcohol and other harmful substances such as tobacco and *mbanje* [dagga/marijuana]. He also pointed out the issue of drinking water from unclean sources, especially running water from Mutirikwi River, which happens to be the main source of water for many families. Low hygiene standards, a poor diet, and in some instances utter food insecurity were mentioned as factors impacting negatively on Karanga people's health.

The main factors that Pauros identified as impacting negatively on Karanga people's health are poverty and poor sanitation. He emphasized that poor households are more vulnerable to illness because of their poor nutritional standards. He also highlighted the issue of poor sanitation, especially in view of the fact that some households within his neighbourhood are still using bush toilets, i.e. they do not have any structure put up as a toilet and whenever nature calls, they go into the bush to relieve themselves. Pauros is of the view that poor households need to be assisted to come out of the cycle of poverty through donations of farming implements and seeds so that they may become self-reliant and be able to effectively utilise their fields and produce their own food. He went on to explain that several households are usually food-insecure mainly because they lack the essential farming implements to enable them to be productive in their fields. As such, Pauros is of the view that if such

families are assisted with farming implements and seed, this could go a long way in rescuing them from the vicious cycle of poverty.

As regards the main challenges encountered in utilising this health-care service, Milton highlighted the inaccessibility of the clinic during the rainy season. He explained that he lives only four kilometres away from the clinic in Matsikidze community; however, it is on the other side of Mutirikwi River such that whenever there are heavy rains, the bridge linking their village to the clinic becomes impassable. It is during such times that all patients relying on this clinic are forced to travel a much longer distance, approximately forty kilometres away, to the provincial hospital, Morgenster, in order to access bio-medical health care. Milton elaborated that very few people who are able to raise transport fees to travel that far can afford this move. As such, those without any financial means are left to endure pain without any relief. He further explained that another challenge lies in view of the fact that the clinic sometimes runs out of essential medication, such that people travel long distances only to be informed that there are no medical supplies. He also raised the issue of a limited staff complement, indicating that most of the time; the clinic is under-staffed such that patients spend long hours waiting in the queue.

Pauros highlighted that he respects and appreciates the effort that the nursing staff put into their work even amidst shortages of drugs and other essential supplies. The main challenges that he noted regarding the use of this facility is the constant shortage of essential drugs and the issue of being served by a limited staff complement. Pauros went on to elaborate that there are times when the clinic runs completely out of the most basic pain tablets such as Panadol or Paracetamol. He also complained about the persistent shortage of qualified personnel at the clinic, and indicated that there are several instances when nurse aides and even the clinic's general workers end up assisting in diagnosing patients' ailments and dispensing medications. In response to all the challenges mentioned, Pauros suggested the need for a more consistent supply of drugs and other essentials since the shortages impact negatively on service delivery. He also added that the government should offer more lucrative working terms and conditions for the nursing staff so that they may attract more experienced and more qualified personnel even in the rural clinics and to cushion the health sector from the unending brain drain.

As for the factors that negatively affect Karanga people's health, Jennifer highlighted the negative impact of drinking alcohol and smoking tobacco and other harmful substances, which is so prevalent particularly in the rural areas. She bemoaned that such behaviour has also become common even among the youth because of their being idle (due to high rates of unemployment). She also pointed out that some people are engaging in risky sexual behaviour such that some married couples are being unfaithful to their partners. Jennifer reiterated that this has impacted heavily on people's health, especially in view of the high rates of HIV and AIDS in the country. She indicated that the community's reliance on migratory labour has worsened the situation because married people are staying far away from their partners and as a result, they end up being unfaithful to each other. When they eventually reunite with their partners, they will not want to own up and initiate safer sex and therefore they spread the infection to their partners. She intoned that this has sent many married people in the community to an early grave and has also left some orphans infected with HIV or AIDS through parent to child transmission.

The major challenges that Jennifer identified in utilising this health-care service is the fact that on several occasions, the clinic runs out of essential medication and when a patient comes to consult, they will be advised to go and purchase their own medication from the pharmacies in the urban areas. She explained that this is very problematic because most people in the rural areas cannot afford such an endeavour, such that they end up hesitating to visit the clinic because they feel that it is failing to provide them with the essential medicines. Jennifer suggested that the clinic should be furnished with a constant and consistent supply of drugs so that people can have the assurance that the clinic is able to cater to all their health needs. She also suggested that people must utilise their age-old natural remedies for minor ailments such as cough, stomach pains, toothache and earache. She explained that there are local medicinal herbs, which are mostly self-administered, that can effectively heal some of these ailments. As such, she is of the view that people need not be too dependent on the clinic because it is not always guaranteed that they will receive the required treatment.

5.4.4 Karanga People's Multiple Health-Seeking Strategies

On the issue of Karanga people using the three health-care systems, Believe acknowledged the fact that this is usually the norm, especially in the rural community. He indicated that even some members of his local SDA church sometimes clandestinely utilise the services of either traditional healers or prophet-healers or both, even though this is against their church doctrine. However, he explained that for him, because of his religious standpoint and because of his late parents' influence, he does not make use of either traditional healers or prophet-healers and he relies solely on bio-medicine. He also reiterated the fact that he tries as much as possible to observe a healthy diet and a healthy lifestyle as well as maintaining very high hygienic standards to eliminate the incidence of diseases. He mentioned that he prefers the clinic because he feels that this service offers him the best health solutions to all ailments. In his view, those who utilise the other health-care systems are probably drawn there because they feel that it is where their problems are adequately addressed. His conclusion is that people should feel free to navigate the various options available, as long as their problems are addressed in a satisfactory manner.

According to Believe, there is no clear-cut link between the three health-care systems, mainly because he feels that they are founded on different principles and their methods of care-giving and healing are different. He argued that for those traditional healers or prophet-healers who charge patients for their services, they hardly refer patients to the clinic since they want to 'hold on' to the clients, lest they lose business. His main concern in such cases is that sometimes patients who will be needing urgent medical care might be delayed by the traditional healers or prophet-healers due to their own selfish reasons such that by the time they seek medical care, it might be too late. He also bemoaned the fact that sometimes people focus too much on a belief in witchcraft such that even if it is a simple bio-medical problem, they will go round and round in circles and end up spending a lot of resources paying for services that might not bring lasting solutions to their problems.

As regards the main factors influencing Karanga people's health-seeking behaviour, Pauros emphasized the fact that usually the nature of the ailment and the accessibility of the nearest facility are the key determining factors. He noted that for him and his family, their first choice is usually the clinic and only if they realise that the treatment received from the clinic

is not being effective, then they will consider consulting some prophet-healer in private. He also referred to the fact that he is aware of some members of the SDA Church who also consult either traditional healers or prophet-healers in private due to the restrictions of their church doctrine. However, he indicated that for those who belong to churches that do not teach against the use of prophet-healers, they openly go to consult them whenever the need arises. Pauros also acknowledged the fact that most people in the community make use of the three health-care systems concurrently. He mentioned that there are certain ailments that are best treated through biomedicine, for instance, if a patient is suffering from HIV related symptoms. However, he argued that if some demonic forces have possessed a patient, the best place where they can receive fast and effective treatment is either at the prophet-healer or from a traditional healer. He reiterated the fact that personally, he does not agree with certain methods used by some traditional healers and therefore, he will not consult them nor will he encourage any member of his family to utilise the services of a traditional healer.

On the issue of whether the three health-care systems are integrated or not, Pauros is of the view that there is very little co-ordination between the three systems, since all the three seem to be operating in isolation and they differ in their ethics. He said that he has never heard of a situation where the nurses refer their patients to a local traditional healer or prophet-healer or vice-versa. He insinuated that most traditional healers and prophet-healers do not refer their patients to the clinic for fear of losing their clientele and this would impact heavily on their source of income since most of them charge a certain amount of money for their services.

According to Milton, there are several factors influencing Karanga people's health-seeking behaviour within the community. This includes beliefs about the causes of certain illnesses, the nature of service delivery, accessibility, cost and stigma. He explained that in a situation whereby a patient is suffering from mental illness, the family would normally consult a traditional healer or a faith healer first because this illness is closely related to works of witchcraft. Moreso, most families prefer these services to the public health care system because mental illness has some elements of stigma attached to it, therefore, they avoid taking such a patient to the bio-medical facility because they lack privacy and sometimes the treatment offered there does not adequately address the root causes of such an illness. Milton also emphasized the fact that in some cases, the choice of which facility to access first is influenced by its accessibility and affordability as well as the quality of service delivery.

Whereas with the traditional healer or a faith healer the terms of payment can be negotiated and in many cases the service fees can be paid for in kind, when it comes to the bio-medical facilities, service fees have to be paid cash up front. This is especially the case at the provincial referral centres where most of the prescribed medicines must be paid for before collecting them. However, for Milton and his immediate family, the first choice is always bio-medical services and only when all avenues within that system have failed, then they will resort to prophet healers. He explained that people should have the freedom to select health services that adequately address their health needs and restore their health and well-being in all its fullness.

In Milton's view, the three health care systems tend to operate in isolation although he acknowledged that there are instances whereby prophet-healers will refer their patients to the clinic. However, he asserted that he has never heard of an instance whereby traditional healers will refer their patients to the clinic or to the prophet-healers.

On the key factors influencing Karanga people's health-seeking behaviour, Jennifer is of the view that people's choices on which practitioner to consult first are mainly influenced by their religious affiliations and in some cases by the nature of the ailment. She indicated that in some cases, for those who are still attached to Karanga traditional beliefs, whenever a person is struck down by an illness that is suspected to be witchcraft-related, they will consult a traditional healer first. She further explained that for those who believe in prophet-healers, whenever illness strikes, particularly those which are regarded as *mweya yetsvina* [spiritually related], they will rush to the prophet healer. According to Jennifer, because of her being deeply rooted in the SDA doctrine, she does not believe in the efficacy of either prophet healers or traditional healers and whenever the choice is upon her, she will rely solely on bio-medicine. However, she mentioned that a few years ago, when her late husband was gravely ill, she was pressurised by her in-laws to accompany him to a prophet-healer because they suspected that his sickness could have been a result of witchcraft. Jennifer explained that she had to give in to the in-laws' demands and she went with them and her husband to consult because if she had resisted, they would then accuse her of having probably bewitched her own husband. She said that even after consulting the prophet healer, her husband did not get any better and eventually, he passed away. She explained that when she was brought before the disciplinary hearing by her church board for having consulted a prophet healer, she

explained to them that it was beyond her own choice but still she had to undergo a period of censure for having transgressed against church doctrine.

As regards people utilising two or three of the health-care systems, Jennifer is of the view that people should feel free to utilise whatever facility offers them the most fulfilling service. She said that although she feels satisfied by the services offered in the bio-medical service, there are other people who feel that a certain traditional healer or prophet healer offers them the best service they need. She also mentioned that some people feel contented when they make use of all the three health-care systems so that they can reap benefits from each of the three facilities, and others use two systems concurrently. On the question of whether the three health-care systems are integrated or not, Jennifer's opinion is that the three systems are not in any way integrated. She argued that all three of them operate so differently and their differences cannot be reconciled.

5.5 An Analysis of the Main Themes Emerging from the Health-Seekers' Experiences

Several common themes emerged from analysing the views and experiences of the health-seekers within the three categories during their search for health-care provision. It is significant to note that most of the key themes that emerged from chapter four where an analysis of the health-care providers was made also tended to emerge from the experiences of the health-seekers. Below is an exploration of the common themes prevalent among the study participants.

5.5.1 Karanga People's Multiple Health Seeking Behaviour

A common theme that runs through most of the study participants' responses is the apparent tendency to make use of at least two or three health-care systems in search for fullness of health and well-being. All the ten study participants who were patients at several prophet-healers mentioned that they had made use of other health-care providers. Depending on the nature of the problem, patients tended to consult the three systems interchangeably. Of the ten patients interviewed during their visit to consult various prophet-healers, four indicated that they had made use of all the three health-care systems. *Mbuya* Esther mentioned that she had tried all sorts of bio-medical interventions for her condition of cervical cancer but had now resorted to focusing on the intervention of the prophet-healer. She indicated that she had made use of traditional medicine in the past but had lost faith in the work of traditional

healers. Terrence explained that he had visited several bio-medical practitioners seeking for healing for his right knee and the numbness that he experienced on the right side of his body. He had also consulted several traditional healers and was now focusing on prophet-healers who seemed to offer considerable relief to his condition. Rukariro also indicated that she alternates between the prophet-healers and the bio-medical system. She noted that before joining the Johane Marange Apostolic Church she used to consult traditional healers for any spiritually related matters but now she focuses on consulting prophet-healers within her church for all spirit-related matters. Veronica indicated that she had consulted several bio-medical practitioners and traditional healers in search of a solution for her failure to conceive but had not received a satisfactory remedy until she resorted to pursuing faith-healers. She had consulted several prophet-healers and this was the third prophet-healer she was visiting.

Six out of the ten patients who had come to consult the prophet-healers indicated that they had also tried bio-medical interventions to no avail; no reference was made to consulting traditional healers. Ingrid mentioned that she had consulted several prophet-healers in search of a solution for her domestic problems with her husband as well as spiritual release from witchcraft and evil attacks. She had also regularly utilised the clinic and hospital to seek treatment for several physical ailments. Her only hope was now with the prophet-healer. Likewise, Samson highlighted that he alternates between the services of a prophet-healer and the clinic/hospital in search of healing from the gastrointestinal disorders and a weak chest that he battles with on a regular basis. In the same light, Wellington mentioned that he also alternates between the bio-medical system and the prophet-healers.

Ruvarashe indicated that she had tried several bio-medical practitioners in search of healing from a severe headache but had subsequently given up on it and she was now focusing on prophet-healers who had offered her lasting relief from her condition. Rumbidzai had been to several bio-medical practitioners trying to fathom the reason behind her unusual and abnormal menstrual cycle but had failed to receive any satisfactory explanation. She had also consulted several prophet-healers within her congregation and had now resorted to consulting another prophet-healer outside her congregation. Likewise, Tawanda had been to several bio-medical practitioners to seek treatment for migraine headache, he had also tried consulting the prophet-healers within his congregation but they had all failed to fathom the real cause of his headaches and had not been able to offer him any lasting relief. He had now resorted to

consulting prophet-healers from other denominations and that is the reason why he had come to the Johane Masowe Apostolic faith-healer where he was hoping to receive healing.

The ten study participants who were interviewed during their visits at the various traditional healers also indicated that they had tried other health-care systems. Six out of the ten patients revealed that they had made use of all the three health-care systems. Laina had tried the use of western bio-medicine as well as faith-healing from various prophet-healers but had not received any lasting solution to the recurring ear-infections and tonsillitis. She had now turned to traditional medicine. In the same way, Runyararo had tried both western bio-medicine and faith-healing for the pains that she was experiencing throughout her whole body as well as continual exhaustion and weakness in her joints. Having failed to receive the healing she was searching for in these two systems, she was hopeful that traditional medicine would be the answer to her woes. Likewise, Grace had also consulted several bio-medical practitioners and prophet-healers for her chest pains. She had been to two other traditional healers and this was her first visit to this traditional healer. Similarly, Susan had made use of western bio-medicine; she had also consulted several traditional healers and many other prophet-healers in search of healing for her leg and her right eye which had subsequently turned blind. Yvonne's experience finds resonance with the others; she had also been to several prophet-healers and bio-medical practitioners but her stomach-pains were not getting any better. This was her first time to visit a traditional healer and she was hoping to receive a lasting solution to her condition. Leslie had also travelled the same path. Due to her continuously deteriorating condition with a lump in her breast, she had tried all three health-care systems and because she was too afraid to undergo the operation to remove the breast as had been advised at the hospital, she was hoping that traditional medicine might remedy her situation.

Four out of ten patients mentioned that they alternated between the use of western bio-medicine and faith-healing. Andrew mentioned that he had utilised various bio-medical systems in search of an explanation and healing for the swelling and stabbing pains that he was experiencing in his foot. Having failed to receive a clear diagnosis and treatment for his condition from the bio-medical system, Andrew had resorted to consulting the traditional healers in the hope that he would receive healing through traditional medicine. Likewise, Edwin related that he had consulted several bio-medical practitioners due to a recurring

headache but he had not responded to western medicine. He had therefore decided to try traditional medicine in the hope that it would offer lasting solutions to his predicament. In the same light, Takwana had tried western bio-medicine in search of healing for his recurring ear problem but for many years, he had continued to suffer from this ailment. As a result, he had now resorted to consulting a traditional healer hoping that he could be healed through traditional medicine. Kelvin had also trudged the same path, he had utilised several western bio-medical services for the pain in his arms and the excruciating back pain but had only received temporary relief. He was hoping that traditional medicine would be an answer to all his unresolved problems.

It is significant to note that the ten patients who were the study participants at the two clinics were all members of the Seventh Day Adventist (SDA) Church. The SDA church doctrine is strictly against its members making any use of either traditional medicine or consulting prophet-healers. It only accepts western bio-medicine and emphasizes the observance of a healthy lifestyle and a life of prayerfulness and temperance as key to fullness of health and well-being. However, despite the church's doctrine strictly forbidding members from making use of traditional medicine and prophet-healers, the reality on the ground is that some members still make use of these forbidden health-care systems.

Six out of the ten patients who are all members of the SDA church mentioned that they had never made use of traditional medicine or prophet-healers; they only focus on western bio-medicine. Believe and Jacob indicated that as a matter of principle, they only rely on western bio-medicine and they do not in any way consider the use of traditional medicine or prophet-healers. Likewise, Ratidzo also mentioned that due to her faith, she makes use of western bio-medicine for major ailments and other home-made natural remedies to treat minor illnesses. In the same light, Nyasha, Sharai and Chipo also reiterated that due to the influence of their church doctrine, they rely on western bio-medicine only.

On the other hand, four out of the ten patients who are members of the SDA church revealed that besides utilising western bio-medicine they had also consulted some prophet-healers. Pauros revealed that he alternates the use of bio-medicine and faith-healing because he feels that at times western bio-medicine does not offer him a lasting solution to his pain and

suffering. He mentioned that he usually consults prophet-healers who live further away from his community in order to avoid being noticed by other members of his congregation, lest he be disciplined for transgressing against the church doctrine. Rutendo's experience is similar to that of Pauros; she also mentioned that although she gave priority to western bio-medicine, but when her condition did not improve, she decided to secretly consult some prophet-healers in the hope that she would receive healing. Likewise, Milton's experience also revealed that he makes use of both western bio-medicine and faith-healing. He related how at one point he was disciplined by the church leadership for consulting a prophet-healer due to a recurring stomach problem. Similarly, Jennifer highlighted that when given a choice, she relies solely on western bio-medicine but noted that at one point she was inclined to consult a prophet-healer by her in-laws when her husband was gravely sick. Jennifer noted that because of this move, she had to go through a disciplinary hearing at the church and was censured for having wandered off the path.

5.5.2 Spiritual, Social and Natural Causes of Illness

Works of witchcraft and evil spirits dominated in being listed as the causes of most illnesses. On the other hand, patients also indicated that some illnesses are due to humanity's neglecting natural laws and abandoning healthy habits. Some also noted that a number of common ailments are due to natural causes.

Only one out of the ten patients at a prophet-healer, *Mbuya* Esther completely rejected the role of witchcraft in causing illness. For her, most illnesses are a manifestation of God's punishment on humanity and she believes that "it is God who grants and takes away life, health and well-being".

Conversely, nine out of the ten patients at the prophet-healers seemed to concur that there are some instances when either witchcraft or evil spirits are suspected to be behind some illnesses. Ingrid pointed out that whenever a major illness strikes her or a member of her family, her first suspicion is that it is the work of witchcraft or the work of evil spirits. For Samson, "witchcraft or malicious evil spirits inflict diseases and ill-health". This is the reason why he always consults the prophet-healers, so that he can be protected from these negative forces. According to Wellington, although he views diseases as something that comes from

God to test one's faith, there are instances when he cannot help but suspect that some diseases are as a result of the work of witchcraft. Terrence is also of the opinion that most ailments are due to the work of witchcraft or evil spirits. Similarly, Rukariro views most ailments and misfortunes as either the work of witchcraft or ancestral spirits tormenting believers. For Ruvarashe, "illness emanates from the devil which is the source of all evil, pain and suffering". Although Veronica believes that some common ailments are due to natural causes, she is also of the view that "some illnesses are caused by the work of witchcraft". In the same light, Rumbidzai believes that some illnesses occur due to natural causes but there are some that she suspects to be as a result of the works of witchcraft. On the other hand, Tawanda views some illnesses as having been caused by humanity's own negligence such as those caused by smoking or in-take of alcohol but he also believes that "some conditions are as a result of the work of witchcraft or evil spirits".

All the ten patients at the various traditional healers viewed witchcraft or evil spirits as being behind most recurrent illnesses that defy any conventional treatment. For Andrew, the main reason that made him to suspect that he had been bewitched is because the western bio-medical system had failed to detect the real cause for his swollen foot and consequently could not treat the pain that he continued to suffer from. Edwin also mentioned that even though his church (the Reformed Church in Zimbabwe) does not openly acknowledge the existence of witchcraft or evil spirits, he however believes that witchcraft and the negative forces of spirits is a reality which affects people's health and well-being. Likewise, Takwana and his parents who are members of the Christian Assemblies of God church highlighted that although God created humanity to live life to the fullest without any sickness, due to "either humanity's failure to live according to God's natural laws or the work of evil spirits upon humanity, people are constantly falling sick". Laina also views sickness as either caused by natural causes, particularly common ailments, but for other strange conditions she believes that they are as a result of the work of witchcraft. For Runyararo, "God created a perfect world and all the created beings were supposed to live in harmony and fullness of life. However, this universe has been pervaded by so much evil such that the evil forces are threatening and disrupting all that which was created good."

Grace regarded some illnesses to be emanating from humanity's neglect of natural and health laws but she also believes that there are many other illnesses that are caused by witchcraft.

For instance, the main reason why she had visited the traditional healer was because she suspected that she had been poisoned through works of witchcraft and she believed that is the reason why her lung was damaged. Susan views major illnesses as emanating from “the work of the evil one, particularly those who practice witchcraft and sorcery.” In Yvonne’s view, “diseases are a result of the work of witchcraft or sometimes they are due to humanity’s failure to adhere to some taboos and regulations”. In the same light, Leslie believes that “people fall sick either because they have been involved in some activities that make them vulnerable to diseases or they might have been bewitched”. She also regards other illnesses as emanating from natural causes. For Kelvin, illness can be interpreted as a punishment from God for some sinful act, particularly if the individual does not repent from their sin. However, he believes that “if the sufferer is right with God, then such an illness can be interpreted as having been caused by works of witchcraft.”

The views of the ten patients interviewed at the two clinics also share some affinities with those of the patients at the prophet-healers and traditional healers. It is significant to highlight that some of their views are influenced by the SDA church’s teaching on health and well-being since they are all members of the same denomination. It is also of interest to note that although the SDA church doctrine refutes and downplays the concept of witchcraft, three out of the ten members of this faith still mentioned the work of witchcraft as being at work in the people’s lives. According to Believe, he views illness as “a result of humanity’s failure to observe God’s natural laws and most importantly, a failure to observe laws of morality, particularly, sexual morality.” He also mentioned that there are some illnesses that are caused by the work of witchcraft. In the same light, Milton, regards some illnesses as “God’s way of chastening humanity and reminding them of his almighty power to heal the sick and to take away life.” He also believes that other illnesses are caused by “evil people who are involved in acts of witchcraft and sorcery to inflict pain on innocent people.” Similarly, Nyasha’s conception of sickness is two-fold. Although she believes that some illnesses are God-given as challenges that people have to contend with, she also conceives some illnesses as a “manifestation of the malicious work of evil spirits that inflict harm on unsuspecting victims.”

In line with the SDA doctrine, seven out of the ten study participants maintained that there is no link between illness and witchcraft. Their understanding of disease is anchored in it being

either a natural occurrence or God-given or due to humanity's failure to follow certain rules and regulations on health. For Pauros, "sickness comes from God and it is the same God who cures all ailments". He does not believe in the work of witchcraft or evil spirits and for him, the only reason why he sometimes consults prophet-healers is because he regards them as God's agents to bring healing and wholeness to humanity. Similarly, Jennifer believes that "God is in charge of humanity's well-being and if people adhere to God's natural laws, observing all the dietary stipulations and adhering to basic health and hygienic rules, incidences of illness will be reduced."

Rutendo views illness as a natural occurrence. She believes that people fall sick due to being "exposed to diseases that are circulating in the environment". She also added that others fall sick because "they are stressed out and anxious about the uncertainties presented by the country's hostile and unpredictable socio-economic and political environment." For Ratidzo, there are two main causes of illness; on one hand she regards disease "as a natural occurrence that God just allows to happen." On the other hand, she views it as "God's punishment to humanity for some transgressions." In the same light, Sharai views illness as a natural process and she believes that God the creator of all there is allows diseases to happen for a reason. Similarly, Jacob regards diseases as God-given. He believes that God ordained diseases for a particular reason. For Chipso, her conception of illness is that it just occurs naturally, there are no outside or malicious forces causing it.

5.5.3 Socio-Economic and Political Factors Impacting on Karanga People's Health and Well-Being

Poverty, food insecurity and a general break-down in the socio-cultural, economic and political environment are the main the factors featuring on the lists of issues identified by the study participants within all the three systems as having a negative impact on Karanga people's health.

All the ten patients at the various prophet-healers explained how poverty, food insecurity and a general breakdown in the socio-cultural, economic and political environment impact negatively on Karanga people's health and well-being in various ways. Ingrid noted that persistent droughts in the region were impacting negatively on food production and causing the whole province to suffer from food insecurity. She noted how this has ripple effects since

food insecurity draws people into a chasm of poverty, exposing many to malnutrition as well as forcing others to adopt risky survival strategies which have “far-reaching repercussions on their health”. *Mbuya* Esther also identified poverty and food insecurity as “major crises impacting negatively on Karanga people’s health and well-being”. She bemoaned how food parcels donated by international NGOs were marred with corruption and favouritism as some village heads tended to neglect those who were in dire need of the food aid due to their wanting to benefit from the bribes offered by some not so needy members of the community who would pay them for having their names included on the beneficiaries’ lists. This is a clear sign of the breakdown of communal values because the village heads are supposed to be impartial and ensure that those who are most vulnerable receive the food aid first.

In the same light, Samson also noted poverty, food insecurity and poor nutrition as significant factors impacting negatively on Karanga people’s health. For Samson, a neglect of the traditional healthy and nutritious diet and the adoption of a poor and unbalanced diet due to the impact of modernisation was another reason that was causing deterioration of Karanga people’s health. Samson also highlighted the high prices of food and the high costs of most medical services which are beyond the reach of most poor people as issues of major concern, causing the poor to suffer much more deprivation than those who have money and can afford to pay the prices. Similarly, Wellington also raised the issue of poverty, food insecurity and poor nutritional values due to the environmental degradation as having a negative impact on Karanga people’s health. He also noted that the high cost of life-saving medical procedures, shortage of drugs in most public medical facilities and high costs of basic food items as contributory factors in the deterioration of Karanga people’s health and well-being.

In the same light, Ruvarashe and Veronica also mentioned poverty, food insecurity, failure to afford basic health care and unavailability of basic foodstuffs as areas of major concern regarding securing Karanga people’s health and well-being. Rumbidzai and Rukariro also mentioned the same issues raised by Ruvarashe and Veronica, and they further added the problem of limited or inexperienced medical personnel in most public health-care facilities. Terrence and Tawanda also highlighted poverty, food insecurity and poor nutrition as significant factors impacting negatively on Karanga people’s health and well-being. They also bemoaned the negative effects of high unemployment levels among the educated and

professionally trained people as factors that forced people into risky survival strategies, to the detriment of their health and well-being.

All the ten patients at the two clinics also reiterated the negative impact of poverty, food insecurity and a general break-down in the socio-cultural, economic and political environment on Karanga people's health and well-being. Believe highlighted the negative effects of partaking alcohol and other harmful substances, unclean water sources, low hygienic standards, a poor diet and food insecurity as a combination of factors that expose Karanga people to poor health and well-being. In the same light, Pauros mentioned poverty, poor sanitation and poor nutritional values. Similarly, Milton also highlighted poverty, food insecurity and poor sanitary conditions, particularly the unavailability of clean water and proper toilet facilities as posing health hazards on the community. Jennifer stressed the negative impact of drinking alcohol and the smoking of other harmful substances as well as high rates of unemployment as factors that impact negatively on Karanga people's health and well-being. For Rutendo, Sharai and Chipu, a general deterioration in maintaining basic hygienic practices due to the high prices and a general shortage of basic commodities such as bar soap amidst the harsh economic climate exposes the rural poor communities to all sorts of diseases. They also bemoaned the poor nutritional values which have become dominant as a result of poverty and the negative impact of modernisation as posing health hazards to the community. In the same light, Ratidzo also mentioned poverty, food insecurity and poor nutritional habits as factors that make Karanga people vulnerable to a wide range of diseases. Similarly, Nyasha noted that poverty and food insecurity which is all caused by the recurrent droughts as factors that impacted negatively on Karanga people's health and well-being. For Jacob, the major problem that he highlighted is food insecurity.

5.5.4 Disintegration of Social Values and the HIV Epidemic

A relationship between the collapse of the social values and the spread of the HIV epidemic was raised as a factor impacting negatively on Karanga people's health and well-being by some of the study participants.

Among the ten patients at the prophet-healers, two of them identified these issues. Terrence highlighted the problem of alcohol and substance abuse and the near breakdown of the social

fibre as issues that impact negatively on Karanga people's health and well-being. He explained how the abuse of alcohol and drugs especially among the youth pushes them into further harmful behaviour such as illicit sexual relationships which in most instances exposes them to the risk of contracting and spreading HIV or AIDS. He also added that this drunken behaviour and drug abuse sometimes pushes the youth to commit crime and this life of crime impacts negatively on the peace and tranquillity of the society. Tawanda also bemoaned how a combination of high levels of unemployment among the youth and meagre salaries paid in most of the professions, forcing many to resort to commercial sexual work or engage in casual sexual relations to drown their sorrows, has a cumulative impact of exposing them to the HIV epidemic. He also noted how inter-generational sexual relations have destroyed the moral fibre whereby some of the elderly people - who are supposed to instil moral values in the young ones - have turned into sex predators who engage in sexual relations with younger people and as a result they exacerbate the spread of the HIV epidemic.

Four out of the ten patients at the traditional healers also highlighted the link between the breakdown of the socio-cultural and economic fibre with the spread of the HIV epidemic. Edwin explained how the problem of high levels of unemployment has increased incidences of migratory labour within and outside the country. He highlighted how in some cases spouses are separated from each other for long periods, leading to instances of extra-marital sexual relationships which often expose them to HIV infection. When they are re-united with their spouses, they will subsequently pass on the infection. On the other hand, Takwana noted that many cases of unfaithfulness within marriages and a lack in most rural communities' understanding of the actual nature of the HIV epidemic was making many people vulnerable to HIV infection with far reaching repercussions on the health and well-being of the community. Laina mentioned that most rural communities' limited knowledge surrounding the HIV epidemic and some circumstances of extreme poverty exposes many to risky sexual practices, making them vulnerable to HIV infection. Leslie explained how the breakdown of the moral values leading to the mushrooming of the 'sugar daddies' and the 'small house' syndrome was destroying family values, annulling cultural taboos surrounding sexual relations and exacerbating the spread of the HIV epidemic. She also noted that the harsh economic situation was forcing many desperate women to engage in commercial sex work, exposing them to high risks of contracting the HI virus.

Four out of the ten patients at the two clinics also mentioned the link between the disintegrating socio-cultural and economic structure and the spread of the HIV epidemic. Jennifer highlighted how the problem of high levels of unemployment pushes many young people to engage in alcohol and drug abuse which clouds their judgement, making them vulnerable to engaging in risky survival strategies and unscrupulous sexual activities and subsequently exposing them to the risk of HIV infection. She also noted that the problem of unemployment pushes many into migratory labour, forcing spouses to live apart and consequently resulting in extra-marital sexual relations which expose many to the risk of HIV infection. In the same light, Ratidzo bemoaned the cumulative effects of the harsh economic environment which forces most married men into migratory labour, leaving their spouses behind and in the process they engage in extra-marital relations, exposing them to HIV infection and subsequently passing it onto their spouses. Nyasha and Ratidzo made reference to the problem of inadequate facilities to respond to the HIV epidemic in the rural communities. They highlighted that although the nurses at the clinics try their best to disseminate information, they have very limited equipment to respond to the epidemic, particularly the unavailability of facilities for testing for HIV and the rolling out of ARVs. With so many people hard hit with the virus, they are all forced to visit the major hospitals for testing and for medication which becomes very problematic amidst the harsh economic climate.

5.5.5 Collaboration and Integration among the Three Health-Care Systems

The study participants presented varied responses to the issue of collaboration and integration between the three health care systems in their care-giving work. Their responses ranged between acknowledging some informal collaboration whereas others were of the view that the systems operate in isolation without any form of collaboration.

Most of the patients at the prophet-healers feel that there is some informal collaboration between the three health-care systems. *Mbuya* Esther gave an illustration of collaboration between the bio-medical system and the traditional healers whereby patients are referred from the western bio-medical institution to the traditional healers registered under ZINATHA. She also added that some prophet-healers combine traditional therapy with their Christian faith-healing ministry. In the same light, Samson feels that there is integration and collaboration between the three health-care systems. He mentioned that some bio-medical practitioners will

refer their patients either to a prophet-healer or traditional healer whenever they suspect that patient's condition has some spiritual origin.

On the other hand, Ingrid and Rumbidzai are of the view that there is very limited collaboration and no integration between the three health-care systems. They gave examples of instances whereby some prophet-healers and traditional healers refer their patients to the western bio-medical system but they indicated that rarely do bio-medical practitioners refer their patients to the other two systems. They also noted that in some isolated cases, prophet-healers and traditional healers will refer patients to each other. On the same note, Wellington and Veronica feel that the three health-care systems are not clearly integrated and their vantage point is that the three practices are founded on very different principles and their operational systems are different. They, however, acknowledged that the practitioners within the three systems sometimes refer patients to each other depending on the nature of the ailment. Resonating with Wellington's and Veronica's views, Ruvarashe also noted that the three systems occasionally and informally refer patients to each other. Similarly, Terrence is of the view that the three systems are integrated to a limited extent, and he noted that they occasionally refer patients to each other. Rukariro explained that the issue of collaboration and integration is not clearly defined because although there are some bio-medical practitioners who will encourage their patients to make use of traditional herbs or consult the prophet-healers, there are some Christian denominations that forbid their followers from utilising western bio-medicine and they insist that the prophet-healers will provide all the necessary healing. Tawanda does not see any integration between the three health-care systems; he feels that each of them operates as separate entities.

Half of the study participants at the traditional healers shared almost the same views with those at the prophet-healers regarding the regular collaboration within the three systems whilst the other half felt that there was no collaboration. Andrew is of the view that there is some informal collaboration between the three health-care systems and he feels that in many cases, practitioners refer patients to each other although there are some people who still try to exaggerate the differences between the three systems. Edwin's opinion is that the three health care systems are not clearly integrated; however, he acknowledged that there are some instances of patients' cross-referrals within the three systems, especially considering that most public health-care facilities are often faced with shortages of some essential

medications. Similarly, Laina feels that the three health-care systems complement each other and since most patients utilise the three systems concurrently like in her case. Although Leslie feels that the three health-care systems are not properly integrated, she however is of the view that the three systems' main goal is to work towards provision and restoration of holistic health-care.

Conversely, Takwana feels that integration is close to none between the three health-care systems mainly because their methods of diagnosing and treating patients are different. More so, he senses some tension and competition for clients between the three different health practitioners and in some instances he feels that some bio-medical practitioners look down upon the role of the other two systems. Likewise, Runyararo and Susan reiterated that the three health-care systems are not properly integrated; they felt that they operate separately and are often antagonistic to each other. In the same light, Yvonne and Kelvin felt that the three systems do not operate in an integrated manner; they sensed that this is probably because of the differences in their values and healing practices.

The views of the study participants at the two clinics also have some resonance with those at the prophet-healers and traditional healers. However, it is significant to note that most of the patients at the two clinics felt that there is not much collaboration or integration between the three health care systems. Sharai is of the view that there is absolutely no collaboration between the three health care systems and she does not envisage how they could ever work together since they are founded on very different principles. Believe and Jacob concurred that there is no clear-cut link between the three health care systems. They feel that this is mainly due to the fact that they are founded on different principles and their methods of care-giving and healing are different. Believe even senses some form of competition such that some practitioners will selfishly hold on to a patient even if they realise that they are not able to deal with a particular condition. Likewise, Pauros is of the view that there is very little collaboration between the three health care systems and he feels that they operate in isolation. Milton reiterated that the three health care systems tend to operate in isolation, but he was quick to add that some prophet-healers refer their patients to the clinic although he had never heard of any instances whereby traditional healers referred their patients to the clinic or the prophet-healers.

On the other hand, Nyasha noted that there is a considerable level of collaboration and mutual respect particularly between the hospitals and prophet-healers where she had witnessed instances of patients' cross-referral between the two systems.

5.5.6 Understanding of *Utano*

The study participants defined *utano* in various ways and the common features that emerged from the three different categories of patients in the three health care systems is that it embraces the physical, spiritual and emotional aspects.

All the ten patients at the various prophet-healers mentioned these three key aspects of *utano*. Ingrid defined *utano* as “physical fitness, well-being, mental stability and freedom from stress”. Similarly, for Mbuya Esther, *utano* encompasses “physical fitness, mental stability appearance, mental and spiritual stability”. Likewise, Wellington mentioned “skin texture and complexion, freedom from stress and peace of mind”. For Terrence, *utano* entails “physical fitness, a presentable appearance, enjoying peace of mind and having adequate food and proper shelter”. Resonating with the other informants, Rukariro noted that *utano* encompasses “physical, spiritual, emotional and social well-being”. In the same manner, Veronica mentioned “a healthy body, having peace of mind and being physically and emotionally settled”. She also added that one should enjoy amicable and mutual relations and be able to provide for oneself. Rumbidzai also noted “physical fitness, absence of pain, peace of mind, having proper shelter and getting access to adequate food”. Likewise, Tawanda mentioned “physical fitness, absence of pain or problems, freedom from all worries, having adequate food and shelter and living peacefully with those around you”.

All the ten patients at the various traditional healers also mentioned these three key dimensions of *utano*. Andrew defined *utano* as “physical and spiritual well-being not just for the individual but the community i.e. one shares other people's struggles in a communal and holistic manner”. In the same manner, Edwin defines *utano* as “healthy, neat and fit physical appearance, enjoying meaningful and fulfilling social relations and having peace of mind”. Similarly, for Takwana *utano* embraces “the physical, emotional and spiritual harmony and balance”. Likewise, Laina mentioned “physical fitness, peace of mind, free from pain and diseases and having access to a balanced and nutritious diet”. Similarly, Runyararo

mentioned “good looking skin texture, normal complexion and general physical fitness”. For Grace, *utano* entails “a healthy body, enjoying peace of mind without any worries or disturbances, having adequate food and living peacefully with others”. Resonating with the others, Susan mentioned “a strong and healthy body, healthy-looking skin texture, peace of mind and being physically, spiritually and emotionally settled”. Yvonne mentioned “a healthy body, peace of mind, smooth and healthy-looking skin texture”. Likewise, for Susan *utano* entails “being healthy physically and living a good life without any bodily pains, having peace of mind and living peacefully with those around you”. Kelvin mentioned “physical fitness, peace of mind and not suffering from any psychological, physical and emotional pain”.

All the ten study participants at the two clinics also defined *utano* as multi-dimensional, highlighting the physical, mental and emotional aspects. Believe defined *utano* as “a fit physical appearance, healthy-looking skin texture and freedom from all sorts of ailments”. Likewise, Pauros highlighted “well-built physical appearance, a healthy and strong body, good quality skin texture and enjoying meaningful and peaceful relations”. In the same light, Milton mentioned “a strong and healthy and neat physical appearance, smooth skin, enjoying peace of mind, maintaining amicable relationships and having enough food”. For Jennifer, *utano* entails “having a healthy looking body and being fit and strong enough to work and support oneself”. Rutendo mentioned “physical appearance and healthy-looking skin texture”. For Ratidzo *utano* is expressed through “a healthy looking body, maintaining cleanliness and smartness, being free from illnesses and having adequate food and shelter”. Similarly, Sharai highlights “a healthy looking body with smooth skin and hair texture that looks healthy and shiny as well as smooth skin”. Nyasha defines *utano* as “a properly functioning body, a sound and healthy mind and a healthy body without any ailments”. For Jacob, *utano* entails “a strong and healthy body as well as maintaining cleanliness and smartness”.

5.6 Conclusion

In this chapter I have brought together the perspectives of the study participants who were involved in the quest for health and healing. I described the views of those who utilised the three tier health systems, namely, prophet healers, traditional healers and modern clinics. Research participants shared their life stories and medical histories, views on *utano*,

challenges in accessing health care and perspectives on the relationship among the three health systems. I also provided an analysis of the responses. In the following chapter, I describe the contours of a Karanga theology of *utano*.

Chapter Six

Towards a Karanga Theology of *Utano*: An Exploration

6.1 Introduction

This study has now examined the Karanga people of Murinye's approach to health, healing and well-being. Having reviewed the relevant literature, analysed the views of health service providers and health seekers' perspectives, this chapter explores the possible characteristics of a Karanga theology of *utano*. Although some scholars have previously studied health and healing in African contexts and have provided theological reflections on this theme, there are only a few studies that outline the contours of African indigenous theologies of healing. Nonetheless, Shoko⁵⁹³ and Chekpwoy⁵⁹⁴ have provided some useful insights. Some Nigerian biblical scholars have also sought to develop an African theology of healing, combining biblical and African approaches.⁵⁹⁵

The need to pursue a Karanga theology of *utano* emerges from the global preoccupation with the theme of health and healing. According to Walter van Laar, "no one who is interested in global ecumenism and mission can miss it: healing is high on the agenda of the church".⁵⁹⁶ Similarly, Elias K. Bongmba has challenged African theologians to focus on "a praxis-oriented reflection on poverty, disease, and illness"⁵⁹⁷ as they seek to make sense of the African condition. Such studies have provided the impetus for this chapter.

One of the key objectives of this study is to contribute towards the emergence of an indigenous Karanga theology of health and healing. The study noted the unease with which many Christians interacted across the different health care systems. In order to mitigate this tension and to further the development of African theology, the chapter identifies some of the

⁵⁹³ Shoko, T. (2008), *Spiritual Healing in Zimbabwe: Continuity and Change* (Uppsala: Universitetsstryckeriet).

⁵⁹⁴ Chekpwoy A.K. ed. (2006), *Religion and Health in Africa: Reflections for Theology in the 21st Century* (Nairobi: Paulines Publications Africa).

⁵⁹⁵ Abogunrin, S.O., et al. eds. (2004), *Biblical Healing in African Context* (Ibadan: The Nigerian Association for Biblical Studies).

⁵⁹⁶ van Laar, W. (2006), "Churches as Healing Communities: Impulses from the South for an Integral Understanding of Healing," *Exchange* 35(2), 226-241, 226.

⁵⁹⁷ Bongmba, E.K. (2012) "African Theology," in E. K. Bongmba, ed., *The Wiley-Blackwell Companion to African Religions* (West Sussex: Blackwell), 241-254, 252.

major tenets of a Karanga theology of *utano*. Although not definitive or final, I contend that adopting the framework suggested below will go a long way in empowering the Karanga people in the area under study to be more proactive in seeking health and healing.

6.2 A Karanga Theology of *Utano*: Some of the Defining Features

This study has shown the centrality of health and healing among the Karanga. Chapter two explored the history of health care in contemporary Zimbabwe and showed how in the past decade, the massive deterioration of the public health care system has been troubling to Zimbabweans. Chapter three highlighted how the Karanga healthworld shares some resonances with many other African contexts, with an emphasis on the preservation and perpetuation of life, health and well-being. As such, anything that diminishes or threatens life, health and well-being is not welcome in the Karanga healthworld, influencing the Karanga people to identify and seek to eradicate all the negative forces threatening health and well-being. In this section, I outline what I consider to be the critical features of a Karanga theology of *utano*. The features described below emerge from the earlier chapters of this study. One can, therefore, argue that I have constructed it in collaboration with the study participants. The views of the study participants shape the theology described below. In developing a Karanga theology of *utano*, I am aware of the debate over the place of indigenous beliefs and practices in the contemporary, post-colonial African period. African theology, however, has sought to uphold the importance of indigenous beliefs and practices in the church.⁵⁹⁸ According to Nehemiah Nyaundi, “However much traditional religious beliefs are disparaged; they remain the single provider of religious socialisation for millions of Africans”.⁵⁹⁹ Similarly, Charles O. Jegede contends that traditional approaches to health and healing must continue to be acknowledged in the contemporary period. For him:

Very few people today would doubt that the traditional medical practitioners possess a large store of knowledge of medicinal herbs and therapeutic acumen. In this inquiry, one can infer that many aspects of the practice are scientific...They use scientific and religious techniques but not in the Western scientific sense. In the indigenous science

⁵⁹⁸ The Karanga are also part and parcel of the African community, hence, by proposing a Karanga theology, this is in line with the thrust of African Theology i.e. drawing from indigenous resources to come up with what is relevant to a particular context. In this case, I am proposing the use of indigenous resources within a community that combines the use of traditional medicine, faith-healing and western medicine in their endeavour to preserve and restore *utano*.

⁵⁹⁹ Nyaundi N.M. (2011) “African Traditional Religion in Pluralistic Africa: A Case of Relevance, Resilience and Pragmatism,” in T. W. Bennett, ed., *Traditional African Religions in South African Law* (Cape Town, University of Cape Town Press), 1-18, 16.

of traditional medical practitioners among the Yoruba, science and religion, physical and spiritual, natural and supernatural are inseparable.⁶⁰⁰

In terms of an approach, I rely principally on inculturation theology and oral theology to inform the positions that I am advancing in this chapter. These two approaches are useful in challenging conservative and exclusivist approaches to health systems in Zimbabwe. As highlighted by the majority of study participants in chapters four and five, a conservative and exclusivist approach to the three health care systems in Zimbabwe does not offer useful and practical solutions to the Karanga in their constant search for *utano*. As such, in this concluding chapter, I argue that combining the three perspectives represented by the three health delivery systems will assist the Karanga people in the area of study to approach health in a more liberating way.

6.2.1 Acknowledging the Agency of Health-Seekers

In order to develop a sound Karanga theology of *utano*, it is critical to acknowledge the agency of health-seekers. Such an approach recognises that health-seekers are actively involved in their own welfare. They are not beneficiaries of help which is provided by outsiders. Throughout the previous chapters, I showed how individuals and families were involved in making choices relating to health and well-being. As Steve de Gruchy emphasised, it is important to realise that poor people are ‘able to do’.⁶⁰¹

As indicated in chapter one, agency refers to the capacity of different actors to act in ways that affirm their initiative. This study has shown that research participants face an array of opportunities and challenges whenever their health is compromised. Chapter three explored the Karanga healthworld and showed how the Karanga conceive of illness in the natural and spiritual realm. In chapters four and five, I documented how individuals understand health, as well as the choices they make regarding the particular health delivery system to approach ill-health. Throughout the study, I have also shown how the socio-economic context in Zimbabwe has made life difficult for most citizens. Despite the massive challenges, the field work revealed that health seekers demonstrated high levels of agency. Individuals were not

⁶⁰⁰ Jegede C.O. (2006). “From Disease Etiology to Disease Treatment: An Inquiry into Religion and the Yoruba Therapeutics,” *Orita: Ibadan Journal of Religious Studies* 38, 167-186, 186.

⁶⁰¹ De Gruchy S. (2003) “Of Agency, Assets and Appreciation: Seeking Some Commonalities between Theology and Development,” *Journal of Theology for Southern Africa* 117, 20-39, 22.

passive victims of their situation, but sought practical steps to resolve their health situations by approaching one, two or all three health care delivery systems.

Acknowledging the agency of health-seekers is critical to any Karanga theology of *utano*. Health is not handed down from above: it is worked for by individuals and their families and communities. Health is the product of individual and collective efforts to address contexts of pain and turn them into conditions of well-being. By placing emphasis on the initiative of health-seekers, researchers would be acknowledging the reality that outsiders are not well equipped to prescribe health solutions to individuals and communities. It is only the individuals, their families and communities involved who can take the necessary steps to ensure health and well-being. This is consistent with the observation by Laura Strivers:

While people on the margins have little political and economic power, this does not mean they are simply victims without the ability to effect change. A liberative economic ethics must pay attention to the obstacles people face as well as the courageous responses they make despite oppressive realities. Approaches that focus solely on oppression can be used to support stereotypes and to legitimate interpretations that claim the supposed pathologies of a group are the cause of their suffering, thereby avoiding any systematic analysis of economic injustice.⁶⁰²

Utano is achieved when, on the basis of Karanga indigenous beliefs and Christian beliefs regarding health, individuals and families invest in refusing to accept ill-health.⁶⁰³ Study participants demonstrated how they sought the opinions of traditional healers, prophet healers and modern health practitioners whenever they felt that their condition was compromised. Although the overall socio-economic environment in Zimbabwe was harsh during the period when this study was undertaken, research participants demonstrated high levels of initiative. They did not wait to die at home or to embrace some fatalistic theology. In fact, they took their destiny into their own hands and tried out the various health delivery systems in search of health and healing. Even the reality of HIV and AIDS did not create a culture of despondency.

⁶⁰² Strivers L. (2013) "Economic Liberative Ethics," in M. De La Torre, ed., *Ethics: A Liberative Approach* (Minneapolis: Fortress Press), 67-87, 81.

⁶⁰³ Bearing in mind the fact that some study participants who identified themselves as Christians also utilized the three health care systems interchangeably, this study also contributes to African Christian theology because the proposed Karanga theology of *utano* also embraces the perspectives and healthworlds of Karanga Christians who are trying to make secure health and well-being utilizing all the available resources within their communities.

A vibrant Karanga theology of *utano* will have to give priority to the reality that communities already possess “assets” that they bring with them to the health care setting (as outlined in chapters three, four and five). As ARHAP has documented, these assets enable individuals and communities to survive and thrive in contexts that appear desperate or doomed.⁶⁰⁴

In the specific case of the Karanga, the study has shown that there is an underlying conviction that life must be lived to the full and that all challenges must be faced with courage and realism. It is this positive philosophy of life that empowers individuals to seek the services of traditional healers, prophet healers or from public health clinics. *Utano* is sought after and when achieved, it must be preserved. Individuals exercise their agency to achieve this goal.

It will be important to embrace oral theology when acknowledging the agency of health-seekers in developing a Karanga theology of *utano*. Oral theology or narrative theology⁶⁰⁵ appreciates the value of sayings of wisdom or proverbs from indigenous cultures. These must be used to mobilise the Karanga people to be actively involved in searching for health and healing. For example, sayings such as “*kure kwegava ndokusina mutsubvu*” [a place is only considered too far where there is nothing of value] must be retrieved to encourage the Karanga to exercise their agency when seeking medical attention.

Combining inculturation theology and oral theology to acknowledge the agency of health-seekers will contribute towards the emergence of a viable and sustainable Karanga theology of *utano*. As the earlier chapters have demonstrated, individuals and communities are determined to access health and healing. However, sometimes conservative church doctrines are used to promote fatalistic theologies. Some individuals have been discouraged from seeking treatment, especially in the context of HIV and AIDS. Study participants in chapters four and five noted how in some instances pregnant women were denied access to life-saving bio-medical care due to the conservative doctrines of the particular Zionist churches that they belonged to which was detrimental to their health and well-being, resulting in the painful death of the mother and the unborn child. Such rigidity resulting in unnecessary and painful loss of life could have been avoided if people could draw a line between what professional

⁶⁰⁴ ARHAP (2006) *Appreciating Assets: The Contribution of Religion to Universal Access in Africa* available on www.arhap.uct.ac.za.

⁶⁰⁵ Healey D and Sybertz D. (1996). *Towards an African Narrative Theology* (Maryknoll, NY: Orbis Books).

medical practitioners can achieve and what *muporofita* can achieve. In some instances, study participants noted how their rigid church doctrine forced them to seek for alternative health-care services at the risk of being disciplined or stripped of their fellowship in the church. A case in point is whereby some prophet-healers in the Zionist churches denied their HIV positive members permission to mix the use of ‘faith-healing’ (Holy water and *muteuro*) with the use of ARVs from the western bio-medical system which was considered as unholy and defiling. Adopting creative biblical interpretations and oral theology can empower individuals and families to embrace life giving perspectives on health and healing. They need to do this in dialogue with an integrated approach to health delivery.

6.2.2 Integrating the Three Health Delivery Systems

Colonialism and rigid theological systems have given rise to exclusive approaches towards health delivery in Zimbabwe. Colonialism promoted the idea that only western biomedicine can resolve health challenges. This idea is hinged on the philosophy of European supremacy and African inferiority. Gordon Chavunduka challenged this approach to health in postcolonial settings.⁶⁰⁶ A viable Karanga theology of *utano* must appreciate that the three health delivery systems are complementary. They must not be regarded as competitors but that each one of them addresses specific needs at specific times.

This study has shown that the Karanga people move back and forth and across the three health delivery systems. The responses by health seekers and health care providers show that there is a great deal of diagnosis that takes place prior to making a decision as to which particular system to approach. As became clear in chapters four and five, when individuals and families are convinced that a particular form of sickness is spiritual, they resort to traditional healers and prophet healers. On the other hand, if they contend that an illness is “natural”, they go to a clinic. However, what might start off as “natural” may later be considered spiritual and the choice of health service provider will be changed accordingly. Such responses to forces that threaten health and well-being are also influenced by the Karanga health worlds discussed in chapter three.

⁶⁰⁶ Chavunduka G. (1994) *Traditional Medicine in Modern Zimbabwe* (Harare: University of Zimbabwe Publishers).

In order to avoid the emotional trauma suffered by individuals who attend theologically conservative churches such as the SDA, it is vital for a Karanga theology of *utano* to have an integrated approach towards the health delivery systems. As Bate argues, there is an urgent need for churches to appreciate the need for “coping healing” in Africa.⁶⁰⁷ Churches would have failed in their pastoral ministry when individuals and families are forced to consult other health delivery systems under cover of darkness due to the fear of censure. Effective pastoral work requires an open and accommodating approach to the burning issues of the day. In the specific case of this study, the SDA Church needs to embrace the three health delivery systems as critical components of God’s plan of healing. All the ten study participants who are members of the SDA Church stated although it is the norm within the Karanga tradition to utilise the three health delivery system, however, their church doctrine strongly forbids its members to use either traditional medicine or consult prophet-healers. Paradoxically, four out of these ten SDA Church study participants revealed that they had transgressed against their church doctrine by utilizing alternative health delivery systems because they felt that the western biomedical system had failed to adequately address their needs.

A life-giving and life-enhancing Karanga theology of *utano* requires theological creativity in the face of the three health delivery systems. Old positions and formulae will not equip African communities to navigate new contexts. This study has shown the struggles and anxieties that characterise the Karanga people’s search for health and well-being. A Karanga theology of *utano* requires that churches ‘accompany’⁶⁰⁸ individuals and families by affirming their choices, rather than condemning non-Western approaches to health delivery. Writing in the context of caring in the HIV era, Ezra Chitando was reminded of the *ubuntu* virtues among the Shona people, where:

Visitors are to be treated with utmost courtesy. When visitors announce their departure, hosts are expected to try to persuade them to stay. When visitors leave, hosts are expected to see them out of the homestead. More importantly, they are also expected to travel with them for a good part of the journey. *Kuperekedza* (to accompany) implies identifying with the person undertaking the journey. In effect, they are told, “You are not alone on this journey. I share your struggle”.⁶⁰⁹

⁶⁰⁷ Bate S.C. (1995) *Inculturation and Healing: Coping-Healing in South African Christianity* (Pietermaritzburg: Cluster Publications), 173.

⁶⁰⁸ I am indebted to Ezra Chitando for the concept, ‘theology of accompaniment’ in his work, *Living in Hope: African Churches and HIV/AIDS 2* (Geneva: WCC Publications, 2007)

⁶⁰⁹ Chitando E. (2007) *Living in Hope: African Churches and HIV/AIDS 2* (Geneva: WCC Publications), 2.

In the same light, churches should be willing to ‘accompany’ health- seekers in their quest for health and well-being, assuring them that ‘they are not alone’ and that they have the support and approval of the church even though their search might require utilizing multiple health-care systems.

By adopting an integrated approach, a Karanga theology of *utano* can equip individuals, families and communities to tap the strengths of the different health delivery systems. Instead of demonising traditional healers and prophet healers, churches must be more creative and consider these as part of God’s grand healing plan. As has been revealed by the responses of all the study participants regardless of their religious affiliation, their understanding of *utano* presents a holistic perspective; embracing the social, cultural, physical and emotional realms. As such, confining patients to one particular health delivery system might not appropriately and adequately cater for their *utano* in fullness. A Karanga theology of *utano*, therefore, must have an expansive and integrated view of the different systems. This is confirmed by Gurli Hanson when she says, “Recently there has grown up (sic) a closer understanding between the two medical systems, where the modern scientific system begins to appreciate the traditional medical knowledge and not least the holistic view of the patient and his/her illness.”⁶¹⁰

A Karanga theology of *utano* recognises the reality of religious pluralism in Africa.⁶¹¹ As noted by J.S. Mbiti, “Africans are notoriously religious”⁶¹² and every undertaking within their existential reality is a religious undertaking. As such, for the Karanga people, issues of health and well-being cannot be separated from their religious perspectives. Chapter three of this study presented an exploration of the Karanga healthworld and noted how for the Karanga, issues to do with *utano* are understood from a religious perspective. Furthermore, in chapters four and five, despite their different religious affiliations, all the study participants identified the source of health and well-being (*utano*) as Mwari, Musikavanhu or Nyadenga which shows that they all regarded *utano* as a gift from the supernatural being or ultimate reality

⁶¹⁰ Hansson G. (1996), *Mwana Ndi Mai: Toward an Understanding of Preparation for Motherhood and Child Care in the Transitional Mberengwa District, Zimbabwe* (Uppsala: Swedish Institute of Missionary Research), 35.

⁶¹¹ Olupona J.K. and S. S. Nyang S.S, (eds.) (1993). *Religious Plurality in Africa: Essays in Honour of John S. Mbiti* (Berlin: Gruyter).

⁶¹² Mbiti J.S. (1969) *African Religions and Philosophy* (London; Heinemann Publishers), 1.

although they referred to this source using different names as influenced by their different religious beliefs and traditions. In the same vein, all the study participants identified the source of ill-health or factors that diminish *utano* as emanating from the influence of evil spirits (*mweya yakaipa/madzinza/varoyi*) or the evil one. What this clearly shows is that the Karanga identify the source of *utano* as a force or a being which is concerned about their welfare and anything that diminishes or threatens their health and well-being is a negative force that should be eliminated by all means necessary.

All the study participants (health practitioners and health-seekers) emphasized the influence of their various religious traditions in accessing or providing health-care. An integrated approach to health and healing enables individuals and families to appreciate the fact that at the heart of all the systems is the quest to support life. Health practitioners from the diverse health systems must be seen as agents of God. By adopting such a holistic perspective, individuals and communities can embrace a more holistic perspective. According to James Cochrane:

Healthy bodies are signs of blessing or religious favour, of the impulse to life in the face of much that threatens it. This is one way of recognizing why and how healing is not only an expression of faith or a tradition but equally a mark of self-understanding in African traditional religions, African Christianities (e.g., the African Independent Churches, or, for much longer, the Coptic Church), Islam in its basic doctrines, and other less prominent religious traditions of Africa. All invoke not merely healing of the body but of relationships and the spirit, however variously defined.⁶¹³

It is therefore apparent that a Karanga theology of *utano* should acknowledge the religious diversity of not only Africa, but particularly, the diverse religious traditions among the Karanga people and how these inform their understanding of *utano*. As such, the three health delivery systems should not be viewed as competitors for clients but more importantly, they should be viewed as complementing each other.

⁶¹³ Cochrane J.R. (2012) "Religion, Health, and the Economy," in E. K. Bongmba, ed., *The Wiley-Blackwell Companion to African Religions* (West Sussex: Blackwell), 430-442 and 438.

6.2.3 Challenging Systems of Death

The study brought out the extent of the deterioration of the socio-economic context in Zimbabwe during the time when it was conducted. The Zimbabwean Ministry of Health struggled to provide drugs, personnel and hospitals became centres of death, not healing. On the other hand, massive unemployment and hyperinflation, food shortages and political violence left citizens highly vulnerable to sickness and death. This forced many Zimbabweans to escape from this humanitarian crisis by fleeing out of the country and seeking refuge in neighbouring countries or any other part of the global community where some continue to suffer from destitution and dehumanization.⁶¹⁴ A Karanga theology of *utano* must be courageous enough to challenge such systems of death and proclaim abundant life for all citizens.

Study participants confirmed that they face massive challenges. These included poor sanitation, enduring long distances, shortage of drugs, dubious healers from all systems and others. Chapter two chronicled the discrepancies in terms of availability of health care services, particularly the huge gap between those who can afford to access quality medical care outside the country and those who cannot afford to access the basic services within the country. A liberating Karanga theology of *utano* must proclaim that the lives of the poorest of citizens must be the primary focus of those who are more privileged. As this study was undertaken, many government leaders sought treatment in South Africa, Malaysia and elsewhere.⁶¹⁵ This is unacceptable. Instead, there should be massive efforts to invest in the national health delivery system as well as denouncing any structures that oppress and deny others fullness of life and well being. The liberation of the country will be incomplete in the absence of an effective and nurturing health care system. A Karanga theology of *utano* should emphasize on a liberative motif which is life-giving and life-enhancing.

⁶¹⁴ For more information on this, See Chirongoma, S (2012) "In Search of A Sanctuary: Zimbabwean Migrants in South Africa" in Joel Carpenter (ed) *Walking Together: Christian Thinking and Public Life in South Africa* (Texas: ACU Press).

⁶¹⁵ For a detailed account of such incidents, see the following online articles; Zimeye, "Zimbabwe: Mugabe Flies to Singapore for Treatment" 14 November 2013 <http://www.zimeye.org/?p=94200> [17 November 2013]; Departure Lounge, "Sick Chiwengwa Airlifted to China," 15 April 2011 <http://messagefromafrica.com/zimbabwe/departure-lounge/> [17 November 2013]; Departure Lounge, "Mugabe's Health Sends Him Back to Singapore," 24 October 2011. <http://messagefromafrica.com/zimbabwe/departure-lounge/> [17 November 2013]; Departure Lounge, "Tsvangirai Speaks Out on Mugabe's Health" <http://messagefromafrica.com/zimbabwe/departure-lounge/> [17 November 2013].

A Karanga theology of *utano* must reiterate that the health of poor people is non-negotiable. The healing ministry of Jesus concentrated on the marginalised members of society. Chapter two chronicled how during the peak of the humanitarian and health care crisis, pregnant women and their unborn children died due to failure to pay for a caesarean section. A life-promoting and life-enhancing theology should ensure that poor people do not die due to failure to pay user fees. Study participants consistently referred to poverty as one of the factors that threatened health and well-being. It is, therefore, critical for a Karanga theology of *utano* to identify and implement practical measures to counter poverty. Local communities already possess valuable resources that can be tapped to improve livelihoods.

An indigenous Karanga theology of *utano* theology should resist the forces of death; it should be anchored on defeating death and promoting life. Church leaders, theologians and activists must formulate a theology that challenges health delivery systems that deliver death, not life. This was the situation in Zimbabwe between 2000 and 2008. In earlier chapters, this study has shown how clinics and hospitals ran out of essential drugs and qualified personnel. According to Emmanuel Katongole,

That is why a theological engagement committed to resurrection in Africa must seek to awaken Africa out of its slumbering tombs; it must engage the conditions that contribute to the drowsy, often half-awake condition that keeps many Africans entombed in poverty and other forms of bondage.⁶¹⁶

Systems of death must be confronted as they prevent the Karanga from enjoying health and wellness. They stifle individuals and communities from achieving their full potential. Stories from indigenous communities emphasise the need to uphold life in the face of the many threats. These indigenous approaches to health and healing challenge poverty and promote a theology of healing and liberation. As the study has shown, the majority of those who do not access health and healing are often the poorest of the poor. On the other hand, those with financial resources have sought treatment in South Africa and beyond the region. A life-giving and liberating Karanga theology of *utano* must motivate individuals and communities to nourish and sustain a movement towards justice. Thus:

⁶¹⁶ Katongole E. (2012), "The Raising of Lazarus and the Sites for African Theological Exploration and Engagement," in A. J. Bwangatto, ed., *Africa is not Destined to Die: Signs of Hope and Renewal* (Nairobi: Paulines Publications Africa): 21-32, 30.

Rather than religion being used by those in power as a disempowering opium of the people, we can have faith in a God of justice, compassion and love, and make religion a liberating sustainer of and for the people and for all of God's creation.⁶¹⁷

By challenging systems of death, the Karanga theology of *utano* will promote indigenous peoples' access to health. Due to negative forces during the colonial and postcolonial periods, indigenous people have been marginalised in health delivery systems. The preceding chapters have described the massive challenges that most study participants had to contend with in order to access health and healing. The odds are heavily stacked against them. Although the Zimbabwean Ministry of Health recorded some impressive results during the first decade of independence (1980-1990), the situation deteriorated dramatically thereafter. A Karanga theology of *utano* which challenges systems of death will empower communities to be agents of transformation.

6.2.4 A Gender-sensitive Theology of Health

Women's health has not received priority in Zimbabwe and globally. Women are expected to give care, especially in contexts of HIV and AIDS, but they are not cared for when in need. According to the study participants, particularly in chapter five of which the majority of these health-seekers were women, it is apparent that women have specific health needs that were not met during the economic crisis.

A Karanga theology of *utano* must be gender-sensitive. It must place emphasis on upholding women's rights and dignity. As indicated in chapter two, the lack of sensitivity to women's issues has seen many women in Zimbabwe being detained in hospital after giving birth. Hospitals hold them at ransom, trying to force their families to pay user fees. This is a blatant abuse of women's rights that must be condemned strongly. Whereas child-bearing is highly regarded as a national and cultural duty among the Karanga as noted in chapter three, such treatment of women within the public health delivery system is deplorable.

As the different chapters highlighted, women in Murinye struggle to receive quality care from the three systems. In some instances, women have endured abuse at the hands of their "healers". This phenomenon has often been downplayed as the healers threaten their victims.

⁶¹⁷ Strivers L. (2013) "Economic Liberative Ethics," in M. De La Torre, ed. *Ethics: A Liberative Approach* (Minneapolis: Fortress Press), 86.

A Karanga theology of *utano* demands that women's issues and concerns are regarded as urgent and given due consideration. Incidents whereby bogus practitioners abuse their powers and either sexually abuse women or instruct their clients to rape virgins have been noted in the preceding chapters. As one of the study participants elaborated, "All practitioners should adhere to the Shona cultural values and do their best to preserve and improve people's lives and not to exploit them in their desperate time of need."

By upholding gender-sensitivity, a Karanga theology of *utano* would ensure that women's issues remain at the core of African theology. The Circle of Concerned African Women Theologians has made a significant theological contribution by insisting on the primacy of women's health.⁶¹⁸ In chapters four and five, study participants noted how some dubious healers either rape their clients or advise their clients to commit rape and incest, particularly due to the 'virgin myth' or the misguided belief in *zvikwambo* [evil magic objects used for mysterious acquisition of wealth].⁶¹⁹ In the proposed theology, the grassroots women of Murinye would no longer need to travel long distances to access health care. Neither would they be on the look-out for abusive healers. Instead, they would have peace of mind in the knowledge that their health and well-being is a concern for both Church and society.

Giving priority to women's health is critical as women suffer the most when health systems collapse, as happened in Zimbabwe during the period under study. In earlier chapters, study participants highlighted women's vulnerability to a wide range of health complications, particularly failing to access maternal services, women dying during child birth, menstrual pains, stomach pains, head-aches, ulcers, tonsillitis and failing to access medication for HIV

⁶¹⁸ See Phiri I.A, Haddad B and Madipoane Masenya (ngwana' Mphahlele) (eds) (2003) *African Women, HIV/AIDS and Faith Communities* (Pietermaritzburg: Cluster Publications); Phiri I.A and Nadar S (eds) (2006) *Women, Religion and Health: Essays in Honour of Mercy Amba Ewudziwa Oduyoye* (Orbis Books: Maryknoll, New York); Chirongoma, S. (2006) "Women's and Children's Rights in the time of HIV and AIDS in Zimbabwe: An Analysis of Gender Inequalities and its impact on people's health" in *Journal of Theology for Southern Africa* Volume 2 No.126 pp. 48-65 November (2006) and Hinga T.M, Kubai A.N, Mwaura P & Ayanga H(eds) (2008) *Women, Religion and HIV/AIDS in Africa* (Pietermaritzburg: Cluster Publications)

⁶¹⁹ Various media reports reveal how healers perpetuate the rape of young women and girls due to the misguided belief that engaging in sex with a virgin cleanses one of HIV or miraculously makes one rich, for more on this, see Chibaya M "False prophets and traditional healers perpetuating child rapes" 30 September 2013 <http://relzim.org/news/8181/> [17 November 2013]; "Zengeza Prophet Sexually abusing female clients" 2 March 2013 <http://nehandaradio.com/2013/03/02/zengeza-prophet-sexually-abusing-clients/> [17 November 2013]; *The Chronicle* "Bulawayo sexually abused female congregant whose husband is blind" 11 January 2013, <http://m.myzimbabwe.co.zw/news/3951-bulawayo-prophet-sexually-abused-female-congregant-whose-husband-is-blind.html> [17 November 2013].

related illnesses. This is principally due to the social construction of women. Women are expected to be self-sacrificing and to give everything for the sake of their families. As many study participants showed, in most instances women are willing to sacrifice their own health for the sake of their partners or for their family members in general.

Sayings such as, “*musha mukadzi*” [the home is the wife/mother], “*kusina mai hakuendwi*” [no-one goes where there is no mother] and “*musha usina mukadzi hauna mapfihwa*” [a home without a wife/mother does not have hearthstones] must be brought back to express the centrality of women. Once there is consensus that women are important to the daily lives of the Karanga, then it will be less challenging to invest in their health. According to Chabata and Mashiri, “Because the Shona people’s identity and personhood is premised on the family institution, proverbs that celebrate the role of mothers display unmistakably the main value-orientations of the indigenous African society”.⁶²⁰

A Karanga theology of *utano* will emphasise indigenous values that promote the welfare of women. By appreciating women’s key role in society, such a theology will mobilise male decision makers to regard women’s health as urgent. They will be forced to invest in health and make policies that facilitate women’s health and well-being. In particular, such a theology will remind men of women’s status in the family and community. According to Clenora Hudson-Weems, the originator of Africana Womanism, this will lead to a re-evaluation of society’s treatment of women. She writes:

Because the woman is the culture bearer, who hands down the legacy of proper values and appropriate behaviour for our children, she is an essential part of the family. To be sure, her role is, indeed, critical to the ultimate salvation of our families and thus, seminal in the overall scheme of things. Without her, whom God has created and ordained as key to life through which we make our journey on this earth, there is no present or future. Therefore, we must respect her for who she is and honour her for what she holds in her hands.⁶²¹

⁶²⁰ Chabata E. and Mashiri P. (2012), “The Significance of Motherhood and Family Stability as Portrayed in the Shona Proverb,” in I. Muwati *et al*, ed., *Rediscoursing African Womanhood in the Search for Sustainable Renaissance: Africana Womanism in Multi-disciplinary Approaches* (Harare: College Press), 103-113, 105.

⁶²¹ Hudson-Weems C. (2012), “Ending De-womanisation, De-feminisation and De-humanisation via Self-naming, Self-definition and Genuine Sisterhood,” in I. Muwati *et al*, ed., *Rediscoursing African Womanhood in the Search for Sustainable Renaissance: Africana Womanism in Multi-disciplinary Approaches* (Harare: College Press), 1-7, 2.

A Karanga theology of *utano* recognises the central role that women play in promoting health and well-being in their families and communities. As study participants demonstrated, it is women as nurses, healers, mothers, partners, sisters and so on, who have invested in promoting health. Operating with minimum resources, they have encouraged (and sometimes carried) men to utilise health systems in order to recover and thrive. Women are constantly defying the odds to promote life in the face of death. According to Nyambura Njoroge:

African women have demonstrated great wisdom and generosity as they have stepped out to take care of themselves and entire families in very difficult and trying times, facing the HIV pandemic, endemic sex- and gender-based violence, hunger, ethnic conflicts, wars and even genocide. It is no exaggeration that, when war breaks out and men take up arms – including the use of rape as a weapon of war – it is women who are left to serve the families, the children (unfortunately today some are recruited as child soldiers), the injured, the sick, and the elderly with few or no resources at their disposal.⁶²²

Recognising the centrality of women to the health and well-being of families and communities, a Karanga theology of *utano* will empower Christian women's groups that continue to be limited by patriarchal interpretations of the Bible. Among the Karanga, it is believed that one must not assault one's mother; otherwise s/he will endure serious misfortune [*kutanda botso*] as discussed in chapter three. However, society continues to assault mothers by not giving them sufficient medical care and turning them into weapons of war through sexual abuse (chapter noted how such incidents were rampant in Zimbabwe during the peak of political tensions between ZANU PF and MDC and during the land invasions).

6.2.5 Embracing a Communal Orientation

Karanga people privilege the community. Although study participants were identified as individuals, it quickly became clear that there are webs of relationships that bind individuals to their families and communities. In this regard, *ukama* [relatedness] is tied to *utano*.⁶²³ An

⁶²² Njoroge N.J. (2012), "Women as Compassionate Champions: The Doers and the Leaders," in A. J. Amman and J. P. Holland (ed.), *Women, HIV, and the Church: In Search of Refuge* (Eugene, Oregon: Cascade Books), 97-109, 101.

⁶²³ For a deeper exploration of this issue, See Murove, M. F., 2005, *The Theory of Self Interest in Modern Economic Discourse: A critical Study in Light of African Humanism and Process Philosophical Anthropology*, University of South Africa; Murove, Munyaradzi Felix (2007) "The Shona Ethic of Ukama with Reference to the Immortality of Values" *Mankind Quarterly*, Vol. 48, No. 2; Murove, M. F., (2009) "An African Environmental Ethic Based on the Concepts of Ukama and Ubuntu; in African Environmental Ethic Based on the Concepts of Ukama and Ubuntu", *African Ethics: An Anthology of Comparative and Applied Ethics*, Murove,

individual's health is not limited to his/her physical status. Instead, it extends to how s/he relates to other members of the family and the community.⁶²⁴

A Karanga theology of *utano* needs to embrace the communal orientation that forms the bedrock of both the community and the church. The notion of *hunhu/ubuntu* [I am because we are] runs through both the community and the church. Individual autonomy does not receive emphasis ahead of the sense of belonging. This is why health issues are not exclusive affairs. Other members of the family are involved in the diagnosis and therapy. In the case of people living with HIV, research participants highlighted the extent to which they relied on other family members to take their medication consistently. This confirmed the importance of the family to the healing process.

As many study participants argued in chapters four and five, the Western health delivery system tends to promote individualism by placing emphasis on “confidentiality” and limiting the number of visitors per patient. This is a very Western approach to health; some study participants commented that this is “a complete departure from the traditional African values of empathy and solidarity with those in difficult circumstances”. A Karanga theology of *utano* must challenge such Eurocentric approaches by embracing a holistic perspective. When a member of the family is unwell, the whole family is unwell. When the whole family is unwell, the whole church and community is unwell. *Utano* can only be restored by ensuring that everyone is healed as delineated in chapter three.

Utilising indigenous wisdom and Christian concepts is helpful in constructing the Karanga theology of *utano* which appreciates the value of the community. Proverbs such as, “*munhu munhu haaenzani nembwa*” [a person is a person, s/he cannot be compared to a dog] and “*murombo munhu*” [a poor person is also a human being] confirm the emphasis on upholding the rights of all persons in the community.⁶²⁵ No individual should be allowed to die because

M., ed., Scottsville, South Africa: University of KwaZulu-Natal Press; Samkange, S and Samkange, T.M (1980) *Hunhuism or Ubuntuism: A Zimbabwe Indigenous Political Philosophy* (Salisbury, Graham Publishing), 9.

⁶²⁴ Murove, Munyaradzi Felix (2004) ‘An African commitment to Ecological Conservation: The Shona Concepts of Ukama and Ubuntu’ *The Mankind Quarterly* vol. xlv, no. 2, 195-215 explains it as follows, ‘*Ukama urimbo kudambura haubvi* [Relationships are like bird lime; even after breaking up they do not vanish... *Ukama makore hunopfekana* [Relationships are like clouds; they interpenetrate each other]

⁶²⁵ Chimuka T.A (2001) “Ethics among the Shona,” *Zambezia* 28(1), 23-37.

of his/her economic status. The community must come together to rescue that particular individual because his/her economic status does not define his/her humanity. The community plays a key role in determining an individual's future. According to Bujo:

Numerous studies have sufficiently shown that African thought and action are deeply determined by the community. Foundational to them is the concept of life. The individual knows him or herself to be immersed in the community to such an extent that personality can develop only in it and through it. This development does not take place in an asymmetrical way but it is based on mutuality. It also includes giving back of what one has received from the community. In concrete terms, there is interdependency which is based on the fact that all members have the task of mutually increasing the life force. Everybody's behaviour and ethical action have consequences for the whole community: the good contributes to the increase of life, while the evil destroys or at least reduces life.⁶²⁶

The western bio-medical approach to health and an emphasis on the doctor-patient confidentiality has led some Karanga people to worry exclusively about their own health. They no longer subscribe to the communal approach to health and healing. The Church, like the community in indigenous African wisdom, stands as a community of those who care for one another. It must be characterised by solidarity and concern for the poor and the vulnerable. Where the traditional system had the king/chief looking after the welfare of the entire community in a representative capacity, the Church too is invited to support the Karanga people as they search for health and healing.

6.3 Areas for Further Investigation

This study has raised many issues relevant to understanding health-seeking behaviour among the Karanga of Murinye in Zimbabwe. It has also offered insights into the key ingredients of a Karanga theology of *utano*. This emerged from the understanding that developing such a theology is necessary as it will equip the Church and the community to respond to health challenges more effectively. However, the study raises the following issues for further research:

- Religion, youth and sexual reproductive health and rights
- Churches and health delivery in rural areas in Zimbabwe

⁶²⁶ Bujo B. (1998) *The Ethical Dimension of Community: The African Model and Dialogue between North and South* (Nairobi: Paulines Publications Africa), 182.

- Pentecostal healing ideologies in rural areas in Zimbabwe
- The impact of HIV and AIDS and healing practices
- The introduction of contextual bible study pursuing themes of health and well-being in indigenous communities. In order to facilitate a progressive Karanga theology of *utano* which acknowledges the agency of health-seekers, it is important to embrace postcolonial readings of the Bible.⁶²⁷ Such interpretations of the Bible promote the total liberation of Africans from colonial and colonising interpretations of the text. This is urgent in developing indigenous theologies, such as the Karanga theology of *utano*, as the colonial project tended to project negative images of Africans. As some of the interviews showed, some converts to Christianity now have a totally negative attitude towards indigenous health delivery systems. By embracing postcolonial biblical interpretation, the Karanga theology of *utano* will reinterpret biblical passages that have been used to demonise traditional healing systems.

It is hoped that other researchers will pursue these themes that have emerged from this study but could not be addressed in detail. Such studies will complement the current study and contribute towards a more detailed analysis of religion and health in Zimbabwe.

6.4 Conclusion

This study has described the key tenets of a Karanga theology of *utano*. Informed by the concepts of health assets and coping healing in churches (see chapter one) and building on understanding the history of health care in Zimbabwe (chapter two), appreciating the Karanga people's perception of health and healing (chapter three) and reactions to the three health delivery systems (chapters four and five), the study has demonstrated the centrality of health and well-being to the Karanga worldview. This study recognises the urgency of a Karanga theology of *utano* as this will empower Karanga Christians to navigate the multiple health delivery systems with a clear conscience. It also draws attention to the need for concerted political action that will transform systems of death into systems of life. This would ensure that when the Karanga declare, "*Tiripo hedu*" [honorific, we are well] in greetings, it would be truly well with them.

⁶²⁷ Dube M.W. et al, eds. (2012) *Postcolonial Perspectives in African Biblical Interpretations* (Atlanta, GA: Society for Biblical Literature).

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Oral sources

Health-Care Providers (Fictive names)

- Moline, (female nurse in her 50s): 5 and 28 December 2006, Shonganiso Clinic, Murinye.
- Patricia, (female nurse in her 40s): 5 and 9 December 2006, Shonganiso Clinic, Murinye.
- Richard, (male nurse in his 50s): 5 and 9 December 2006, Shonganiso Clinic, Murinye.
- Monica, (female nurse in her 30s): 7 December 2006, Mashenjere Clinic, Murinye.
- Violet, (female nurse-aide in her 20s): 7 and 8 December 2006, Mashenjere Clinic, Murinye.
- Miriam, (female prophet- healer in her 40s): 15 December 2006, Murinye.
- Takunda, (male prophet- healer in his 60s): 17 December 2006, Murinye.
- Kwangwari, (male prophet- healer in his 30s): 12 and 17 December 2006, Murinye.
- Phineas, (male prophet- healer in his 70s): 12 December 2006, Murinye.
- Patrick, (male prophet- healer in his 50s): 15 and 19 December 2006, Murinye.
- Raramai, (male traditional healer in his 60s): 20 December 2006, Murinye.
- Vonai, (female traditional healer in her 50s): 21 December 2006, Murinye.
- Nyaradzai, (female traditional healer in her 50s): 14 December 2007, Murinye.
- Shingirirai, (female traditional healer in her 50s): 15 December 2007, Murinye.
- Mufudzi, (male traditional healer in his 20s): 16 December 2006, Murinye.

Health-Seekers (Fictive names)

Andrew, (male in his 40s): 19 December 2005 and 21 November 2006, Murinye.
Edwin, (male in his 60s): 21 December 2006, Murinye.
Takwana, (male teenage): 22 December 2006, Murinye.
Laina, (female teenage): 23 December 2006, Murinye.
Susan, (female in her 50s): 23 November 2006, Murinye.
Runyararo, (female in her 30s): 24 and 25 November 2006, Murinye.
Jacob, (male in his 40s): 16 December 2007, Murinye.
Ruvarashe, (female in her 50s): 11 November 2007, Murinye.
Ingrid, (female in her 40s): 12 December 2005, Murinye.
Esther, (female in her 70s): 13 December 2006, Murinye.
Samson, (male in his 40s): 15 December 2005, Murinye.
Wellington, (male in his 60s): 16 December 2005, Murinye.
Terrence, (male in his 60s): 17 December 2005, Murinye.
Believe, (male in his 20s): 28 December 2006, Murinye.
Pauros, (male in his 30s): 8 December 2006, Murinye.
Milton, (male in his 40s): 29 December 2006, Murinye.
Jennifer, (female in her 30s): 29 December 2006, Murinye.
Rutendo, (female in her 50s): 29 December 2006, Murinye.

Appendix 1: Research Questions [Healers e.g. Nurse, MuPorofita or N'anga]

1. Name Age and Gender?
2. Religious affiliation (*Christian if so, which denomination? Or Traditional Believer?*)
3. Educational qualifications?
4. Role in the system (Nurse, nurse aid, etc), Traditional healer, Prophet?
5. How does your religion influence your work as a healer/health-care provider?
6. When was this clinic established? If church ask when it was founded and who is the founder and when and how they started their healing ministry as a prophet-healer? If Traditional healer, ask when they started, why and how?
7. Approximately how many people does this clinic/prophet, traditional healer serve (catchment area)?
8. What is the furthest distance that people have to travel from to access the clinic/prophet, traditional healer?
9. How many people work here and what are their duties and responsibilities?
10. What is your role in this clinic/church or healing ministry i.e. how do you heal people?
11. How many patients come to the clinic/prophet, traditional healer per day and what are the common sicknesses treated?
12. What are the major challenges you encounter in providing health-care here?
13. What suggestions would you make to improve the situation?
14. What key socio-economic and environmental factors influence Karanga/Shona people's health negatively and positively? e.g. poverty or food insecurity?
15. What key religious and cultural factors influence Karanga/Shona people's health-seeking behavior/preferences; that is to whom do they usually turn to first when they are sick (clinic, n'anga or muporofita) and why?
16. What are your views regarding sick people using the three health systems, that is do you feel there are certain illnesses that are better treated in a particular context e.g. clinic and not traditional healer or vice-versa? If so give examples and explain your views.
17. To what extent are the three health systems (clinic, n'anga or muporofita) integrated in providing holistic health-care?

18. If they are not, why?
19. Do they co-operate in their efforts of care-giving? Or is the work of the different areas of health care in conflict? If so, how and why? What solutions would you suggest to resolve the conflict?
20. What is your definition/understanding of being healthy (Utano)? Say as much as possible.

Appendix 2: Research Questions (PATIENTS/HEALTH-SEEKERS)

1. Name
2. Age and Gender?
3. Religious affiliation (*Christian if so, which denomination? Or Traditional Believer?*)
4. Educational qualifications?
5. Nature of Sickness/Ailment? For how long have you been suffering from this condition?
6. What other ailments are you being treated for and where are you being treated?
7. Have you been treated somewhere else in the past e.g. another clinic (hospital)/prophet, traditional healer? If so, what made you to leave that service provider and opt for this one?
8. How does your religion influence your response to sickness i.e. do you suspect witchcraft, normal misfortune or God's punishment when you fall ill? Please explain your response.
9. How often do you visit this clinic/prophet, traditional healer?
10. What kind of service do you receive here i.e. what makes you prefer this service provider?
11. What is the furthest distance that people in this community have to travel to access the clinic/prophet, traditional healer?
12. What are the major challenges you encounter in accessing health-care here?
13. What suggestions would you make to improve the situation?
14. What key socio-economic and environmental factors influence Karanga/Shona people's health negatively and positively? e.g. poverty or food insecurity?
15. What key religious and cultural factors influence Karanga/Shona people's health-seeking behavior/preferences; that is to whom do you and your family turn to first when you are sick (clinic, n'anga or muporofita) and why?
16. What are your views regarding sick people using the three health systems, that is do you feel there are certain illnesses that are better treated in a particular context e.g. clinic and not traditional healer or vice-versa? If so give examples and explain your views.

17. To what extent are the three health systems (clinic, n'anga or muporofita) integrated in providing holistic health-care?
18. If they are not, why?
19. Do they co-operate in their efforts of care-giving? Or is the work of the different areas of health care in conflict? If so, how and why? What solutions would you suggest to resolve the conflict?
20. What is your definition/understanding of being healthy (Utano)? Say as much as possible.

Oil

Microwave Sample Preparation Note: XprOP-1
Category: Oils

Rev. Date: 6/04

Sample Type: Oil
Application Type: Acid Digestion
Vessel Type: 55 mL
Number of Vessels: 12
Reagents: Nitric Acid (70%)
Method Sample Type: Organic
Sample Weight: 0.5 gram

Step 1:

<u>Acid Type</u>	<u>Volume</u>
Nitric	10 mL

Heating Program: Ramp to Temperature Control

Stage	Max. Power	% Power	Ramp (min.)	Pressure (psi)	Temperature (°C)	Hold (min.)
(1)	1200 W	75	15:00	-	200	15:00

NOTE A: This procedure is a reference point for sample digestion using the CEM Microwave Sample Preparation System and may need to be modified or changed to obtain the required results on your sample.

NOTE B: Manual venting of CEM closed vessels should only be performed when wearing hand, eye and body protection and only when the vessel contents are at or below room temperature to avoid the potential for chemical burns. Always point the vent hole away from the operator and toward the back of a fume hood.

NOTE C: Power should be adjusted up or down with respect to the number of vessels. General guidelines are as follows: 8-12 vessels (50% power), 13-20 vessels (75% power), >20 vessels (100% power).

NOTE D: "Organic Method Sample Type" should be used for most sample types. Choose "Inorganic" for samples with more than 1 gram of solid material remaining at the bottom of the vessel at the end of the digest (ex. leach methods). Choose "Water" for samples that are largely aqueous prior to digestion.