The African Religious Landscape: An examination of Shona traditional beliefs and practices in light of HIV and AIDS, and its ramifications for mitigation and care

by

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SUPERVISOR: Professor A. Groenewald
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DEDICATION

I dedicate this thesis to the following essential people in the research my life:

1. My wife, Patience Marashe for her love, support encouragement and understanding. I will always cherish this kind of spousal support for the rest of my life.
2. My grandfather, Mr Wilson Farawe Dube Manzara and Mbuya Dube, who inspired me to value and pursue academic excellence during my formative Muzite Primary School years, and encouraged me to be the best I could be, and
3. My parents, Mr Nelson Jubani Marashe & Mrs Sophie Dube-Marashe, for encouraging me to soldier on with education as well as for their financial and material support throughout my academic years.

ABSTRACT

This study examined traditional Shona beliefs and practices in light of HIV/AIDS in the rural communities of the Chipinge District in Zimbabwe. The focus of the study was to examine selected Shona traditional beliefs and practices, and evaluate how they respond to the HIV/AIDS threat. The study aimed to examine the traditional beliefs and practices that people in Chipinge rural communities still practise, have stopped practising, or have modified due to the encroachment of HIV/AIDS into the communities' socio-moral space. It also aims to discuss the traditional beliefs and practices that are safe and those that expose people to HIV infection, in addition to the communities' knowledge about HIV/AIDS. Grounded in the traditional Shona religious landscape, and from a phenomenological perspective, the study utilised a qualitative survey research design. Using purposive and snowball sampling procedures, 72 study participants, knowledgeable in the Shona people's traditional beliefs and practices, were selected. The study used non-scheduled structured interviews and a questionnaire, with both closed and open-ended questions, to gather data from the participants. Most participants defined HIV/AIDS as a blend of sexually transmitted infections (STIs) that take time to treat. They believed that AIDS results from 'pollution' caused by sexual intercourse with 'unclean' women, while a few attributed it to having unprotected sex with an infected partner. Results show that *kuputsa* (pledged or child marriage), *barika* (polygamy), and *kugara nhaka* (wife inheritance) are harmful marriage practices that expose people to HIV infection. As old habits die hard, the study suggests modifications to such marriage practices, where people willing to be involved should take an HIV antibody test. Given that information about HIV/AIDS is communicated through posters and pamphlets written in English, it would benefit the community, if the Ministry of Health and Child Care could provide information in the Ndau language.

Key Words

African Traditional Religion, AIDS, antiretroviral therapy, ancestral spirits, child marriage, HIV, spirit possession, traditional leader, traditional medicine, witchcraft beliefs

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ABBREVIATIONS

AIDS	Acquired Immune-Deficiency Syndrome
ANCs	Antenatal Clinics
ART	Antiretroviral Therapy (Antiretroviral Treatment)
ARV	Antiretroviral drug
ATR	African Traditional Religion
BBC	British Broadcasting Corporation
CD	Compact Disc
CD4	White blood cells responsible for the body's defence or immune system
CDU	Curriculum Development Unit
DA	District Administrator
DDF	District Development Fund
DMD	District Medical Director
DNO	District Nursing Officer
e.a.	emphasis added
ESAP	Economic Structural Adjustment Programme
FACT	Family AIDS Caring Trust
FGD	Focus Group Discussion
GZU	Great Zimbabwe University
HBC	Home Based Care
HIV	Human Immuno-deficiency Virus
MDC-T	Movement for Democratic Change - Tsvangirai

MDGs	Millennium Development Goals
MoHCW	Ministry of Health and Child Welfare
MoHCC	Ministry of Health and Child Care
NAC	National AIDS Council
NGO	Non Governmental Organisation
OAU	Organisation of African Unity
PEP	Post-exposure prophylaxis
Pers. Comm.	Personal Communication
PLWHA	People Living with HIV and AIDS
SAfAIDS	Southern Africa HIV and AIDS Information Dissemination Service
SDA	Sabbath Day Adventist
STIs	Sexual Transmitted Infections
SW	Short Wave
TV	Television
UCCZ	United Church of Christ in Zimbabwe
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
VCT	Voluntary Counselling and Testing

VHW	Village Health Worker
VOA	Voice of America
WHO	World Health Organisation
ZANU (PF)	Zimbabwe African National Union – Patriotic Front
ZBC	Zimbabwe Broadcasting Corporation
ZINATHA	Zimbabwe National Traditional Healers' Association
ZRP	Zimbabwe Republic Police

STATEMENT OF ORIGINAL AUTHORSHIP

I, **Joel MARASHE**, hereby declare that this thesis entitled: ***The African Religious Landscape: An examination of Shona traditional beliefs and practices in light of HIV and AIDS and its ramifications for mitigation and care***, being submitted for the degree of Doctor of Philosophy at the University of Pretoria, is my own original work and has not previously, in its entirety or in part, been submitted to any other university for any examination or degree.

Joel MARASHE

Date: 31 August 2017

UNIVERSITY OF PRETORIA

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I, Joel Marashe, declare that this thesis is my own original work. Where secondary material is used, this has been carefully acknowledged and referenced in accordance with university requirements.

I understand what plagiarism is and am aware of university policy and implications in this regard.

03 October 2017

SIGNATURE **DATE**

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TO WHOM IT MAY CONCERN

I, Barbara Wood, am a PEG-registered professional researcher and editor and hereby confirm that I have language-edited:

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George, March 2018

BARBARA WOOD

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CHAPTER 1

BACKGROUND TO THE STUDY

…researchers identify the research problem as accurately as possible, always assuming that the problem is acquiescent to empirical methods as well as give the researcher relevant evidence about the concepts such as their main characteristics, dimensions and key elements (Cohen et al. 2007:286).

1.1 Introduction

The study is an examination of selected traditional beliefs and practices of the Shona people of Zimbabwe in the rural and impoverished Chipinge District in light of the HIV and AIDS pandemic. The study is anchored in the African traditional religious milieu and examines the Shona people's attitudes, perceptions, fears and knowledge about the HIV and AIDS pandemic. The researcher conducted this examination to determine whether the traditional beliefs and practices of the Shona people in the Chipinge District have responded to the twin threats of the virus and the disease, and in what ways. The study aimed to identify the traditional practices and beliefs that have been discontinued, adjusted or have remained unchanged despite the HIV scourge. It also aimed to suggest those practices that may not expose people to the HIV infection. In broad terms, the study is an examination of the interface between the Shona people's traditional religious practices and the health sciences, as represented by the HIV and the AIDS epidemic.

The chapter begins by presenting the background and rationale of the study. It explains some of the terms found in the discussion of the subject and provides working definitions to clarify issues discussed in the study. Furthermore, the researcher places the study within its proper geographical context. The study describes the research setting entirely (the Chipinge District) as well as the specific places of fieldwork activities.

The chapter identifies and explains the main research topic or statement of the problem, which is, *The African Religious Landscape: An examination of Shona traditional beliefs and practices in light of HIV & AIDS and its ramifications for*

mitigation and care. After identifying the study topic, the chapter outlines the primary objectives of the research. These objectives give the study its proper footing and meaning to the rest of the chapters as they gradually unfold.

The chapter also outlines the reasons for, and motivation in carrying out the survey and the researcher highlights these in the justification of the study section (1.4). The section explains and justifies the research considering that scholars might have conducted similar studies locally and internationally. The section on the justification of the study is similar to a key that unlocks the study processes and sets them in motion.

Related to the objectives are the do's and dont's of the study, which relate to the conduct of fieldwork or the research ethics. The section on ethics (1.7) explains the rights of the research participants, where the researcher explains the study and its aims to the participants through a consent letter, after which they sign a consent form. The consent form states that participants are free to withdraw from participation at any time during the study. The form also outlines that participation is voluntary, free of charge and that the study is for academic purposes and that their identities would remain anonymous.

Furthermore, the chapter outlines the parameters of the geographical area of study and the study participants – the rural and impoverished Chipinge District and the specific villages that constitute centres of fieldwork. It also identifies the sacred practitioners and elders in the communities who would participate in the study. Delimitation of the survey place, study participants and the time frame are cardinal aspects of a study. The researcher specifies these in the study.

The chapter also indicates the shortcomings and challenges experienced during the conduct of this study. Some of the limitations remained beyond the control of the researcher. For instance, time has always been an elusive resource, and sometimes meeting set targets and deadlines proved difficult. Financing the study was also a challenge, primarily as gathering the research data meant extensive travelling from one place to the other, which was costly. The University of Pretoria postgraduate bursary, though not adequate, helped and cushioned the researcher in a big way. The road networks in the rural areas of the Chipinge District, compounded by the

incessant rainfall during the time of fieldwork and data collection were limitations the researcher had no control over. However, these only slowed down the process, but did not in any way affect the quality of the data the fieldwork yielded.

Also highlighted in the chapter is the theoretical framework that underpins the study. The phenomenological theory provided the study with a sound theoretical grounding and framework, guided by the feature of 'bracketing out' pre-conceived notions about the issues under investigation as well as the call or the maxim that 'the believer is always right'. Adopting some of the phenomenological theory's significant aspects ensured the researcher extracts raw data from the primary sources during the fieldwork. Indeed, there is nothing as good and fulfilling as tapping data from the source, especially from the custodians of the cultural beliefs and practices of the Shona people of the Chipinge District.

The chapter further presents a resume of a literature review that is bifocal. It reviews the literature concerning traditional beliefs and practices of the Shona people (from a traditional religious vantage point) and then outlines the Shona people's understanding of the 'twin health devils' of the HIV and AIDS epidemic (from the health sciences). The interface between these two disciplines ensures a rich discussion and identification of practices that, because of HIV and the AIDS pandemic, are either not safe anymore for the people, or have been adjusted or have remained unchanged. Furthermore, the chapter outlines the communities' knowledge, fears and perceptions about the HIV and AIDS pandemic. Conclusively, the chapter gives an overview of the structure of the study and chapters that constitute this research report, its conclusions and summary.

1.2 Background and rationale for the study

African[1] Traditional[2] Religion (thereafter referred to as ATR) provides the setting for this study. ATR is an indigenous religion, which the Africans "… had and practised

[1] Dating back to the days of Pliny, credited with the first use of the term, 'African' has been a contentious term, referring to the dark-skinned people who lived south of the Sahara and were united by a similar culture (Mwandayi 2011:58). In this report, the term refers to people from Sub-Saharan Africa, specifically those in Zimbabwe.

[2] Derived from the Latin *trader*, traditional in this research report retains its meaning, that life experiences and expressions are orally handed down from one generation to the other, and also that

long before the introduction to the continent of these other new religions" such as Christianity and Islam (Kibicho 2010:45). The setting is essential in the study because some of the indigenous religious beliefs and practices form the backbone of this research. The studies of African traditional religious beliefs and practices, in general, have gone through numerous stages, each having different objectives and opinions (Ray 1976:2; Brand 2002:15). In the earlier studies authored in the 18th and 19th Centuries, traders, ethnographers, missionaries and explorers described ATRs as savage, pagan, fetish, barbaric, primitive, idolatry, magic, animism, devilish or ancestor worship (Chidili 2007:326; Dopamu 1991:19; Sundermeier 1998:1;). While it is not the primary objective of the current study to discuss the implications of these different terms and negative perceptions about the African Traditional Religion in great detail, the researcher tries to highlight a few issues.

It is possible that earlier writings and reports about ATR used the derogatory and distorted nomenclature because they thought that Africans had no religion at all (Olowola 1993:10). However, Gwaravanda *et al.* (2013:241) citing Davies (1988:11) argued that '"… religion has permeated human life since early and obscure times"'. Similarly, Beyers (2010:2) citing Opoku (1993:67) in an article, "*What is religion: An African understanding,"* argued that the genesis of African Traditional Religion was "the experience and deep reflection" of the African progenitors. He further stated that Africa's cultural heritage and insight moulded her religious experiences. This argument demonstrates that religion has existed among Africans since time immemorial. Distortions and prejudiced perceptions of the African indigenous religion are evident in the often-cited works of the explorer of note, Sir Samuel Barker. While presenting a report about the Nilotes of South Sudan to the London's Ethnological Society in 1867, Barker stated:

> Without an exception, they are without a belief in a Supreme Being, neither have they any form of worship or idolatry, nor is the darkness of their mind enlightened by even a ray of superstition. The mind is as stagnant as the

they are firmly secured by a functional indigenous moral campus system deriving from its historical heritage and customs from the past (Mwandayi 2011:61).

> morass, which forms their puny world (Evans-Pritchard 1965:7; Kibicho 2010:46-47).

Similarly, in West Africa, Dopamu (1991:20) cited Sir Richard Burton, who argued that:

> The Negro is still at the rude dawn of faith-fetishism and has barely advanced to idolatry. He has never grasped the ideas of a personal Deity, a duty in life, a moral code, or a shame of lying.

What is common in the above quotations is a presentation of a people, whose comprehension of religion was neither rudimentary, with no belief in a Supreme Being and not even belief in idol worship, nor superstitious. Africans were believed to be without a real moral campus and as people who prided themselves in lying. Everything about the African religious beliefs and practices was presented as wrong and demonstrating a lack of civilisation. However, many questions come to mind after examining the discourses about perceptions from the early accounts on ATR. Some of the questions are: Were these observations valid? Were the perceptions well grounded? How justifiable were these descriptions? Kibicho (2010:46) postulated that the quoted 18th and 19th Centuries' reports about ATR, its beliefs and practices "were mostly based on unreliable sources and distorted views, much coloured by the prevailing cultural-racial prejudices". Perhaps, these distortions were a direct result of African indigenous religions involving a broad range of traditional beliefs and practices, which earlier European writers failed to understand. In the words of Edgerton (2000:131), "… some [*traditional*] practices remain permanently beyond the comprehension of outside observers ..." (*my emphasis added*).

The next phase was when some African scholars such as J. S. Mbiti (1969), E. B. Idowu (1973) and others, who were graduates from Christian mission-administered schools and universities, endeavoured to present a positive image of African religious beliefs and practices from an African perspective[3]. They made every effort

[3] Olowola (1993:8) conceded that most literature on traditional African beliefs was written by non-Africans, and as such, contained uninformed and disparaging criticisms that have been rightly discarded by Africans.

to correct the negative perception people had about African traditional beliefs and practices[4] (Olowola 1993:8) and they developed reasonable and user-friendly terms to describe some aspects of ATR. They dropped the use of ancestor worship to ancestor veneration (Adogame *et al.* 2016, Idowu 1966:186-187)[5]. Awolalu (1976:275) argued that the African indigenous religious practices and beliefs are not fossiliferous. He noted that they were, and continue to be cardinal elements of a religious tradition that the African people live and practise every day. Thus, this new breed of scholars presented African traditional religious practices as a way of life, wherein there is a thin line between the sacred and the profane. Commenting on the same idea, Thorpe (1992:3) confirmed Mbiti's (1990:1; 1969:2) claim that:

> ...traditional religions permeate all the departments of life, there is no formal distinction between the sacred and the secular, between the religious and nonreligious, between the spiritual and the material areas of life.

In essence, Thorpe (1992) and Mbiti's (1990) argument was that Africans have been and are religious people in every aspect of their lives. The sacred and the secular aspects jelly into one another such that separating them becomes almost impossible. Therefore, describing Africans and their religion by using the pejorative terms indicated above was very unfortunate.

It could not have been possible that Africans did not have a religion of their own. Chidili (2007:330) addressed this issue in an article, where he specifically examined, whether African religion is indeed a religion. He found that African Traditional

[4] On a re-evaluation of ancestral traditions and addressing the same issue, Gerrit Brand (2002:69) argued that the writings of African theologians were a critical response to traditional Western approaches, in which they affirmed the depth and richness of Africa's religious past in the face of denials by Westerners of any significant religious consciousness in pre-colonial Africa. Even as way back as 1977, Robert C. Mitchell reckoned that African culture was rich and intricate.

[5] Adogame *et al.* (Eds) (2013) identified scholars who took their time to write on the different terms used in describing African religions and presenting the African religious traditions in the way African people understood them. The most notable of those they identified included some of the following: Van Gennep (1960), Beier (1966), Mbiti (1969), Opoku (1978), Awolalu and Dopamu (1979) and Ray (2000).

Religion is "indeed the fundamental mode of behaviour that every African expresses every day, each and every community in Africa embraces religion in its totality".[6]

It is important to note that although African Traditional Religion is a way of life, it is not monolithic. ATR comprises an array of different beliefs and practices[7]. Because of that, one does not talk about one African religion, but many African religions. Owing to the complexity of whether ATR is one or several, it is impossible to study everything about African religions as some have attempted to do. The present study strived to search for the continuities and changes found in the traditional beliefs and practices of the Shona people of the Chipinge District in Zimbabwe about the threat posed by the HIV and AIDS epidemic (Brand 2002:15). This poses the question, who are the Shona people who are the subject of this study?

As a people, the Shona constitute several linguistic groups that include the following: the *Zezuru, Kore-kore, Karanga, Kalanga, Nambya, Utee, Barwe, Hwesa, Manyika* and *Ndau*. The last three groups are from Manicaland Province, and the Ndau language dominates in the Chipinge District of Manicaland. Ndau is the name and language of the people who participated in the current study (Perman 2010:426-427; 2017:148), hence its significance. Mwandayi (2011:49) citing MacGonagle (2007) and Beach (1980), stated that Ndau was a 19th-Century nickname. The name Ndau was coined by the Gaza-Nguni raiders (Figure 1:1) to describe the Shona people of the Eastern frontier, who announced, "*Ndau-we Ndau-we* (we salute you) as their customary greeting, when they entered a homestead".[8] The greeting signified humility and respect, traits that the people still possess even to date. What is noticeable in this brief description is that the Shona people comprise too many groups to engage them all in a single meaningful study, especially considering the acceptable time frame for the study. At the same time, it might be misleading to indicate that the survey involves all the Ndau people because of the fact that people identified as such stretch from the Chipinge District into some territories deep into

[6] Mitchell (1977:1) pointed out that traditional African culture is endowed with sacredness, religious mystery and spiritual forces that pervade every aspect of the African traditional life.
[7] The consensus among the majority of scholars is that although there is no single monolithic system of belief, African religious traditions exhibit certain general features and patterns that justify talk of African Traditional Religion in singular terms. See also Mbiti (1969:1).
[8] Bulpin (1965:45), and Duri and Gwekwerere (2007:3) expressed the same opinions as well.

the Republic of Mozambique. For instance, the Gwenzi area near Jersey Tea Estate is too small a part as compared to the more massive chunk of the Chieftaincy that stretches deep into Mozambique (Figure 1:1). The same applies to most areas that lie along the border with Mozambique.

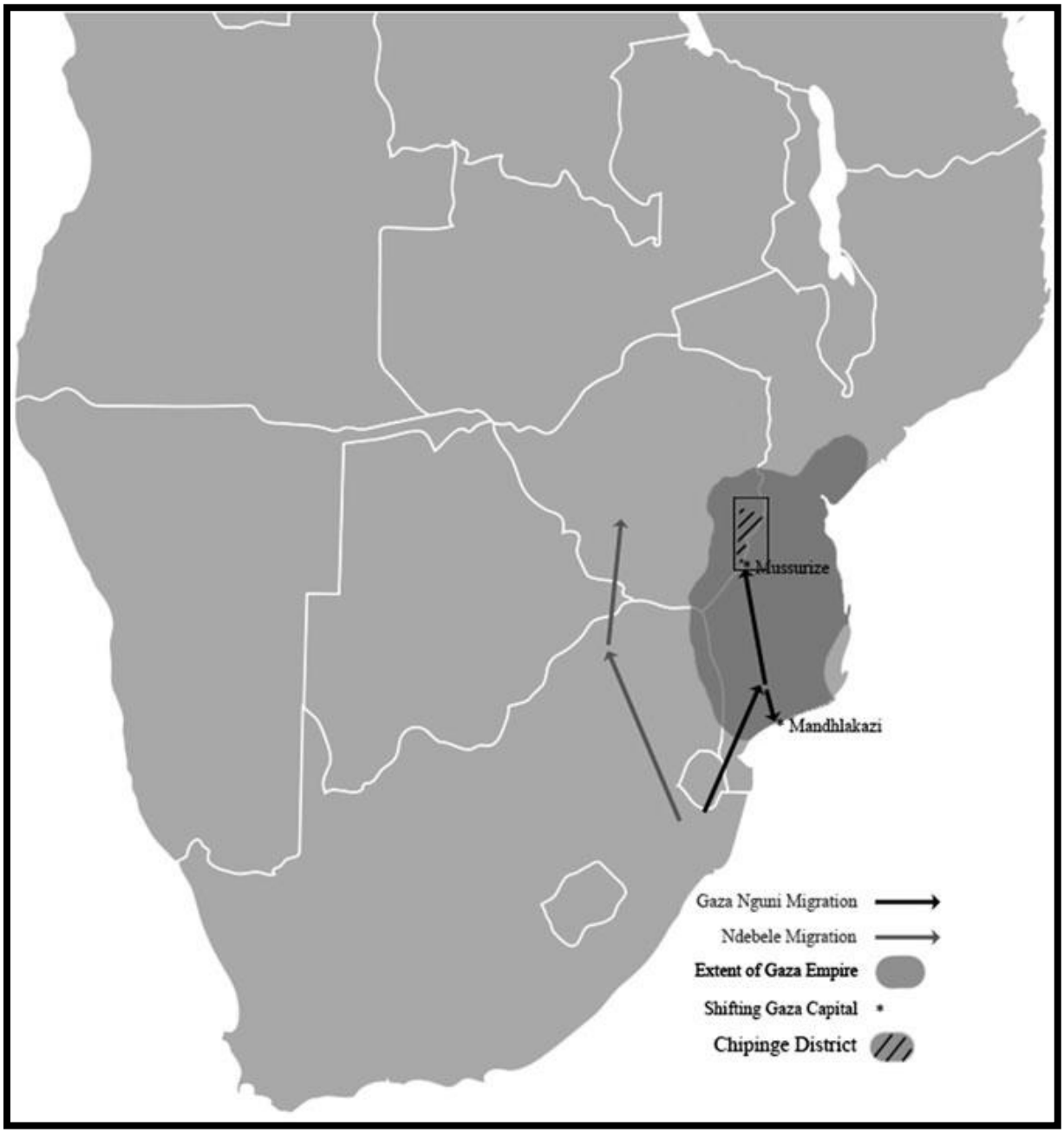

Figure 1.1 Gaza-Nguni Migration North during the Mfecane

Source: Perman (2017:150)

To avoid confusion, therefore, this study uses the statement *the Shona people in the Chipinge District* (and its variants) to refer specifically to the Ndau residents in the Chipinge District (and not their Mozambican counterparts).

Now that the study has identified the likely population of the research[9], it is equally significant to reiterate that the survey aimed to provide an interface between the traditional beliefs and practices, and the contemporary health issues such as the HIV and AIDS scourge, with particular reference to the Shona people of the Chipinge District. For this study, and as highlighted in the literature review section, traditional beliefs and practices selected are those that are likely to expose people to HIV, and make them vulnerable to contracting the virus. The desire to be practical about what lecturers teach students in lectures motivated the researcher to carry out this study. It appeared pointless to study religion or traditional customs in lecture rooms and end there. Like some scholars suggested, there is a need to interrogate these issues, engage the communities about them, and through research, provide solutions to societies' problems, and not for the findings "to remain in the academic sphere alone" (Nickel 2015:127). The implication is that religion should provide solace to people who face these worldly tribulations and epidemics, and not confine the discussions to within the lecture halls/rooms. Accordingly, and from a cultural vantage point, the study strove to establish the extent to which some of the traditional beliefs and practices were not, in fact, endangering the very lives that they are supposed to protect as the people practise them.

Naturally, African people in general, and the Shona in particular, subscribe to a myriad of traditional beliefs and perform different traditional practices. At the same time, and according to a Joint United Nations Programme on HIV/AIDS (UNAIDS) report on Zimbabwe, HIV and the AIDS menace are wreaking havoc in Sub-Saharan Africa in general and Zimbabwe in particular (UNAIDS 2005:1). Statistically, the HIV infection rate in Zimbabwe is frightening. Taylor (2010:304) citing UNAIDS (2008) pointed out that one person in every seven is HIV seropositive.[10] Even though the

[9] The study shed more light and details on the population of study, sample and sampling procedures in Chapter 3 that explains the research methodology.

[10] Endnote 1 of Taylor (2010: 323-324) has more statistics, and details about the state of HIV infection in Zimbabwe.

government has upped efforts to contain HIV infection, Zimbabwe continues to rank as one of the countries with the highest rates of HIV infections, and most severe AIDS epidemics in the world (Taylor 2010:304). While the real cause of the escalation remains obscure, the prevailing Shona traditional beliefs and practices seem to be contributing to the severity of the scourge. Some of these traditional beliefs and practices include the belief in ancestral spirits and spirit possession, marriage practices such as *kugara nhaka* (wife inheritance)*, kuputsa* (forced or pledged marriages)*,* and *chimusamapfiya* (sister marriage), among others. The pandemic brought about many perceptions, anxieties and fears among the Shona people in the Chipinge District. The perceptions result from the fact that HIV infections and the AIDS pandemic cause immune-system breakdown rather than a specific disease. Consequently, people eventually die of any one or a combination of the opportunistic diseases present in Southern Africa in general and Zimbabwe's Chipinge District in particular. People may die from opportunistic infections due to immune system breakdown, while they attribute it to either witchcraft or angry alien, ancestral or avenging spirits. Such beliefs are a cause for concern in this study.

Therefore, given the above, this study was concerned with those beliefs and practices that might fuel the transmission of the HIV and AIDS pandemic. The researcher assumed that some of the traditional beliefs and marriage practices such as *kugara nhaka* (wife inheritance) (Mandaza 1997:58), belief in spirit possession and spirit mediums, and some traditional healing practices might be possible agents that fuel HIV infections and the AIDS pandemic in the Chipinge District's impoverished rural communities. While the medical field has established the ways of HIV infection and transmission, most traditional leaders, healers and others have remained silent about the life-threatening infection and disease. Of interest in this study was an interrogation of the challenges and threats wrought by HIV infections and an examination of the changes that have occurred in the Shona people's attitudes regarding their traditional institutions such as those of healing, widow inheritance and traditional marriage practices. It is important to note that 70% of Sub-Saharan Africans are reported to be visiting traditional healers mainly in rural areas, where Western health service delivery is not readily available. The visit to traditional healers normally happens, when patients have been discharged from the hospital to

go for home-based care programmes (Mills *et al.* 2006:360). In Zimbabwe, a recent survey by the Ministry of Health and Child Welfare indicated that 85% of the people seek the services of traditional or faith healers. The report did not indicate whether people consult traditional or faith healers in large numbers, which could be attributed to high medical fees that could be beyond the reach of many people, especially in a situation, where Zimbabwe is experiencing a serious financial or liquidity crunch.

However, it is the contention of this research that some communities have drastically altered, or discontinued some, and rejuvenated other traditional beliefs and practices. These changes are indicative of the dynamism of traditional practices in their response to the horrendous challenges of the HIV infections and the AIDS scourge. The interface between traditional beliefs and practices, and HIV infections and the AIDS pandemic has hardly been researched and understood. It is one of the principal purposes of this study to establish the influence of the HIV and the AIDS pandemic on the traditional beliefs and practices of the Shona people of the Chipinge District.

It is important to note that the study took place in a district, where no significant research had been done to date on how traditional beliefs and practices are responding to the challenges posed by the twin problems of HIV infections and the AIDS scourge, especially in the impoverished rural Chipinge District, except for two studies conducted by Taylor in 2007 and 2010, respectively. In the first publication, entitled *"A Place of Trouble": The Political Ecology of HIV/AIDS in Chipinge, Zimbabwe,*[11] Taylor (2007:223-256) discussed some of the traditional practices, HIV and the work of traditional healers in disease control in an urban setting of Chipinge Town. She subsequently published another study entitled, *"Because I was in pain, I just wanted to be treated"*: *Competing Therapeutic Goals in the Performance of Healing HIV/AIDS in Rural Zimbabwe".*[12] In the latter study, Taylor (2010:308)

[11] In this *Safundi* publication, T. N. Taylor (2007: 223-256) discuses traditional practices, HIV and traditional healers from an urban setting of Chipinge town

[12] In this *Journal of American Folklore* Taylor (2010: 308) provides details of a case study of a traditional healer attending to a patient who had shingles (or herpes or zoster), a common HIV-related infection, in a high-density suburb within the precincts of Chipinge town.

provided a case study of a traditional healer, a medium of both ancestral and *dzviti*[13] spirits, who took turns to attend to a patient who had shingles (or herpes zoster), a standard HIV-related infection, in a high-density suburb of Chipinge Town. The latter article helped to highlight the significance of traditional healers in the management of sickness, even in urban centres such as Chipinge Town. In the former study, Taylor (2007:251) concluded that poverty and the insecure volatile socio-political environment in the impoverished rural areas of Chipinge incapacitate families and individuals from coping with HIV infections and the AIDS epidemic. She also highlighted that the ever-growing numbers of people living with HIV overburden hospitals and clinics, which consequently fail to provide basic health services and medicines.

These publications give this study valuable leads. The current study examines the interface between a gamut of the people's cultural practices and beliefs and the HIV and AIDS pandemic *Sitz im Leben*.[14] Perman (2011) also made significant contributions to one's understanding of spirit mediums and possession[15] in a study he conducted in Muzite village, situated to the south-southeast of the town of Chipinge. He concluded that the *mandlozi*[16] spirits, a reality in the rural areas of the Chipinge District, are intertwined with the mediums themselves and their day-to-day habits. The life of the medium, especially the skill to diagnose and heal different diseases, is a recapitulation of what the *dzviti/ndlozi* used to do during his lifetime. This relationship means that the personhood of the mediums and that of the *madzviti/mandlozi* that possess them are inseparable. However, while the study described in depth, in some instances (Perman 2011:231-232),[17] it remained silent

[13] *Dzviti* is the singular form of *madzviti,* referring to the spirit of Zulu or Nguni warriors. See Note 11 as well.
[14] *Sitz im Leben* is a German term that refers to a situation, place or setting in life. In this context, the researcher was, through fieldwork, able to study or gather data straight from the custodians of culture, and in their setting – the rural communities of the Chipinge District.
[15] Spirit mediums and spirit possession is one of the major highlights of Chapter 2.
[16] Perman (2011:63, 65 & Note 1) defined *Mandlozi* generally to refer to several 'alien' spirits that include *madzviti* (spirits of Nguni warriors), *zvipundha* (young nannies), *mbhongo* (spirits of mermaids from Mozambique) and *zviayungu* (spirits of Shona soldiers). Taylor (2010:306) identified *mbhongo* as a water spirit, and not related to any specific water body.
[17] In this article, Perman described the *mandlozi* drumming ceremony in the Ndau community in detail, showing the intricacies of the dance and song, as well as the relationship between the *mandlozi* spirits and their mediums.

on how people become mediums in the community. It is the 'how' people in the communities under study 'become mediums' that concerns the current study.

The process of initiation into the mediumship cosmology and its interface with HIV and the AIDS pandemic are some of the challenges that this study sought to establish. The study is, therefore, an attempt to provide relevant information that the rural and vulnerable communities in the Chipinge District might use to reduce the health impacts of some of the traditional practices and beliefs. The information may also be useful in mitigating the impact of traditional beliefs and practices that could be fuelling the transmission of HIV infections and the AIDS pandemic in the impoverished rural Chipinge District. At this point, the chapter offers a brief description of the study area, the Chipinge District, setting up the stage, where the cast (participants) showcase their drama skills (fieldwork). The section brings forth and in brief, what the Chipinge District is like geographically, socio-economically and politically. These factors are significant in understanding the people's traditional beliefs and practices about HIV infections and the AIDS epidemic that continue to threaten the socio-moral and cultural fabric of the communities under study. It is important to take note of the fact that the section below is a word-for-word citation of the researcher's earlier publication and a by-product of this study.

1.2.1 A description of the Chipinge District

> The Chipinge District is 5 296 km^2 (1.4% of the total area of Zimbabwe) and is located in the southern part of the Eastern Highlands in Manicaland Province in Zimbabwe. Thomas Moodie established the town as a trading post in 1892 (see note 14 in Taylor 2007:229). According to the preliminary report on the 2012 national census, Chipinge District is home to approximately 326 467 people (2.5% of the total population of Zimbabwe) of whom 25 675 live in Chipinge Town (Dzinotizei 2012:15). To the north of Chipinge is the Chimanimani District. The Chiredzi District is to the south-west, the Buhera District to the north-west and the Bikita District to the west.

The area is replete with fertile soil suitable for commercial farming. It is situated between the 'Chimanimani mountain range and a heavily forested plateau' in the east and the basalt soil of the low-veld (Taylor 2007:228). The eastern side of the District is very good for commercial farming because of its red soil's good capacity to retain water and the high level of rainfall. The Tanganda Tea Company is the largest, and one of the most successful multinational companies in Chipinge. It owns vast tracks of macadamia, avocado, coffee and tea estates such as Jersey, Zona, Ratelshoek, New Years' Gift and Clear Water. The undulating slopes ensure the proper drainage of excess water and are carpeted with pine and wattle tree plantations that punctuate the terrain in the eastern part of the District that becomes flat as one move to the semi-arid low-veld to the west.

With regard to traditional leadership, the Chipinge District falls under the jurisdiction of seven chiefs, namely Mpungu, Garahwa, Mahenye, Musikavanhu, Mutema, Mapungwana and Gwenzi. It is worth noting that the position of chieftain – which dates back several centuries – is the fulcrum of the Ndau culture. Chiefs are sacred and immune to modern day democratic forces. They are sacred because they are associated with the origins of the particular communities they rule. They are immune to the democratic processes as they are not voted into the esteemed traditional offices, but inherit their positions from their predecessors (Beall, Mkhize & Vawda 2005:760; Miller & Skinner 1968:188). Their sanctity imbues them with the power to rule their subjects.

However, the Zimbabwean Government – like other emerging democracies in Africa – passed the *Traditional*

> *Leaders Act* (2000), Chapter 29:17, to regulate the activities of all traditional leaders. It spells out in detail the duties of chiefs, headmen and village heads. For instance, in Chapter 29:17, Part II, Section 5(b), the chiefs are given the power to promote and uphold cultural values and preserve the institution of the extended family as well as to promote traditional family life. Furthermore, the issue of land is fundamental to the chiefs' powers; it is a resource, from which about 300 792 people of Chipinge's rural populace obtain food (Dzinotizei 2012:15). The Chiefs hold power not only to allocate or withhold land, but also to mediate in local disputes between members of the community under their jurisdiction (Campbell 2010, citing Ntsebeza 2006). As the 'custodians of tradition', the chiefs wield power and authority and are revered by all and sundry, particularly the elderly in the community (Campbell 2010:1638; Marashe 2014:2-3).

The Chipinge District is a tale of two different regions. The eastern side naturally receives above average rainfall in a good season; and hence, the presence of several multinational companies such as Tanganda Tea Estates that own vast tracts of tea and coffee plantations. The west is semi-arid, but blessed with the nutrient-rich black soils, which the people commonly refer to as *ndowoyo*. The majority of the population reside in the rural and impoverished areas, an indication of decades-long political neglect from central government. Poverty and starvation are the order of the day for the majority of the people in the rural areas, who also bear the brunt of HIV and the AIDS epidemic because most seropositive relatives come back home from various towns and cities. The elderly guardians, with meagre earnings or nothing at all, carry the heavy burden of taking care of the sick. All this makes the rural areas of the Chipinge District favourite targets of the study's fieldwork as shown in Figure 1.2 overleaf. It indicates the position of Manicaland Province (in yellow) in relation to other provinces. Additionally, it indicates the position not only of the Chipinge District, but the areas, where the researcher conducted fieldwork – marked in green.

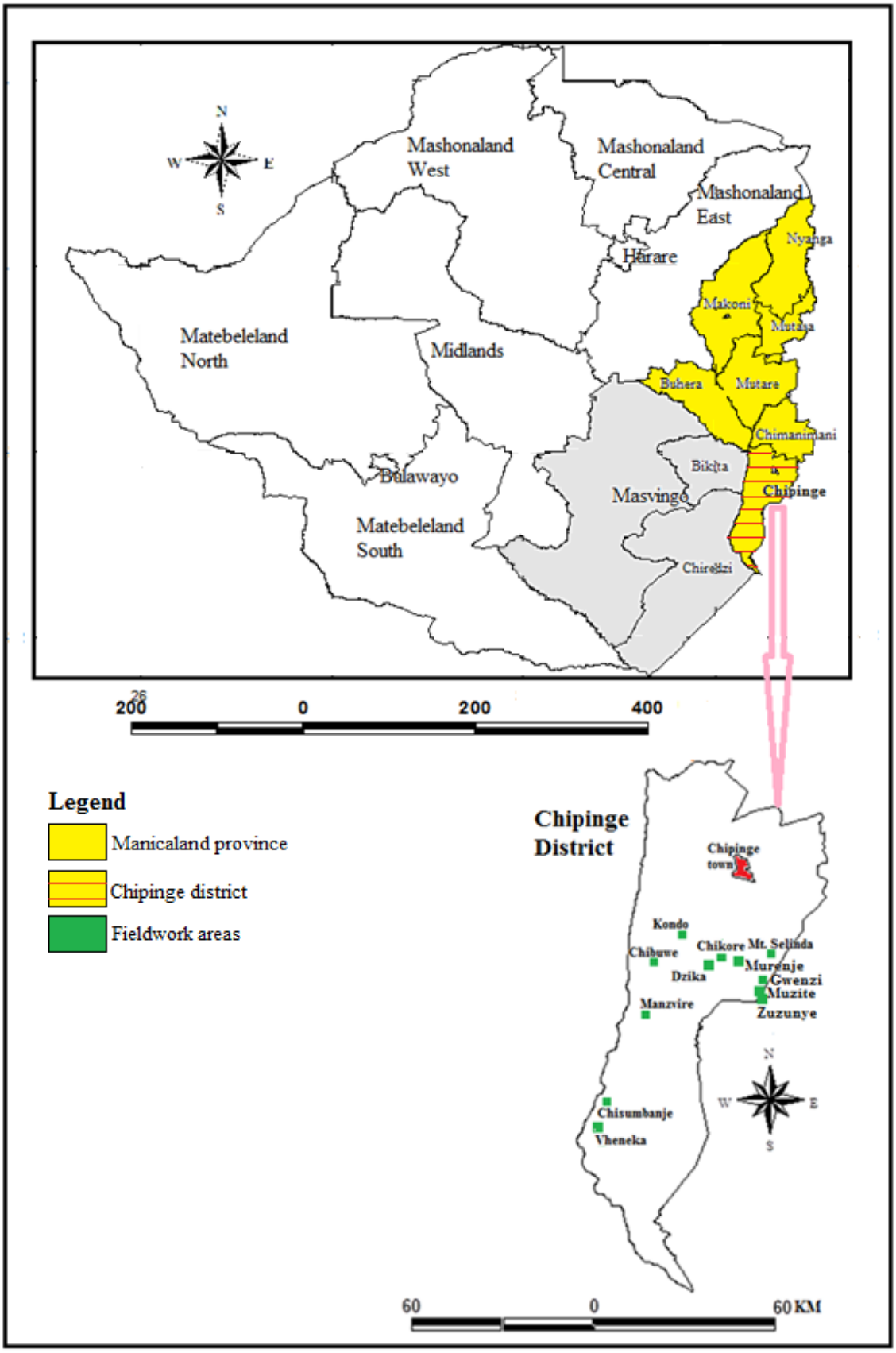

Figure 1.2: Zimbabwe Map showing Manicaland Province, the Chipinge District and places of fieldwork

1.3 Statement of the problem

African traditionalists hold beliefs that concern salvation and promises of well-being and wholeness in this world (Brand 2002:61). Because African Traditional Religion celebrates life in its fullness, lively traditional ceremonies and festivals characterise most of their practices (Mbiti 1991:14, 27). Traditional customs are a concoction of shared values, beliefs and activities organised in the daily routines of life, as well as interactional experiences that have emotional meaning (Weisner 2000:142). Thus, in Africa, these practices and beliefs are a way of life. As such, the questions of great concern to this study include: Which traditional beliefs and practices have withstood the test of the ever-changing times? Which ones have been discontinued, or have been revitalised altogether because of the HIV infections and the AIDS epidemic onslaught? Are there traditional practices and beliefs that contribute to the mutation and transmission of HIV, or delay quick health mitigation efforts to those who are infected? The ballooning statistics of people dying of AIDS-related illnesses are a cause for concern. For instance, a report of 200 000 adult and child deaths in Zimbabwe was recorded in 2001 alone, and this was projected to increase to 6 million deaths by 2015-2050, which is a real cause for concern (Garbus & Khumalo-Sakutukwa 2002:5, 10). Moreover, to date, no one has come in the open to alert the nation in general, and the stakeholders in the Chipinge District in particular, about the role of some of the traditional beliefs and practices such as witchcraft or widow inheritance, in the promotion of the HIV and AIDS scourge. It was in search of answers to these and other pertinent questions that the researcher conducted this study. The researcher approached the study from a traditional religious standpoint, considering the fact that the difference between the sacred and the secular wears thin in the lives of the people in the study area. The study examines how the HIV and AIDS pandemic have influenced the traditional beliefs and practices of the Shona people in Chipinge District, and the impact these beliefs and practices might have on the HIV and AIDS mitigation and care efforts. The guiding or leading research topic was: *The African Religious Landscape: An examination of the Shona traditional beliefs and practices in light of HIV and AIDS and its ramifications for mitigation and care.*

1.4 Aims and objectives of the study

The primary purpose of this study was to examine the traditional beliefs and practices of the Ndau speaking Shona people in the Chipinge District, and determine how these people are responding to the challenges resulting from HIV infections and the AIDS pandemic. The cultural beliefs and practices of the Shona people in the Chipinge District are essential elements that constitute the moral fabric of the society. Unfortunately, that moral fabric is under severe attack from the HIV infections, and the AIDS scourge. The study recognises the fact that traditional beliefs and practices and the HIV and AIDS belong to two distinct disciplines. The former belongs to the traditional religious field, and the latter to the medical domain. Therefore, approaching the research problem from two angles in juxtaposition was significant in the study. This approach enriched the traditional religious discipline in several areas, chief among them being the identification of user-friendly beliefs and practices. Moreover, the study will recommend modifications to some of the practices as a way of providing solutions for medical problems resulting from cultural practices that expose the people to HIV and the AIDS pandemic, that are encroaching into the communities' long-cherished traditional socio-medical space.

In light of the above explanation, this study, which was carried out among the Shona people of the Chipinge District in eastern Zimbabwe, sought to accomplish several listed and latent objectives, and provide answers to the research problem. Therefore, the principal objectives of the study were to:

i) Examine how the HIV and AIDS pandemic has impacted on the people's traditional beliefs and practices;

ii) Analyse cultural beliefs and practices likely to perpetuate the risk of the HIV infections and AIDS pandemic;

iii) Examine current knowledge, fears, perceptions, attitudes and beliefs about the HIV and AIDS pandemic;

iv) Discuss traditional beliefs and practices that have continued, discontinued or been modified due to the threat of the HIV and AIDS pandemic;

v) Recommend modifications to the traditional practices to become safe for those who practise them, and

vi) Propose culturally-appropriate behaviour change strategies.

1.5 Justification of the Study

The study focused on traditional beliefs and practices of the Shona people in the Chipinge District on the one hand, and HIV and the AIDS pandemic on the other hand. These two topics had been researched as separate entities.[18] Many scholars researched traditional beliefs and practices or traditional religion. Some of the scholars include Taylor (2007), Edgerton (2000), Mbiti (1969), and Gelfand (1962). Other authors such as Mills *et al.* (2006) and Chipfakacha (1997) conducted studies on HIV and the AIDS epidemic. United Nations agencies such as UNAIDS (2005, 2006) and UNESCO (1999) produced reports on many aspects of HIV in Zimbabwe. Unfortunately, nothing significant has been done so far on how the Shona traditional beliefs and practices are responding to the challenges that are a direct result of the effects of HIV infections and the AIDS pandemic. Patterson (2005:2) reported that the state of the AIDS epidemic in Sub-Saharan Africa, of which Zimbabwe is a part, "... remains rampant", while Taylor (2010:304) citing UNAIDS (2008) stated that globally, Zimbabwe was experiencing one of the severest pandemics. These reports indicate a dire health-threatening situation; one too dangerous to ignore, hence the need for attention from all angles – medically, epidemiologically, and socio-culturally. In agreement with Taylor's (2010:307) submission, the study took place in the Chipinge District because of:

> …the high rate of HIV infection, and excess of socio-economic and political variables known to exacerbate individual vulnerability to HIV infection.[19]

Furthermore, the study is justified because it intends to determine the interface between traditional beliefs and practices, and the HIV and AIDS epidemic.

[18] Chapter 2 discusses many of these works in detail.

[19] Citing Jackson (1992) and the National AIDS Council of Zimbabwe Taylor (2010:307) identified the variables as "poverty, gender inequality, forced labour migration, long-distance trucking routes, and a thriving sex industry."

Additionally, the submission that the Chipinge District is an HIV and the AIDS pandemic hotbed makes it attractive for this study. Besides, the research findings will add more knowledge to the already existing repertoire of traditional beliefs and practices, thereby creating a database of knowledge useful in the quest to reform traditional practices that might delay quick mitigation programmes for HIV and the AIDS pandemic victims.

Most studies on the topic tended to focus more on traditional practices, and there is a glaring deficiency in research and literature that focuses on how the beliefs and practices are responding to the onslaught of HIV infections and the AIDS pandemic that are threatening families with total annihilation. As a major point of departure, this study sought to explore how traditional practices, under the tutelage of traditional leaders such as the chiefs and headmen, have responded to the HIV and AIDS pandemic. The study examined the metamorphosis that some of the cultural practices have undergone for them to remain relevant so as to address the people's socio-cultural needs and aspirations. It is this research and information gap that the study sought to explore thoroughly and diligently.

Above all, this study finds justification in its novelty to traditional societies in that from the onset, by non-governmental and civic organisations have articulated HIV and AIDS issues, but never from a traditional or cultural perspective. Therefore, assessing how traditional beliefs and practices are responding to the HIV and AIDS menace could be of interest to most traditional families of Chipinge that are hitherto heavily burdened by caring for relatives who are both affected and infected by HIV and AIDS.

1.6 Delimitation of study

The scope of this research was confined to the rural and impoverished communities in the Chipinge District, which lies to the southern part of Zimbabwe's Eastern Highlands, and is one of the seven districts in the Manicaland Province (Figure 1.2). The study drew participants from the Shona people, born and bred in the District, who are fluent speakers of the Ndau language. Participants came from different villages and communities of the study area as indicated in Figure 1.2. According to the 2012 national census, particularly in the Manicaland Provincial report, the

Chipinge District is home to an urban population of about 25 292 and a rural population of 298 841 (ZimStat 2012:20)[20]. Most of the people who stay out of town live in sparsely settled rural homesteads. Others live on formerly white-owned farms, which the new Zimbabwe Government distributed to them soon after independence in the 1980s as well as through the fast-track land redistribution programme in the 2000s (Taylor 2007:229). The Chipinge District is mostly rural and impoverished[21]. The researcher confined the study to the rural areas because of the nature of the information expected. It sought information on cultural beliefs and practices from the elderly members as well as traditional leaders in the communities in the research areas. The latter is the *bona fide* custodian of the customs that find more expression in rural settings. Furthermore, and from the same research area and participants, the study sought information about the HIV and AIDS epidemic, participants' perceptions, knowledge and fears of the virus and the disease, and their hopes. It was in the selected areas in the rural and impoverished constituencies in the District that fieldwork for this research took place. The participation by human subjects in the study was inevitable, and that called for the observance of guidelines that ensured their freedom of participation, or withdrawal from the study. The next section gives further highlights on the ethics of conducting the empirical study, when human subjects are involved.

1.7 Ethical considerations

The last section set the parameters from where the study and fieldwork took place. This section looks at the do's and don'ts of carrying out a study that involves human participants. Participation in the study was voluntary (Glesne & Peshkin 1992:111). The researcher obtained a cover letter from the research directorate at the University of Pretoria that defined the study as an academic undertaking and the researcher as a *bona fide* postgraduate student of the institution (Appendices A and E). The letter boosted participants' and stakeholders' confidence because of the genuineness of the clearance or testimonial letter. The University of Pretoria letter helped to minimise response bias. Participants needed to understand the reasons for the data

[20] According to the 2012 national census, the District of Chipinge has a total population of 324 133.
[21] The District comprises four political constituencies – Chipinge Central, Chipinge East, Chipinge West and Chipinge South. All constituencies are basically rural, except for Chipinge Central. The study took place in the selected communities of the rural constituencies (Figure 1).

being collected, and how the researcher was going to use it (Copestake, Johnson, & Wright-Revolledo 2005:60). The confirmation letter helped to make participants realise the genuineness of the study and, in some way, might have helped that they provided reliable data. Furthermore, the questionnaires did not require any personal identification from the respondents, thereby assuring respondents of their confidentiality. The study promoter keeps all research data gathered in a secure place, where access is restricted to the researcher, the study supervisor and possibly, the internal and external examiners of the research report. This arrangement helped in maintaining confidentiality at all the times. Also, participation in the study, either by filling in a questionnaire or by responding to interview questions, was never risky for participants. Lastly, the researcher allowed participants to answer only questions they were comfortable with and informed them that they were free to withdraw their participation from the study at any time (Glesne & Peshkin 1992:112). The study, therefore, conferred some level of freedom on respondents to participate without coercion and allowing them to withdraw at any time from the study at no cost or penalty. After reading a consent letter, participants signed a consent form as an indication of their willingness to take part in the study (Appendices B and C).

1.8 Constraints

One of the major limitations of the study was establishing contacts with potential participants in the communities under study. The nature of the study required participants to answer questions on their knowledge about HIV and AIDS and marriage practices. As such, it involved discussing issues to do with sexuality. It is important to note that in the rural communities of the Chipinge District, the subjects of HIV and the AIDS pandemic are usually associated with immorality and prostitution, and therefore, an unpleasant topic to talk about publicly. The other challenge was the cost involved in travelling to the places of study. Roads in the rural areas are in a state of neglect and therefore difficult to navigate. The dereliction of the road network in the district is indicative of the government's failure to maintain the roads that the Smith government constructed during its reign. Consequently, public transporters charge exorbitant fares, citing the poor conditions of the roads. Additionally, organising interviewees and the time required to conduct the interviews

was problematic; potential participants were sometimes too busy for the study. It is, however, the conviction of the researcher that despite these and other challenges discussed later in this study report, data from the non-scheduled structured interviews and questionnaires complemented each other well. These research instruments yielded enough data, and at times, led to a data saturation point (Kajawu *et al.* 2015:46)[22], from which the study drew informed conclusions about traditional beliefs and practices in relation to the HIV and AIDS pandemic.

1.9 Theoretical framework

The phenomenological theory guided this study. The theory is especially significant because it is concerned with observing a phenomenon, behaviour or religion as the adherents see them, rather than imposing any external value judgment. In fact, the theory provides a means for investigating the way people come to know reality (Cox 1992:15). Through the process of *epoché,* the researcher was able to gather data after the expunction of any value judgments and preconceived notions (Douglas 2005:189; Chitando 2005:300, 305; 2001:184) about the beliefs and practices of the Shona people of Chipinge District. By use of this theory, the researcher suspended verdicts concerning the truth, value or validity of the phenomenon. In this case, he suspended judgements about the Shona people's traditional beliefs and practices, and the HIV and AIDS pandemic. The theory was essential because research findings on traditional beliefs and practices of the Shona people in the Chipinge District were not judged or evaluated through the spectacles of other people's traditions, beliefs and practices. They mirrored what and how the participants in the study perceived them, and how they were responding to the threat of HIV infections and the AIDS pandemic. Thus, the researcher studied the Shona traditional beliefs and practices *sui generis*. The researcher used this approach because of its advantage regarding its application, as well as the ability to differentiate between the *noumena* (things as they are), and the *phenomena* (things as people perceive them) Cox (1992:15). The phenomenological approach was advantageous in that it helped in the gathering of first-hand data from the participants in the field, particularly when used in juxtaposition with questionnaires that have open-ended questions, and

[22] This is a point in data gathering, where the researcher does not get new concepts from subsequent interviews or questionnaires.

buttressed by the interviews as was the case in this study (Fraenkel & Wallen 1996:447)[23]. Having looked briefly at the theoretical underpinnings that guided this study, the next section briefly examines the available literature related to this study.

1.10 Literature review[24]

1.10.1 A preview of African Traditional Religion, traditional beliefs and practices

While the preceding section briefly explained the theoretical framework that guided the study, the current section is a snippet of the next chapter that reviews the available literature to determine what scholars have already studied concerning the Shona traditional beliefs and practices as well as in the area of HIV and the AIDS pandemic. The Shona traditional beliefs and practices are some of the major components of the indigenous religions of the Africans. These have been orally handed down from generation to generation by the progenitors of the present generations of Africans and are still being adhered to in the present day (Awolalu 1976:275, Dopamu 1991:21). Scholars describe the religion as traditional because, as Dopamu (1991:22) argued, it has its origins on the African continent. In addition, ATR did not have any membership drive, as every African was born into it and, therefore, not converted into the religion.

Therefore, the term 'traditional' is an epithet serving the purpose of differentiating the religion from other religions that missionaries brought to Africa. While other faiths have evangelisation and religious books or literature, African Traditional Religion needs neither 'sermon' nor written text for adherents to recognise the existence of the Supreme Being. However, while African Traditional Religion has no passion for the membership drive, the religion charms everyone across the age divide. As Sundermeier (1998:1) argued, African religion is human centred and is a way of life for African people. Beyer (2010:2) further observed that ATR does not have a

[23] Chapter 2 Section 2.6 provides further details of the phenomenological theory, its historical trajectory, and its use in this study.

[24] This section presents a preview of the Chapter on Literature Review. First, it highlights African traditional practices and beliefs, and makes in-roads into the Zimbabwe situation as it relates to the District of Chipinge. This is followed by a brief summary of the trajectory of HIV and the AIDS epidemic in Zimbabwe, and in the District of Chipinge. Chapter 2 deals with these issues in greater detail.

specific founder, but finds expression and continuity through art, symbolism and proverbs. In African religion, the difference between the sacred and the profane is thin. However, it was not the purpose of this research to study every aspect of African religion, but to concentrate on those Shona traditional beliefs and practices that HIV infections and the AIDS epidemic might influence. The argument of the study is that the presence of HIV and AIDS in the Shona communities of the Chipinge District might have led to adjustments, and adaptations in the way the people conducted their traditional practices.

Africans in general and the Shona people of the Chipinge District in particular, believe in a spiritual cosmology, one in which the ancestral spirits and several other spirits live. Uka (1991:46) pointed out that ancestral spirits are the spirits of the dead, who, even in death, are still closely related to the families from whence they came, and have specific rights and duties. Consequently, they continue to influence the lives of their relatives, either positively or negatively (Nyamiti 1984:16). Because they play mostly protective roles, Gelfand (1962:51) described the ancestral spirits as guardian spirits.[25] Ancestral spirits become angry, if their living family members neglect them. The ancestral spirits send misfortunes of different degrees and kinds to the living in retaliation for negligence. For this reason, the living kith and kin often offer libation and venerate them. There is, therefore, a mutual relationship between the living and the dead. It was the assumption of this study that the people's belief in the continued interaction between the living and the dead was likely to interfere with the mitigation and care efforts regarding HIV and the AIDS menace. For instance, when people get sick from HIV infection or AIDS, they might delay getting proper medical care, thinking that they might be suffering because of misfortune from angry ancestral spirits.[26]

The belief in ancestral spirits, or any other spirit for that matter, is closely intertwined with the belief in spirit mediums and spirit possession. The reason for this close relationship is because the spirits, in their various forms, find expression and function

[25] In *The Genuine Shona: Survival values of an African culture,* Gelfand (1973:114) argued that the dead are expected to care for their own descendants, and the link person, through which contact is made, is the grandfather, and after him the father.
[26] This line of argument is developed fully in Chapter 4, where the results of the study are discussed.

through spirit mediums. These two need each other's company in order for them to play their meaningful roles in society. Bourdillon (1976:274) argued that spirit possession takes place at all levels in Shona traditional religion and that when spirits possess their mediums, they exhibit their character – that is, speaking in a voice other than the medium's and in dialects elders of the family comfortably recognise. It is worth noting that several spirits could possess the same mediums − *mashave* (alien spirit), *midzimu* (ancestral spirits) or *mhondoro* (territorial spirits). The spirit mediums, as hosts, give the spirits a voice. They enable the spirits to communicate with their families or communities, depending on the type of spirit and message.

The Shona people of the Chipinge District believe that spirit mediums bring them messages of goodwill from the spiritual world. Mutekwa (2010:162) pointed out that spirit possession and mediums are pivotal in the religious life of the society and act as the community's cultural and moral compass. Therefore, spirit mediums guard and protect the society and its traditions. Sundermeier (1998:138) postulated that mediums interpret dreams for the good of the community. Spirit mediums also play significant roles during the installation of traditional leaders in the communities. What is of concern to this study is how the spirits choose their mediums. The researcher contends that the manner, in which spirits select people to become mediums, may in a way interfere with health intervention efforts. This study looked at this process with a keen interest to determine its impact on the HIV and AIDS epidemic mitigation and care efforts.

The assumption result from the fact that pre- and post-independence literature suggested that illness is a precursor to spirit mediumship (Zvarevashe 1970:45; Gelfand 1973:127; Bourdillon 1976; Bucher 1980:48 and Sundermeier 1998:137). These scholars agreed that when the spirits choose would-be mediums, the chosen mediums display symptoms of illnesses of varying degrees and severity. They observed that the illnesses related to the spirit possession were challenging to deal with because even if doctors administer Western medicine, it would not have any effect at all (Gelfand 1962:84-85). The people who might be sick because of spirit possession recuperate only after the intervention of a traditional healer who then diagnoses and helps the families to conduct the proper rituals befitting for spirit

mediums. In some instances, and as Bucher (1980:276) wrote, the mediums would typically undergo a series of tests to weed out impostors.

This study intends to establish, through fieldwork, how the communities' belief in spirit possession and mediumship interferes with HIV infections and the AIDS pandemic mitigation and care efforts. As Ashforth (2002:126) conceded, most people infected with HIV invariably contract diseases associated with AIDS such as tuberculosis, persistent headaches, weight loss, stomach aches and respiratory problems.

The study asserts that when symptoms of AIDS show, people in the rural areas may perceive them to be indications of a call for one to become a spirit medium. As a result, they may delay seeking proper HIV and AIDS medication. By the time they realise that the illness is not related to spirit possession, their CD 4 Cell Count[27] would be too low and too insignificant to commence antiretroviral therapy (ART).

Linked to the causes of illness and several other social ills in the Chipinge District are the beliefs in witchcraft. The belief in witchcraft is firm, and not unique to the Shona people in the Chipinge District. Idowu (1973) and Brand (2002) described the belief in witchcraft as permeating all strata of societies in Sub-Saharan Africa, and indeed in the Muslim world, despite strong Islamic traditions (Perlmutter 2013:74-75). Writing about the Shona people in general, Bourdillon (1976:199) observed that people use the belief in witchcraft to explain any misfortunes, sicknesses and even death. In developing the same argument, Bourdillon further conceded that the natural causes of death might be evident if one, for instance, dies in a brawl. However, the Shona people would still want to know what made the aggressor kill his victim on that occasion, when he might have been involved in scuffles before without any harm. In that situation, witchcraft is roped in to explain the mishap. In a qualitative and exploratory study in Epworth, Kajawu *et al.* (2015:47) found that African traditional medical practitioners attribute mental health disorders to witchcraft as well. Therefore, the Shona in general, and the Ndau of the Chipinge District in

[27] According to online information provided by the US Department of Health and Human Services (AIDSinfo), CD4 count is a test that measures the number of CD4 lymphocytes or cells in a blood sample, the result of which indicates the state of the immune system. It is used to determine the commencement of antiretroviral therapy (ART), and measures the response to antiretroviral drugs.

particular, identify witchcraft and wizardry as chief causes of diseases, sickness and death in their communities (Masaka & Chingombe 2009:192; Ashforth 2002:122). While literature abounds on witchcraft in other African countries and Zimbabwe, no one has done an extensive study on witchcraft, the HIV and AIDS pandemic among the Shona in the Chipinge District. This study thus seeks to establish the validity of such a belief in the District. It is important to note that there is widespread agreement that HIV causes AIDS, but most people, especially in the rural areas of the Chipinge District, do not understand why some people are more vulnerable to the disease than others. It is therefore, the premise of this study to examine the extent to which belief in witchcraft is still intact in the wake of the HIV and AIDS pandemic, and the influence such a belief has in the spread of HIV in the rural populace of the Chipinge District.

The Shona traditional attitudes, beliefs and practices about sex are also cardinal in this study. The interface between the Shona traditional beliefs and practices, on the one hand, and HIV infections and the AIDS pandemic, on the other, becomes more explicit, when examined in juxtaposition. It is their relationship and influence on each other that the study seeks to uncover. Nyoni (2008:98) argued that there might be several sexual practices that put many people at the risk of contracting the deadly HIV, primarily as they relate to the Shona marriage institution. Some of the practices include *kugara nhaka* (wife inheritance), *kuripa ngozi* (appeasing the avenging spirit), *chigadzamapfiya* (sister marriage) and *kuputsa* (pledged or forced marriage).

Kugara nhaka (wife inheritance), a practice whereby a young brother takes over his late brother's widow as a wife, usually takes place once the spirit of the deceased has been settled in his family home (Mandaza 1970:58, Bourdillon 1976:249; Weinrich & Benn 2004:27). The family and community take due diligence in conducting the widow-inheritance rituals. Most traditional families are concerned with the sanctity and integrity of their cultural practices. Therefore, to ensure the integrity of the *kugara nhaka* practice, the widow is tested to confirm whether she did not commit adultery. Among the Karanga people in Masvingo Province, the widow is asked to cross over her late husband's knobkerry, which the ritual presiding officials would have laid across the door (Sango 1970:75-76). The woman passes the test, if she does not fall upon crossing her late husband's traditional weapons. She then

chooses a husband by offering him a dish of water. The same tradition is observed in the Chipinge District with due care, for fear of reprisals, if people do not conduct it properly. The widow has the freedom to accept or decline to be inherited (*kugarwa nhaka*). The widow was 'free' to exercise her freedom of choice, and her objections were respected, however, the power of cultural and societal expectations to conform customarily carried the day.

This study contends that wife inheritance tradition places the widows and the deceased's agnates in a vulnerable position of exposure to the risk of contracting HIV, considering that the cause of death might be unknown, and also considering that the country's and the District's statistics of the rate of HIV infection is high (Gregson *et al.* 2002). As Gausset (2001:513) argued, if a man died of AIDS, his wife/wives is/are likely to be infected, and might infect others, if inherited by a younger brother or any of his agnates.

It could be argued that most traditional practices might have a hand in fuelling the HIV infections, especially if people do not take due care in conducting the traditional marriage practices. Therefore, some Shona traditional marriage practices need to be critically examined to show their role in the spread of HIV and the AIDS pandemic. Perhaps, with more information on these beliefs and practices, there could be a way of lobbying for culturally sensitive beliefs and practices as well as influencing behaviour change, with the aim of reducing the HIV and AIDS infections. The preceding is a brief review of the Shona people's traditional beliefs and practices. However, what is the state of HIV and the AIDS pandemic in Zimbabwe? The next section attempts to address the question by taking a survey of the evolution of the pandemic in Zimbabwe.

1.10.2 A brief trajectory of HIV and the AIDS epidemic in Zimbabwe

The previous section provided brief highlights of the traditional beliefs and practices of the Shona people of the Chipinge District. This section proceeds by providing a brief trajectory of the HIV and AIDS epidemic in Zimbabwe in general, and that of the Chipinge District in particular. A United Nations report stated that the first reported case of AIDS in Zimbabwe occurred in 1985 (Mabhunu 2013:86; UNAIDS: 2005:20). Statistical projections indicated that by the end of the 1980s, HIV had infected about

10% of the adult population. Perhaps, because of inadequate health management systems and budgetary constraints, this figure rose dramatically in the first half of the 1990s, peaking and stabilising at 29% between 1995 and 1997.[28] It is worth noting that the epidemic is driven mostly by heterosexual sex transmission, which accounts for 92% of all infections. Transmission through homosexuality is rare because of the Zimbabwe Government's anti-homosexual stance (Garbus & Khumalo-Sakutukwa 2003:5).

Records indicate that 1.3 million people were living with HIV and that AIDS claimed the lives of 200 000 adults and children in 2001 in Zimbabwe alone (Garbus & Khumalo-Sakutukwa 2003:20). The records indicate that AIDS-related complications became a leading cause of death in Zimbabwe for the 15 to 49 age groups. An online Averting HIV and AIDS (Avert) publication entitled *Introduction to HIV/AIDS in Zimbabwe* stated that one in every seven adult lives with HIV.[29] These statistics, therefore, made Zimbabwe "... one of the world's most severely AIDS-stricken countries" (Patterson 2005:61).

However, there are also reports of a decline in HIV prevalence in Zimbabwe since 1997, making it one of the first African countries to witness such a trend. According to government figures, by 2003, the estimated adult (aged 15-49) prevalence rate was 24.6%, but it fell to 15.3% in 2007 (UNAIDS 2010:25, 28, 68; Chipunza 2007:2; Patterson 2005:61; Ministry of Health and Child Welfare 2004).

Garbus and Khumalo-Sakutukwa (2003:20) warned that people should be cautious when interpreting these results. Sceptical about the decline, they argued that it could be a sign of many individuals who may not have been included in the survey as they had been displaced from their homesteads. To support their argument, they cited the Tibaijuka UN special report on Zimbabwe, which showed that 2.4 million people

[28] The 1990s was the time, when the Government of Zimbabwe liberalised the economy and adopted the Economic Structural Adjustment Programme (ESAP) to drive it. The effects were devastating as many companies and factories closed shop, and the workforce was retrenched in numbers, thereby reducing the contributions to the fiscus as pay-as-you-earn (P.A.Y.E) dwindled. The situation was made worse by the government's ad hoc participation in the Democratic Republic of Congo (DRC)'s civil war against an armed gang called Banya Mulenge. The venture was costly, and drained the state's finance reserves, paralysing many government functions (Garbus & Khumalo-Sakutukwa 2003:24).

[29] Article can be accessed through the link www.avert.org/aids-zimbabwe.htm

might not have been included in the survey as a result of displacement from Zimbabwe's towns and cities during the *Murambatsvina* (Operation Restore Order) in 2005. On this score, the results cannot, therefore, be taken as wholly representative of the situation.

In a related but comparative survey of the impact of Shona traditional beliefs on HIV and the AIDS pandemic intervention in Zimbabwe, Goercke (2004) found that there were attitudes, beliefs and practices that permeated traditional customs and which seemed to contribute to the severity of the AIDS pandemic. The study cited, for instance, the belief that HIV infections were a result of ancestral spirits that had not been venerated, rather than unsafe sexual practices, polygamy and traditional healing practice. The major weakness of Goercke's study was that it was more concerned with comparing rural and urban students' knowledge of HIV and the AIDS epidemic and just inferred from their responses that cultural beliefs and practices might have a hand in the transmission of the HIV. The role of cultural practices in the transmission of HIV was the major premise of the present study to be conducted through fieldwork in the impoverished rural communities of the Chipinge District.

This study explores those cultural practices that might be responsible for the escalation of the AIDS scourge in Zimbabwe. The premise that guides the survey is that a significant factor contributing to this pandemic involves the Shona traditional beliefs and practices. The traditional beliefs and practices could affect and shape the manner, in which Zimbabweans in general, and the Shona people in the Chipinge District in particular, view such health-related issues such as condom use, sexual practices and the causes and treatment of AIDS-related illnesses.

1.10.3 The motivating force for the study

Research studies that have been conducted hitherto are replete with the HIV and AIDS epidemic prevention messages focused on knowledge improvement and ostensibly directed at cultural factors in the context of practice, but none at all in the milieu of belief. It was therefore prudent to carry out a study, where traditional chiefs, healers, elders and local authorities participated in establishing the interface between traditional beliefs and practices and HIV and the AIDS pandemic. This information might be useful in the development of effective intervention programmes for HIV and AIDS epidemic by the

relevant stakeholders (Burnett *et al.* 1999:481). Perhaps, people might change their attitudes and behaviour towards matters of sexuality for the betterment of their lives. It is, therefore, the hypothesis of this study that traditional beliefs and practices have been less responsive to the HIV and AIDS pandemic such that many victims, who might have been saved by early intervention programmes, have perished because of the influence of cultural beliefs and practices.

1.11 Research methodology[30]

1.11.1 Introduction

This section presents the research design of the study in brief. It presents highlights of the population of the study, sample and sampling, and data collection procedures. Research instruments such as the interview and the questionnaire provided the researcher with raw qualitative data for analysis and discussion.

1.11.2 The research design

A research design is a plan that guides the research process. It is a manifesto of a study that directs the research process and enables the researcher to draw inferences concerning causal relations among the variables under investigation and to suggest solutions to identified problems (Nachmias & Nachmias 1981:75). The present study utilised the descriptive survey research design, which falls under the qualitative paradigm. The descriptive survey design describes research data in detail and helps classify it for better understanding. The study utilised this research design because of its "ability to produce a representative distribution, or a cross-section of the "target" population" (Gray *et al.* 2007:122). It focuses on the meaning of data and how the study participants interpret their own experiences. Its strength lies in the fact that it is as descriptive as it is inductive (Creswell 1994; Glesne & Peshkin 1992:6; Merriam 1988).

In this design, the researcher was the primary data-gathering instrument (Bogdan & Biklen, 1982:28), and bears witness to the study's progression through research visits to the custodians of Shona traditions such as chiefs, village heads, local

[30] As in Section 9 above, this section presents brief highlights of Chapter 3 that presents the Research Methodology in greater depth.

authorities and the elderly in the society. The gathered data requires a detailed descriptive account of the observations the researcher makes before making inductive conclusions. The study aimed to describe the collected data in sufficient detail *so that one who has not experienced it can understand it*" [emphasis added] (Ary, Jacobs & Razaviel 1990:445). One of its primary advantages is that it is less costly, can be used to collect data in a relatively short space of time and allows for thorough inquiry (Kelley 2003:262). Moyo (1992) used the descriptive survey design in a study of electoral politics in Zimbabwe, and his results were both reliable and valid.

1.11.3 The population of the study

According to Doodley (1984:245), and Rosnow and Rosenthal (1996:188), a population of the research study is a collection of or a pool from which the researcher can extract information from a fraction of that pool, and results can be deduced or inferred from this sample. The population for this study included the traditional leaders, traditional healers, and elders in the communities under study.

It is important to note that it was not feasible to question every member of the population in the study because time and resources − financial or otherwise, were not sufficient. Accordingly, the researcher selected a sample, which had approximately the same characteristics as of the population.

1.11.4 Sample

A sample is a small collection of units from a much more significant population, such that the researcher can study it and generate accurate generalisations about the population (Neuman 2006:219). The study had 60 purposively chosen participants from different parts of the rural and impoverished areas of the Chipinge District. The sampling method was appropriate for this study, which aimed to gain a deeper comprehension of the interface between traditional religious beliefs and practices, and HIV and the AIDS pandemic (Neuman 2006:222).

The study deliberately chose the elderly to participate because of the philosophy that they are the custodians of cultural beliefs and practices, so their wisdom and knowledge could benefit this study. Traditional and political leadership, under whose jurisdiction the area of study falls, granted permission for the study to proceed.

1.11.5 Research instruments

The primary data gathering tools for the study were the non-scheduled structured interviews and a questionnaire. The researcher conducted the structured interviews and administered the questionnaire. The questionnaire had closed and open-ended questions. Some of the interviews were audio-recorded for further analysis and identification of common themes after study participants granted consent. While interviews provided opportunities for the researcher to collect first-hand information and further probing for clarification, the questionnaire allowed participants to express their thoughts freely as best as they could (Bless & Smith 1995). The researcher valued the study participants' ability to express themselves on paper.

1.11.6 Data presentation and analysis

The study adopted the thematic approach in data analysis. The analysis was made possible by the use of Atlas.ti qualitative data software for Windows. Data from interviews and questionnaires were transcribed and uploaded in the Atlas.ti software. The software enabled easy coding. The researcher created code families and super codes, and generated themes for analysis. Code families, super codes and themes provided effective tools with which to measure cultural practices and make inferences about a group of beliefs (Sarantakos 1998) about the HIV and AIDS epidemic. Some of the themes identified included: Knowledge about traditional beliefs and practices, attitudes to people living with HIV and AIDS, and the Shona traditional beliefs about HIV and the AIDS pandemic.

1.12 An Overview of the Thesis Chapters

1.12.1 Introduction

From an African traditional religious perspective, the study examined the interface between the HIV and AIDS epidemic and the traditional beliefs and practices of the Shona people in the impoverished rural communities in the Chipinge District. The District, found in the Manicaland Province, lies to the southeast of Zimbabwe and shares its eastern border with the Republic of Mozambique. The study sought to establish how traditional beliefs and practices were responding to the encroachment of HIV and AIDS into the socio-moral fibre of the communities under study and determine the practices that have been discontinued or adjusted on account of HIV

and the AIDS epidemic. Traditional leaders, elders (inclusive of teachers and nurses), and the traditional healers in the communities provided rich and valuable data that led to informed conclusions and recommendations. The research report consists of five chapters. The sections below highlight the summaries of the main foci of the chapters that constitute this study report.

1.12.2 Chapter 1: Introduction and background of the study

The first chapter is a prelude to the research. It introduces the whole study by giving highlights of what follows. It deals not only with the background of the survey, but also describes the statement of the problem, before introducing the aims and objectives of the study. The introduction is vital as it validates the whole study. Methodological concerns are stated and expounded. The chapter also provides a résumé of the literature concerning the traditional beliefs and practices of the Shona people of the Chipinge District as well as the state of the HIV and AIDS epidemic in Zimbabwe in general and in the study area in particular. In addition to the highlights of the literature review, the chapter concludes with a summary of the research methodology, which includes the research design, sampling and the data collection instruments the study utilises. The next section is a review of literature related to the survey.

1.12.3 Chapter 2: Literature review

Chapter 2 reviews the literature concerning a wide range of selected traditional beliefs and practices, commencing with an overview of the Shona traditional worldview or cosmos. An examination of the Shona people's spiritual world, which involves such spiritual beings as ancestral spirits, alien and avenging spirits, follows the review. The chapter further assesses the role of sacred practitioners, and it critiques beliefs in the role of witches and sorcerers. It also examines the literature on marriage practices on the basis that the HIV and AIDS epidemics are more than 90% heterosexually transmitted infections and illnesses. Thus, some marriage practices are discussed to determine their roles in fuelling (or hindering) the spread of HIV.

Furthermore, the chapter reviews the literature on the people's understanding of HIV and the AIDS pandemic – its causes and symptoms, as well as their interface with

some of the Shona people's traditional practices and beliefs. It tries to gauge their perceptions, beliefs and basic knowledge about HIV and the AIDS pandemic. The literature is essential as it sets the platform, from which the study examines the influence of the HIV and AIDS epidemic on the Shona people's traditional beliefs and practices in the rural and impoverished Chipinge District.

Another significant highlight of the chapter is a description of the theoretical framework that underpins the study. The phenomenological theory or method powered this study. The study employed this theory because of some of the attractiveness of its primary qualities, which among other features, include perceiving a phenomenon under study from the way the participants see it and through epoché or 'bracketing' of one's pre-conceived notions about the phenomena under study. Thus, the study endeavours to understand the Shona traditional beliefs and practices as well as the HIV and AIDS epidemic, having achieved the same wavelength with the study participants. The approach's other attraction is its emphasis on the elaborate description of the phenomenon under study such that it becomes crystal clear to a point where participants identify themselves with the phenomenon, and above all, the overarching idea that 'the believer is always right'. Chapter 3 unveils the *modus operandi* of the study, the research methodology.

1.12.4 Chapter 3: Research methodology

While the preceding section provided highlights of the Shona people's traditional beliefs and practices and their understanding of the HIV and AIDS epidemic, Chapter 3 reviews the research methodology. The study utilised the descriptive survey design, which falls under the qualitative method paradigm. The study used structured interviews and the questionnaire to gather the requisite data. The questionnaire had closed and open-ended questions to allow participants ample space to express their opinions. The participants in the study included traditional leaders, traditional healers and elders (inclusive of teachers and nurses) in the communities under study. The researcher conducted the interviews and administered the questionnaire. This data collection process involved much travelling. Some places were far and difficult to reach because of the poor state of the roads. The researcher received clearance from the relevant government ministries and departments to research in the rural and impoverished areas of the Chipinge District.

Furthermore, the researcher observed a strict code of research ethics – participants read the consent letter, after which they signed the consent form. Participation was wholly voluntary, and the study participants were informed that they could withdraw their participation at any point of the study. The researcher transcribed the data and uploaded them into the Atlas.ti software for coding in preparation for data presentation and analysis.

1.12.5 Chapter 4: Research findings and analysis of data

By presenting the results of the investigation from the fieldwork, Chapter 4 provides a vital link with the first chapter. Data collected from custodians of culture, chief among them being traditional leaders, traditional healers and the elderly, are presented and analysed. The presentation adopted a thematic approach to avoid dealing with peripheral issues. Through themes, trends, patterns or synergies were identified and explained according to the primary objectives of the study and the main research topic - *The Religious Landscape: An examination of the Shona traditional beliefs and practices in light of HIV and AIDS and its ramifications for mitigation and care.*

1.12.6 Chapter 5: Summary, conclusions and implications

The findings on the primary objectives, research question and review of the literature and the theoretical framework of the study are all summarised in Chapter 5. The chapter also provides a summary of the major critical issues discussed in all the preceding chapters. Conclusions, which have a bearing on the objectives of the study, are drawn, and a few informed recommendations are proposed. A reflection on wise living is given, and areas for further study are highlighted. The chapter winds up by giving a conclusion to the whole research report. Appendices, providing further valuable information about the study are placed at the end of the research report.

1.13 Conclusion

Chapter 5 provided a summary of all the Chapters of the investigation report. Chapter 1 discussed the goals and objectives of the survey, and one of the major highlights is an indication of the leading research question: *The African Religious Landscape: An examination of the Shona traditional beliefs and practices in light of HIV and AIDS and its ramifications for mitigation and care.* The traditional beliefs and

practices of the Shona people of the Chipinge District, as well as their understanding of HIV and the AIDS epidemic are discussed in Chapter 2 that closes by an examination of the phenomenological theory that provides technical direction to the whole study. The study was qualitative research as shown in Chapter 3. It made use of the descriptive survey research design. Non-scheduled structured interviews and a questionnaire provided the raw data, which the researcher transcribed and uploaded into the Atlas.ti software for coding. The coding process created super codes and code families, from which the researcher generated themes that became units of analysis and were processed in Chapter 4. Indeed, the Shona people in the Chipinge District have modified some of their traditional beliefs and practices as a result of the impact of the HIV and AIDS epidemic. However, similarities between people who become sick because of HIV and those chosen to become spirit mediums are grey areas that confuse the communities, an identified problem that could delay the administration of antiretroviral therapy (ART) until it is too late. Thus, some of the traditional beliefs about the causes of sickness are an obstacle in the mitigation and care of people living with HIV or AIDS. The whole study is summarised and concluded in Chapter 5. Recommendations, as well as areas for further study are also outlined therein.

CHAPTER 2

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

Theoretical framework…is significant in the establishment of the study's theoretical roots, clarification of opinions and in the development of the research methodology. It serves to enhance and consolidate one's own knowledge base and in the interpretation of findings with the existing body of knowledge (Kumar 2011:46).

2.1 Introduction

The first chapter introduced the study by providing the background of the whole research. Among several issues it covered, the chapter presented the statement of the problem, which is, *The African Religious Landscape: An examination of Shona traditional beliefs and practices in light of HIV & AIDS and its ramifications for mitigation and care*. The research topic is bi-focal as it draws data from traditional practices and beliefs within the indigenous African religious milieu, as well as the HIV infection and AIDS pandemic from the health arena. One of the main reasons for drawing from the African (Shona) traditional religion is that it is through the people's indigenous religion that traditional beliefs and practices find expression, relevance and meaning. In addition, the cross-pollination of research from different fields of study might lead to meaningful and practical suggestions on the mitigation and care of HIV infections and the AIDS menace. The chapter set the stage by introducing the participants and the study area, from which the researcher collected data – the Shona people living in the Chipinge District. The researcher confined the study to the Chipinge District because of the realisation of the impossibility of doing a study that spans the whole country because of the limited time available, heavy work commitments and limited financial resources at the researcher's disposal.

Grounded in the African traditional religious milieu, the current chapter examines the relevant and related literature on traditional beliefs and practices as well as on HIV infections and the AIDS pandemic. In a way, the chapter explores literature that discusses different traditional beliefs and practices to determine, whether different practices and beliefs expose people to HIV infection. For instance, the chapter examines the Shona people's beliefs in witchcraft and spirit mediums in order to determine how these might impact on the mitigation and care efforts for the HIV and

AIDS pandemic. The Witchcraft and Suppression Act (1899, Ord 14) and its repeal shall be of interest to this study. Other legal documents that could shed more light on some of the traditional practices include the Traditional Leaders' Act (2000, Chapter 29:17), and the Traditional Medical Practitioners Act (2002, Chapter 27:14). These acts regulate the activities of traditional chiefs in Zimbabwe, and the conduct of traditional and faith healers in Zimbabwe's medical landscape respectively.

Recognising the fact that more than 90% of HIV infections are heterosexual, it is essential that the study pay more attention to traditional practices that are sexually oriented such as the Shona marriage practices. Therefore, the chapter reviews the literature on traditional marriage practices such as pledged marriages, polygamy and substitute-wife or substitute-husband and wife inheritance (Levirate marriage).

From the health landscape, the chapter examines the literature on the HIV and AIDS pandemic to establish and understand the nature and extent of HIV infection in Zimbabwe as a country, and in the area of study, the Chipinge District. Reviewing of literature aims to reveal how the AIDS pandemic might be influencing some of the traditional beliefs amongst the Shona people in the area of Chipinge. It also evaluates existing literature to establish the amount and impact of research on the current research topic with the intention of establishing research gaps that justify the present study.

The chapter adopts a thematic approach in its examination of the related literature. The method is appropriate for organising data from the literature for analysis and evaluation. Also, it helps to classify data from the fieldwork, especially after data transcription and coding for easy analysis and discussion.

2.2 A Review of the Shona Indigenous Religion, selected traditional practices and beliefs

African traditional beliefs and practices are some of the major components of the indigenous religions of Africans.[31] These beliefs and practices have been orally

[31] In this study, Africans include the Shona people who are naturally resident in the communities of the District of Chipinge. Most people refer to the Shona people in this District as the Ndau, taking after the Ndau or ChiNdau dialect. The District shares its eastern border with Mozambique, and some communities in Mozambique speak Ndau as well. Therefore, for purposes of clarity, this study shall

handed down from generation to generation by the progenitors of the present generation of Africans. Though they have existed since time immemorial, they are still being adhered to even today (Awolalu 1976:275, Dopamu 1991:21). Most universities across Sub-Saharan Africa that have Faculties and Departments of Theology or Religious Studies refer to this indigenous religion, as traditional because:

> ...it originated from the people's environment and on their soil. It is neither preached to them nor imported by them. Every African is born into it ... and not converted into it (Dopamu 1991:22).

Therefore, the term 'traditional' is an epithet that serves the purpose of differentiating the African religion from others that the missionaries brought to Africa through evangelism. While there are evangelisation and religious books for other faiths, the African Traditional Religion (ATR) needs neither 'sermon' nor written texts to recognise the existence of the Supreme Being. In ATR there is no passion for a membership drive, but the religion charms everyone across the age divide. Thus, as Sundermeier (1998:1) described it, African religions are 'human' as their focus are the people. Therefore, to Africans, religion becomes a way of life, where the difference between the sacred and the profane is hairline thin. It is not the purpose of this study to examine every feature of African traditional beliefs and practices. This study focused on those traditional beliefs and practices, whose practice the HIV and AIDS menace have changed and continue to change. However, before delving into the details of the Shona traditional practices and beliefs, and the HIV and AIDS pandemic, the researcher briefly presents the Shona traditional cosmology. The rationale for the presentation is that the people's cosmos has a bearing on their traditional beliefs and practices, which happened to be the primary concern of the

use the statement, the Shona people in the Chipinge District, to refer to the Ndau people resident in the Chipinge District.

current study. Traditional beliefs and practices also help explain reality[32] (Kalu 1991:13).

The Shona traditional cosmology is spiritual, and that is significant to the people. According to Bucher (1980:18), the Shona people's perception of spirits originates from their belief in the existence of super-human powers and ultimate values. People, in groups or as individuals, relate well to the experiences of their total environs. The overall philosophy in such cases is that whatever happens to a person happens to the group. An individual could say, "I am because we are, and since we are, therefore I am" (Moyo 2009:39). Musikavanhu (the Creator or Supreme Being), as the Shona people in the Chipinge District believe, controls the cosmological order from the higher cosmic order, far away from his creation (Moyo 2009:38). Summarising the concept of the Supreme Being and His attributes Arinze (1970:30) noted:

> God is the supreme spirit, the creator of everything. No one equals Him in power. He knows everything. He is altogether … merciful … does harm to no one…. He sends rain … and it is from Him that each individual derives his personal spirit.

In the same vein, Imasogie (1985:33) citing Furrow (1969) added that the Supreme Being is "…infinitely good and unique." Thus, while He is in His abode, the higher cosmic order, He is uniquely present in His creation.

The Earth is the natural habitat for humankind, nature, plants, animals and the spirits. The religious functionaries such as traditional healers, diviners, chiefs or spirit mediums in both the divine and the human worlds conduct rituals that act as a lifeline for both the human and the spiritual realms (Hammond-Tooke 1986; Kalu 1991:16). The ancestors are the administrative juniors of Mwari (the Supreme Being); hence, they are on Earth. Spirit mediums differ – some are good, and others are bad. Spirits and weird creatures or strangers inhabit the underworld. It is also a place for the

[32] A cardinal question that any cosmos seeks to answer is how a Supreme Being created the world (Hammond-Tooke 1989:46).

ancestors. Therefore, the Shona traditional cosmos is tripartite in structure (Moyo 2009:38) and profoundly spiritual. There is an intricate relationship between the human and the divine worlds, and rituals bind these worlds together.

Some of the spirits that reside in the spiritual world include, but are not limited to these: ancestral, alien and avenging spirits. According to Uka (1991:46), ancestral spirits are the departed spirits of the dead who stand in close relation to their families of origin. As members of the community, they have their specific rights and responsibilities. Nyamiti (1984:16) conceded that ancestral spirits have an ambivalent character. They have both benevolent and malevolent powers and continue to act, either to the benefit or the detriment of the living. Hammond-Tooke (1989:47) identified some of the reasons for ancestral spirits' interference in the lives of humanity as:

> …the neglect of the 'customs of the home', the necessary rituals that should be performed, particularly at the pivotal points of the life cycle, and failure to accord due respect to seniors…

Gelfand corroborated this argument, when he stated that:

> If the [ancestral] spirit is annoyed in any way, it may punish one of the grandchildren or one of its sons or daughters by causing sickness, an accident or even death. Failing to remember the spirit elders is sufficient to disturb it and cause it to show its presence by producing sickness (Gelfand 1977:91).

The above citation demonstrates that, though dead, ancestral spirits continue to influence the day-to-day affairs of their relatives, and on this account, Mbiti (1990) referred to them as the 'living dead'[33].

[33] Mbiti (1990:81-89) discussed in detail the nature and roles of the 'living-dead' and, and explained why they are so close to mankind.

Therefore, to avoid the wrath of the living-dead, African ancestors came up with some taboos to regulate human behaviour (Mandela 2010:9)[34]. The restrictions enforced morality and living in harmony with the ancestors and fellow human beings. Such living was enough to diffuse the work of evil spirits and their nocturnal friends. As such, seasonal cleansing rites (Kalu 1991:17) countered droughts, epidemics and any other misfortune. Senior ritual officers trained the ritual presiding officials to ensure ritual purity. Carelessness spoiled the ritual action and endangered the lives of many people in the process.

Gelfand (1962:51) perceived ancestral spirits as guardian spirits because they are predominantly protective in function. In *The Genuine Shona: Survival values of African culture,* Gelfand (1973:114) further argued that the dead are expected to care for their descendants, and the link person through whom contact is made is the grandfather, and after him, the father. Therefore, there is a continuous interdependence between the living and their dead. If families neglect their ancestral spirits, the latter become angry, and in retaliation for negligence, they send them strange and hard-to-explain misfortunes. For this reason, the living parents often offer libations to venerate the ancestral spirits. It was one of the assumptions of this study that the people's belief in the continued interaction between the living and the dead, and others discussed below, were likely to interfere with HIV and the AIDS pandemic mitigation and care efforts. How could that be? People get HIV infection, and when they fall sick, they may delay getting antiretroviral medication because they attribute their sickness to misfortunes from the angry ancestors.[35]

Related to the belief in the existence and benevolent roles of ancestral spirits is the belief in spirit possession and spirit mediumship. According to Bourdillon (1976:274), spirit possession takes place at all levels in Shona traditional religion. He observed that spirit mediums or hosts are possessed, when the spirits take control of their bodies and speak in strange voices associated with the spirit. Thus, mediums possessed by very ancient spirits speak dialects intelligibly only to the elderly

[34]. In the book, *Conversations with Myself*, Nelson R. Mandela allowed people to read his life as he experienced it and the early pages of the book exposes how he learned early in his life.
[35] This line of argument is developed fully in Chapter 4, where the research report discusses results of the study.

members of their families. Besides, it is worth noting that the spirit could be of a *shave* (alien spirit), *mudzimu* (ancestral spirit) or *mhondoro* (territorial/clan spirit). The spirit mediums (*masvikiro*) are essential, as people believe they bring them messages of goodwill from the spirit world, and the skill to be industrious. As Hugh (1929: 97) described it, spirits, for instance, alien spirits, bestow on their mediums' mental faculties, "…skills such as blacksmithing and pottery …."

The spirit mediums sometimes deliver messages about the coming of the rains or an epidemic. Thus, they warn the people of the impending danger and make them prepare for it. Citing Lewis (1971), Mutekwa (2010:162) argued that spirit possession and mediums, which include *mhondoro* (territorial/clan) spirits and *vadzimu* (ancestral) spirits among the Shona of Zimbabwe:

> ...are at the centre of the stage in the religious life of the society and play a crucial and direct role in sanctioning customary morality.

In line with Mutekwa (2010) and Gelfand (1962), it can thus be concluded that spirit mediums (*masvikiro*) are the guardians of societies' traditions and morality. Sundermeier (1998:138) added that spirit mediums say what they would have seen and heard in dreams or trances. The community leaders also consult the clan (*mhondoro*) spirits in the inauguration of traditional chiefs and their deputies. Of great concern to this study was how the spirits chose, and continue to choose, their mediums. The study sought to determine whether the ways spirits chose their hosts did not interfere with the HIV and AIDS pandemic mitigation and care efforts or not. It was the assumption of this study that the manner, in which spirits selected their hosts, might interfere in some ways with the HIV and AIDS reduction efforts.

Literature available so far indicated that illness, in varying degrees, is a predecessor to spirit possession and mediumship. Sundermeier (1998:137), Bucher (1980:48), (Gelfand 1977:24,118), Bourdillon (1976), Gelfand (1973:127), and Zvarevashe (1970:45) agreed that persistent illness was a regular preamble to spirit possession. The scholars cited all noted that the people who might have been chosen to become mediums regularly displayed symptoms of diseases – persistent headaches, appetite loss, fever and recurring fits. Bourdillon (1976:277) even cited a case, where an

unwilling Kore-kore medium had an illness, which lasted four years. Zvarevashe (1970:45) observed that guardians might take an ill person to the hospital, where all diagnoses reveal no sign of disease. Western medicine could be administered, but without effect (Gelfand 1962:84-85). As Van Dyk (2001:61) wrote, the questions "why" and "who" are paramount among traditional African people, when they want to comprehend illness, so they consult traditional healers, when the disease persists. If the diviner interprets the illness as a symptom of the spirit's wish to use the person as its medium, senior members of the family take steps to test the authenticity of the calling, particularly when a *mhondoro* (territorial/clan) spirit is involved (Bucher 1980:48). They conduct the verification exercise to weed out ambitious and greedy impostors. Divination is very likely, especially in cases where, as Bourdillon (1976:276) wrote:

> …a patient has a late close relative who was a medium, or if the general circumstances are such that the emergency of a medium is likely...

How might belief in spirit possession and mediumship interfere with HIV infection and the AIDS menace mitigation efforts? As Ashforth (2002:126) conceded, most people infected with HIV invariably contract diseases and symptoms associated with AIDS such as tuberculosis, persistent headaches, weight loss, stomach aches and respiratory problems. Thus, individuals with the HIV infection might stay for a long time without any symptoms of illness, and the time between infection with HIV and the onset of full-blown AIDS varies widely as does the period one might survive with the disease (Ashforth 2002:127). It is the contention of this research that when symptoms of AIDS show, the people might misconstrue them to be a calling to become a spirit medium, and thereby delay seeking appropriate medical care. By the time they realise that the illness is unrelated to spirit possession, CD 4 cell count could be so low that it might be too late to intervene by administering the antiretroviral therapy (ART).

Linked to the causes of illness, a significant number of the Shona people in the Chipinge District might attribute illness, and any other misfortune, to witchcraft. In concurrence with Idowu (1973), Brand (2002) described belief in witchcraft as

permeating all strata of the Shona society.[36] As Liepe (2016:9) and Bourdillon (1976:199) observed, people use the belief in witchcraft to explain any mishap, "... from minor ailments to conflict with an employer or losing one's job ..." and that "... death is always due to witchcraft". Belief in witchcraft does not negate belief in the natural causes of illness or death. The people use the witchcraft phenomena to explain sickness or death, when natural causes are not convincing enough in their role in causing disease or death (Bourdillon 1976:199; Rodlach 2006:55;). Furthermore, Bourdillon (1976) conceded that the natural cause is apparent if one dies in a brawl, but the Shona people in the Chipinge District would still want to establish what made the aggressor kill his victim on that occasion, when he might have been involved in scuffles before without being harmed. They thus believe that tragedy in this instance must be due to witchcraft. The belief in witchcraft is real to the Shona people of the Chipinge District, though people from other districts regard it as a sign of backwardness. In 1954, the Acting Chief Native Commissioner of Southern Rhodesia had a similar perception. When referring to the people who believed in witchcraft, the Acting Native Commissioner of Southern Rhodesia remarked that:

> The measure of the natives' progress from the state of savagery can be gauged to a large extent by their departure from or adherence to witchcraft beliefs. There is no doubt whatever that only a handful are completely free of the shackles of sorcery and witchcraft (Rutherford 1999:98, citing Mittlebeeler 1976:161).

Such perceptions do not consider the rationale and philosophy for the people's belief systems. In this instance, while natural causes account for the 'how', witchcraft was and is used to account for 'why', why to this person, today, at this place (Bourdillon 1976). Therefore, the Shona people in the Chipinge District, like many Africans

[36] The existence of witchcraft laws in most African states is indeed a demonstration of the reality of the belief in the practice by the people. According to Mgbako and Glenn (2011:396), countries such as Benin, Chad, Gabon and Mali criminalised witchcraft, while most British colonies such as Kenya, South Africa and Zimbabwe have Witchcraft Suppression Acts that criminalise both the practice and the one who accuses anyone of witchcraft. Zimbabwe repealed the law in 2006, through the efforts of Professor Madhuku, a legal expert.

elsewhere, tend to draw upon the witchcraft discourse to interpret causes of diseases (Hammond-Tooke 1989:48). That trend fits so well into the people's philosophy of explaining causality, which they succinctly express in the Shona proverb, *chiripo chari uraya, zizi harifi ngedutu* (something must have killed it, the wind cannot kill an owl). Proverbs are expressions of people's beliefs, customs and indigenous knowledge.

However, while literature abounds on witchcraft in Zimbabwe (Maxwell 1995:310-311; Rutherford 1999:100; WHO 2002:1,20) and other Sub-Saharan African states (Liepe 2016:1; Mgbako and Glenn 2011:389^{ff}, Sanders 2003:338 and SANPAD 2003:1-36), no one has done extensive research on the interface between witchcraft, HIV and the AIDS pandemic among the Shona to date. The dearth in this kind of investigation is a surprising lacuna, more than three decades after the first confirmed case of AIDS in Zimbabwe. In addition, people might be unwilling to delve much into the witchcraft discourse, as doing so, and demonstrating knowledge of it leads to the suspicion that one might be a witch. As Ashforth (2002:122) wrote, available literature so far falls far short in addressing the challenges that arise from the fact that people infected with HIV or suffering from AIDS-related illnesses frequently perceive themselves as suffering from the nocturnal work of witches. The witchcraft paradigm provides answers to the fundamental questions of causation – why me and why now? People ask these questions in order to understand the causes of diseases related to the HIV and AIDS pandemic. The question, 'who is to blame?' would always arise, irrespective of how people interpret the illness. It is noteworthy that there is widespread agreement that HIV causes AIDS, but people do not fully understand why some people are more vulnerable to the disease than others, especially when exposed to similar virus conditions. It was one of the premises of this study to examine the extent to which beliefs in witchcraft influence the management of the HIV and AIDS mitigation and care efforts.

The Shona traditional attitudes, perceptions, beliefs and practices about sex are cardinal in this study. As Nyoni (2008:98) posited, some sexual practices put many people at risk of contracting the deadly HIV, primarily as they relate to the Shona traditional marriage institution that is firmly embedded within people's cultural practices and beliefs. Furthermore, the relationship between the Shona traditional

beliefs and practices epitomised in the various marriage practices on the one hand, and the HIV and AIDS pandemic, on the other, is a rich vein of data, which might benefit the communities under study in the management, mitigation and care of the HIV and AIDS menace. The relationship or interface between the Shona cultural practices and the HIV and AIDS pandemic are the primary concern for this study. They are the reason, why the researcher embarked on this research. The aim was to influence behaviour change in the communities under study as well as policy formulation about the management of people infected and affected by AIDS or the virus. Some of the practices the study examined in detail include *kugara nhaka* (wife inheritance), *kuputsa* (forced or pledged marriage) for purposes of *kuripa ngozi* (appeasing the avenging spirit) and *chimutsamapfiya* (substitute wife).

Kugara nhaka (wife inheritance) is a practice whereby a consanguine brother or uncle inherits the widow of a deceased brother (Baloyi 2015:484). Kuper (1954:23) also stated that the widow could also be inherited by one of the "sons by other wives …." The inheritance ceremony usually takes place, once the family has *settled the spirit* [emphasis added] of the deceased in his family home (Bourdillon 1976:249; Mandaza 1970:58). The living family members complete the *settlement of the deceased spirit* [emphasis added] through a *doro retsvisa*[37] (beer of spirit restoration) ritual. It is important to note that before the settlement of the deceased's spirit, the people believe that it would be wandering, dangerous and without a fixed abode (Holleman 1953:2, 22; Imasogie 1985:37). The *doro retsvisa* ritual enables the spirit to settle down at the family's homestead. Weinrich and Benn (2004:27) observed that the *kugara nhaka* ceremony is a cultural practice that a man should inherit or 'marry', as it were, the widow of his deceased brother. While Sakala in Mc Fadden (1999:49) argued that, "... often, the wife is given a husband against her will", Mandaza (1970:58) noted that the inheritance ceremony provides an 'option' for the widow(s) to become the wife or wives of one of the deceased's younger brothers. Baloyi, citing Waruta and Kinoti (2000:108), justified the wife inheritance practice by stating that:

[37] *Doro retsvisa* is the ritual integration of the deceased spirit to become an ancestor of the household.

> …few men would agree or want to marry a woman who belonged to other people who had paid bride-wealth for her. …, once a woman was married to another man, not many men would be interested in marrying her following the death of her husband… (Baloyi 2015:484).

Therefore, the communities use the wife inheritance practice as a safety net for the widows against abuse and stigma that such society attaches to lonely widows. It also serves as a means of maintaining the socio-economic and emotional support that comes with the practice.

Generallly, as Bourdillon (1976:250) stated, the widow(s) is or are traditionally expected to accept "the inheritor or some other close kinsman of her late husband". While the widows 'might' be free to choose whether to re-marry or not, the customs of the Shona people in the Chipinge District make them feel obliged to accept the inheritors. Therefore, the freedom and right to choose are eradicated by the communities' cultural expectations. A Zimbabwean Afro Jazz music legend and icon, Dr Oliver Mutukudzi, weighed in on the same subject of wife inheritance when he sang songs entitled *Ndagarwa Nhaka* (I am inherited) and *Sandi Bonde* ([inheritance] *is not sex*). In the former song, the widow seems to appreciate the practice of wife inheritance. She notes that she has found a protector and a shoulder to lean on in times of trouble. However, in the latter song, the lyrics urge men to take part in the practice to care for the bereaved family, to be the father of the children and not to be involved only for the sake of having sex with the widow. These songs lend weight to the existence of this practice. They are a reminder to the communities to reflect about the practice. The introspection would mentally prepare the people for wife inheritance, and for the responsibilities that come with the practice. In the lyrics of the songs, Oliver Mutukudzi urged people to be responsible regarding wife inheritance issues. The wife inheritance practice itself is a ritual.

On the day of the ceremony, the family conducts a fidelity test to determine if the widow did not commit adultery (*kupishe guva*[38]). The loyalty ritual tests differ from

[38] *Kupishe guva* or *thuna* is a term people use to describe a widow committing adultery before the *doro retsvisa* ritual.

one district to the other. In the area of Chipinge, people customarily refer to it as *kudarike uta* or *tsvimbo dzababa* (Gundani 1994:126). It involves a widow jumping over her late husband's traditional weaponry that lay across the door (Sango 1970:75-76). The weaponry includes, among other things, all or a combination of these: bow and arrows, an axe, walking stick or a knobkerrie. These traditional weapons signify an owner was a real man of note in the family, clan, village and society. It is important to state that on its own, sacredness imbues this rite. It is sacred because, customarily, women do not touch their husbands' traditional weapons, particularly if they are menstruating, or *mundlezana*[39] or *mhandatsva*[40]. It was and is still a taboo of the highest order for women to touch the traditional weapons. One of the reasons for the prohibition derives from the people's belief that women on their menstrual cycle or those nursing young babies are ritually 'dirty' and might consequently 'weaken' the potency of the weapons. Therefore, it is the argument of this review that, to ask the widows to jump over the traditional weapons lying on the doorway could be seen as a reversal of the same custom that prohibits any direct contact with them and possibly causes cognitive dissonance.

The *kudarike uta* or fidelity ritual is not just an ordinary practice. It is a sombre test of sexual faithfulness in the period that ranges between the day the husband dies and the day of the ritual. Through the ritual, the deceased, his family, village and society that sanctions it, are asking the widow to pass the test, and get, in principle, a 'certificate of fitness'. The deceased husband, represented by his traditional weapons, conducts the examination himself; the family and others present are mere witnesses. During the act of leaping over the weapons, the 'husband' examines 'his' wife's most private parts like a laser beam, to determine if they have not been tampered with by the rogue elements in society and makes a 'judgment' congruent with the belief that governs the fidelity rituals. The people believe that if the widow had engaged in *kupishe guva (thuna)* ('burning the grave') before the *doro retsvisa* and inheritance rituals, she would stumble and fall on leaping over her deceased husband's traditional weaponry. The fidelity ritual is indeed an examination of the

[39] *Mundlezana* is an Ndau term (possibly borrowed and adopted from the Zulu/Ndebele term *Mdlezane*) people use to refer to a woman who has just given birth.
[40] *Mhandatsva* specifically refers to a woman who has given birth for the very first time in her life.

essence of womanhood and integrity of being a wife worth her value. The net effect of the loyalty ritual ‘shocks’ the widow's conscience to be honest about her sexual activities. This shock might be in consideration of the reversal of the taboos concerning the handling of the traditional weapons, or their symbolic representation of the husband as they lay on the doorway. She ‘passes’ the test if she does not stumble and fall. This is significant in the life of the widow, as she gets a ‘certificate of fitness’. The ‘passing’ of the fidelity test is essential to the widow, her family and the community. She is a woman among women who could stand up to be counted.

It is worth noting that during the fidelity test ritual, the widow leaps over the traditional weapons as she goes out of the hut. Therefore, by passing the test, the widow gets the freedom to choose a new husband by offering him a dish with water. The witnesses and everybody else become happy and proud of her, that is, the widow's, and her husband's families and even the village in which she lives. By stepping out of the hut and over the deceased's traditional weaponry, the widow is by the same rite leaving her old life with the dead and assumes a new life with the new husband. By the same ritual, the man, represented by his weapons, ‘sees' his wife for the last time at the entrance of their matrimonial hut and ‘allows’ her to move on with her new love life.

However, as Bourdillon (1976:250) observed, if the widow, armed with the freedom gained by passing the fidelity test ritual "...objects to all her late husband's agnates, the marriage is dissolved", and her objections and choices are respected. It is worthy to note that the widow is ‘free' to choose and her objections respected, but usually the power of cultural and societal expectations to conform wins the day. Therefore, this study argues that the practice of wife inheritance places both the widows and the deceased's agnates in a vulnerable position that exposes them to the possibility of contracting HIV. This vulnerable position is notably worsened considering that no-one might be aware of the cause of death, and the statistics that one in every four Zimbabwean adults is infected with the human immunodeficiency virus (Gregson *et al.* 2002). As Gausset (200:513) argued, if a man died of AIDS, his wife/wives is/are likely to be infected, and could infect others.

Kuputsa (pledged or forced marriage) infrequently takes place, notwithstanding legal prohibitions. It is a cultural marriage practice where, because of grinding poverty, famine or indebtedness, parents pledge their daughters to older and often wealthy men for marriage. Thus, as Bourdillon (1976:61) pointed out, this kind of forced marriage happens, when the family is in dire need, usually after a bad harvest. *Kuputsa* might also result from the family's need to appease *ngozi* (avenging spirit). Marashe (2014:6) corroborating Mutekwa (2010:163) and Bourdillon (1976:183), defined *ngozi* as the spirit of a relative or close acquaintance who died with a grudge or is aggrieved over a grave injustice suffered during his life time, or the spirit of a murdered stranger. Maxwell (1995:311) further noted that the deceased's spirit would discreetly and ruthlessly kill members of, or relatives of the "offending family before revealing its identity". Several types of *ngozi* (avenging spirits) are perceptible among the Shona indigenous religious and cultural landscapes. They include spirits of servants, whose employers owed them their wages, people who died complaining about unreturned borrowed items, as well as spirits of parents wronged by their children or those of spouses, who had died miserably as a result of ill-treatment by their husbands (Owomoyela 2002:37).

The attack by *ngozi* is hazardous. Sometimes, it announces its presence by possessing someone from the offender's family, making that person its medium (Owomoyela 2002:37). When the avenging spirit strikes, it often leads to a series of mysterious deaths in quick succession and the remedy is to appease it. The most dangerous of these avenging spirits is that of a murdered person[41]. UNICEF reports of a classic instance of a *ngozi* appeasement in Chiredzi District, just outside the study area of the Chipinge District, where:

> ...a girl was sold for ZW$1 500 to a person who needed a girl for a family he had wronged to make peace with vengeful [*ngozi*] spirits (Marashe 2014:6; UNICEF 2000:134).

[41] Gelfand (1973:122) stated that the spirit would take revenge on the family members of the one who committed murder, whether it was intentional or not.

The young lady in the example above was at the mercy of the men in the family that 'bought' her. The family who sold their young and innocent girl would use the money from the transaction to support the rest of the household. The family who would have bought her would either marry her off or just hand her over to the offended family. The family would use the lobola (bride price) from the marriage to pay-off the family from where the avenging spirit originated. All these are forms of paying recompense for the avenging spirit. Bourdillon (1976) conceded that after selling the young girl, her parents, upon agreement with the buyers, might stay with her until she was of marriageable age. However, in a society where, for instance, some men and traditional healers believe that virgin sex is medicinal for the HIV infection, the practice exposes the child to abuse and to the dangers of contracting the virus. In a situation, where the young girl is married off to appease *ngozi,* she would be obliged to please the man who came to the rescue of her family, which can expose her to HIV infection, AIDS and STIs. In short, she becomes vulnerable to sexual and all kinds of abuse. It is significant to mention that the belief in *ngozi* spirit on its own might not be problematic at face value, especially when considered in relation to the HIV and AIDS pandemic. However, the problem arises when families use young girls without their consent, as compensation for the spirit of the aggrieved persons. While there might be other ways of reparation, most avenging spirits are believed to get satisfaction when their killers' families compensate them with either young girls or both young girls and a herd of cattle. The traumatic experiences of the mysterious deaths in the affected families force them to comply with the demands and wishes of the aggrieved persons. Researchers might not be able to verify the prevalence of some of these marriage practices because the families concerned keep them as carefully guarded secrets.

Closely related to *kuputswa* is the traditional practice of *chimusamapfiya* (replacement-wife or sister marriage). The bride's family gives their son-in-law the late bride's younger sister as a wife, and he does not pay lobola for her. If the woman's younger sister is not available, a niece, the daughter of the bride's brother replaces her. As a surrogate wife, she has no position other than being a medium for bearing children for her sister (Sundermeier 1998:72). As highlighted in other traditional marriage practices, the surrogate wife practice exposes the bride to the

dangers of HIV infection and the AIDS menace. She gets into a relationship, most probably against her will, and is obliged to do everything for a man who has been forced on her and who may have contracted the HIV virus from the late wife or even passed it on to her. This arrangement means that the new wife might not have a say in issues of reproductive health, and perhaps her husband breaches her reproductive rights with impunity.

It is important at this moment to comment that this study critically examines some of the Shona traditional practices and beliefs to expose their possible roles (if any) in the spread of HIV. Perhaps, with more information on these beliefs and practices, there could be a way of persuading and lobbying for culturally sensitive beliefs and practices as well as influencing behaviour change, in order to manage the AIDS pandemic and reduce new HIV infections. However, what are the states of the HIV and AIDS pandemic in Zimbabwe in general? What are the states of HIV and AIDS menace among the Shona people in the Chipinge District? How have HIV infections and the AIDS pandemic influenced the people's traditional beliefs and practices? These and more questions set the tone for this study, which partially addressed these inquiries, by taking a survey of the evolution of the pandemic in Zimbabwe in general, and its influence in the Chipinge District.

2.3 A general résumé of the HIV and AIDS epidemic in Zimbabwe

The state of the pandemic in Zimbabwe, in general, is a national disaster. Zimbabwe is one of the hardest hit Southern African countries, along with Botswana and the Republic of South Africa, while Africa itself is the global epicentre of the HIV scourge (Halperin *et al.* 2011:1). As statistics show, the AIDS pandemic is claiming the lives of 3 000 people every week (NAC/MoHCW 2004:14; Simmons 2012:3; Taylor 2007:232). According to Simmons (2012:2), one cannot escape the omnipresence of the HIV and AIDS pandemic in societies; it is reflected in electronic and print media – on radio, television, in cinemas or newspapers and magazines.

According to country reports by NAC and the Ministry of Health and Child Care (2014) and UNAIDS (2005), the first reported case of AIDS in Zimbabwe occurred in 1985. By the end of the 1980s, estimations indicated that HIV had infected approximately 10% of the adult population. UNAIDS further reported that the figure

rose dramatically in the first half of the 1990s, peaking and stabilising at 27.7% in 1997. The epidemic's mode of transmission is primarily heterosexual, and this accounts for 92% of all infections in Zimbabwe. Mother-to-child transmission accounts for 7% of the infections, while infections through blood transfusion are rare. There could be underestimations concerning transmission or HIV infections through homosexuality, considering that the Zimbabwe Government holds an anti-homosexual stance (Garbus & Khumalo-Sakutukwa, 2003:5).

HIV InSite, a project of the University of California's Centre for HIV information estimated that 1.3 million people were living with HIV and 140 000 deaths were recorded in 2007 alone in Zimbabwe. Thus, the AIDS pandemic has become a leading cause of mortality in Zimbabwe for people between the ages of 15 and 49. According to a Situational Assessment conducted by UNICEF in 2000, one Zimbabwean dies of AIDS-related illness every five minutes. According to research published in *Lancet*:

> One in every four [Zimbabwean] adults are currently infected, a level which, if maintained, means that a young person entering the sexually-active population today would have two out of three chances of acquiring HIV infection before his or her fifty-fifth birthday (Gregson et al. 2002).

An online article entitled, "Introduction to HIV/AIDS in Zimbabwe" stated that one in every seven adults lives with HIV". A Zimbabwean doctor confirmed these statistics, when he explained to reporters that, "Put simply, people are dying of AIDS before they can starve to death" (*The Sunday Times*, 2 April 2006). World Health Organisation (WHO) pointed out that the average life expectancy of Zimbabwean men and women now stands at only 40.9 and 37.89 years, respectively. The statistics make Zimbabwe "... one of the world's most severely AIDS-stricken countries" (Patterson 2005:61).

It is important to note that HIV infections cut across people's social status. For instance, the *Report on the Global HIV/AIDS epidemic* by UNAIDS in 2002 showed the obliteration effect the HIV pandemic wrought on Zimbabwe's education system.

The pandemic does not spare anyone from learners to teachers, and the statistics are frightening. The report cites a study that UNIFEM conducted in Manicaland Province of which the Chipinge District and the study area are a part, and:

> …found that 19% of male teachers and almost 29% of female teachers were infected with HIV — almost exactly the same proportion as among working men and women in the general population (UNAIDS 2002:52-53).

This finding is as significant as it is surprising. Teachers in Zimbabwe and everywhere in the world are among the erudite of the communities in which they live. By virtue of their status in the communities, many young people aspire to be educators of tomorrow. Nevertheless, if the HIV pandemic does not spare the learned in communities, considering the statistics reported by UNAIDS, who among the general people in the communities would the HIV pandemic spare? To demonstrate the severity of HIV infection situation, the report further stated that:

> …in Zimbabwe, 50% of all in-patients in [hospital] wards studied were [sic] infected with HIV. Without major interventions, the problem will worsen[42] (UNAIDS 2002:51).

The situation this statistic depicts is serious. It becomes even worse because the infections are occurring in a non-performing economy. Lack of stable employment and income compromises the households' abilities to sustain the sick. Moreover, the economic meltdown affects hospitals as well since they get their support from the government's fiscus allocation.

However, since 1997, new HIV infections have declined, making Zimbabwe one of the first African countries to witness such a trend. According to government figures, by 2003, estimated adult (aged 15-49) prevalence was 24.6%, which fell to 15.3% in

[42] The government's ability to allocate adequate financial resources to sustain the Ministry of Health and Child Care programmes, including procurement of essential drugs for hospitals and clinics, will come under scrutiny in Chapters 4 and 5, wherein the researcher presents, discusses and analyses the results of this research.

2007 (Patterson 2005:61; Ministry of Health and Child Welfare 2004; *The Herald* 2007:2).

In a study on HIV infections and the AIDS pandemic in Zimbabwe, Garbus and Khumalo-Sakutukwa (2002:5) warned people to be cautious when interpreting these results. They argued that it was difficult to establish, whether the trend was a sign of a long-term change or merely a temporary movement, given a large number of homeless and displaced people living in Zimbabwe who might have missed the survey. For instance, according to the United Nations' special report on Zimbabwe, people who may not have been part of the study include about 2.4 million (18% of the population) displaced from Zimbabwe's towns and cities during the 2005 *Murambatsvina* (Operation Restore Order) (Tibaijuka 2005:34). Thus, the results cannot be representative of the real situation. Perhaps, a rise in the number of people dying from AIDS might have played a significant role in the decline, as well as an increase in the number of individuals (HIV seropositive or otherwise) who, because of the economic meltdown, had migrated to other countries. Nonetheless, a January 2014 to December 2014 report co-authored by the Ministry of Health and Child Care (MoHCC) and National AIDS Council (NAC) of Zimbabwe attributed the decline of the HIV prevalence to:

> ...the impact of prevention programmes aimed at behaviour change (high condom use and reduction in multiple sexual partners), elimination of Mother to Child Transmission, and successful treatment, care and support services (NAC & MoHCC 2015:6).

However, commenting on the speculative reports of the declining HIV infections in the country, UNAIDS and WHO argued that the lower than expected infection rates were due to inaccurate estimates of Zimbabwe's actual population size. They added that:

> The corrective estimates, therefore, show no real decline in the country, but do confirm the levelling off of prevalence rates at very high levels since the late 1990s (UNAIDS & WHO 2003:9).

Garbus and Khumalo-Sakutukwa (2003) contended that there might be a decline in HIV prevalence, especially among women attending antenatal clinics (ANCs), but the causes of this decline remain a mirage.

There is evidence of positive change in sexual behaviour as pointed out in the UNAIDS November and December reports on Evidence for HIV decline in Zimbabwe and epidemic update, respectively (UNAIDS 2005:39, UNAIDS 2005:20). Condom use increased. A higher number of young people are delaying first sex, and many people have reduced their number of sexual partners (UNAIDS Global Report 2006). The Zimbabwe Demographic and Health Survey showed that around 76% of women and 81% of men know that condoms can reduce the risk of HIV infection (UNGASS 2006-07). Possibly, increased awareness of HIV and AIDS may have influenced these changes. In any case, people may have changed their behaviour after witnessing the agonising effects of the epidemic first hand through the deaths of friends or relatives (UNGASS 2006-07).

In a survey of the HIV and AIDS state in Zimbabwe, Goercke (2004) concluded that those prevailing attitudes, beliefs and practices that permeate traditional culture seem to be contributing to the severity of the pandemic. Some of these beliefs and practices include, for instance, the belief that HIV and AIDS infections are a result of ancestral spirits that have not been venerated rather than unsafe sexual practices, the practice of polygamy and traditional healing practices. The major weakness of Goercke's study was that it focused more on comparing rural and urban students' knowledge of HIV and AIDS, and inferred from their responses that cultural beliefs and practices might have a hand in the transmission of HIV in the rural environment. Goercke's study did not examine specific traditional beliefs and practices to determine how the HIV menace had influenced them. The role of these cultural practices in the transmission of HIV was the major premise of the present study. One of the primary drivers of this study was the assumption that some of the Shona traditional beliefs and practices might have a hand in fuelling the spread of HIV.

In 1999, UNESCO and UNAIDS conducted a joint study in the District of Binga concerning a cultural approach to HIV and the AIDS scourge in Zimbabwe. The study aimed to stimulate discussion as well as revisit existing tools in dealing with

HIV infections and the AIDS pandemic. The project also sought to examine the interaction between cultures and the evolution of AIDS. Some of its key findings were that the Tonga cultural practices of polygamy, marriages of young girls to older men and widow inheritance were widespread. It also showed that early pregnancies and prostitution were rife because of the continued marginalisation of women and the girl-child.

The major weakness of the joint UNESCO/UNAIDS study, however, was on methodology. It used convenience sampling, also known as haphazard or accidental sampling. The terms 'haphazard' or 'accidental' sampling clearly indicates the drawback of the manner of sampling those who participated in the study. These researchers chose community members who were close or those they saw nearby to take part in the study. This mode of sampling produces unrepresentative samples and misrepresents the population or severely limits the validity of the research findings (Mouton 2001:118; Neuman 2006:220; Ruane 2005:117). The results should, therefore, be regarded as "indicative or instructive" rather than as statistically "representative" (Booysen & Arntz 2003:2397), and, therefore, researchers should interpret them with caution. Moreover, the researchers did not have enough financial resources to send a team of investigators in the field. They used only three researchers, which negatively influenced the *modus operandi* of the study. These and other limitations might have compromised the outcome of that survey.

While the outcome may be relevant for the Tonga people, it might be risky to generalise them to the Shona groups, considering the flaws that were inherent in the sampling method that the researchers did not address. While some of these beliefs and practices might be similar among the other ethnic groups, it was difficult to apply the same results *mutatis mutandis* to the other ethnic groups in Zimbabwe. A study focusing on the Shona was thus found necessary. The report downplayed the role of traditional beliefs and practices in HIV transmission by identifying poverty and the superimposition of Western culture on people who are hardly equipped with skills to cope with fundamental survival issues as the underlying driving factors in the spread of HIV. Therefore, the current study investigated the role that traditional beliefs and practices might be playing in the transmission of HIV.

In a related study, Chipfakacha examined knowledge, beliefs, practices and experiences of traditional healers concerning sexually transmitted infections, HIV and the AIDS pandemic in Botswana (Chipfakacha 1997:418). The results show that the advent of HIV and AIDS and the introduction of home-based care programme in most African countries in general and Botswana in particular, increase the caseload of many traditional healers, which proportionately increases the risk of contact with people infected by the virus. Consequently, most patients discharged from healthcare centres on home-based care programmes usually end up consulting traditional healers as relatives seek a second opinion, or merely because they disagree with the diagnosis of the incurable disease (Chipfakacha 1997:420). Furthermore, healing practices such as bloodletting [sucking of blood by their mouths], repetitive use of unsterilised sharp objects and the belief that HIV and AIDS are not a new disease, expose traditional healers to HIV infection and mutation. In concurrence with Mills *et al.* (2006), this research intended to provide information on how to minimise the impact that some traditional healing interventions might have in the spread of HIV.

Findings of another study at the University of Botswana are quite revealing. The study entitled *HIV/AIDS in Africa* showed that certain traditional taboos and practices fuel the spread of the HIV and AIDS pandemic. The study cited instances, where bed-ridden men have sex with virgins, believing that this will make them recuperate. The research also found that there is a belief that a long illness is a result of a spell or a curse that has nothing to do with one's sexual behaviour.

It is one of the aims of the current study to explore those cultural practices that might be contributory to the escalation of the HIV and AIDS scourge in Zimbabwe. The researcher premised the study on the assumption that traditional beliefs and practices might be significant factors contributing to the severity of this pandemic. They affect and shape the manner, in which Zimbabweans view such pivotal health-related issues such as condom use, sexual practices and the causes and treatment of HIV and AIDS-related illnesses.

Traditional beliefs influence many Zimbabweans in their handling of social problems such as marital and sexual relationships, illness, death and the supernatural

phenomena. All these seem to affect HIV and AIDS mitigation efforts to varying degrees. Bourdillon (1998:319) contended that traditional influences are stronger in rural areas because of the influence of the chiefs who wield higher authority, and weaker in urban areas. Therefore, identifying cultural factors that contribute to the spread of HIV might be a positive step forward in leading to an effective HIV and AIDS mitigation programme. However, it is worth noting that changing long-held attitudes, traditional beliefs and misconceptions is a gradual process because of deeply ingrained habits and convictions. Health workers may still confront the necessary task of convincing traditionalists to accept contemporary medical findings, findings which may contradict their cultural beliefs and practices.

A study in Zambia conducted by Population Services International (PSI) in 2003 found that participants often mixed correct information with misconceptions. It also showed that some participants believed that people with "weak blood" are more vulnerable to infection than those with "strong blood." Those with weak blood consequently display symptoms of infection earlier than their strong-blooded compatriots. Other participants believed that women shed the virus during menstruation, thereby taking longer to show symptoms of HIV infection.

Those who attributed transmission to sorcery and witchcraft posited that people infected with the virus act as if they have been bewitched and display bizarre behaviour. This perception shows that participants continue to rely on outward appearance as a means of gauging infected individuals. While these findings are perhaps entirely valid, the study did not pursue the belief in sorcery or witchcraft as one of the possible causes of the spread of HIV infection and thus responsible for delaying early intervention. The current study aimed to unravel the extent to which sorcery, witchcraft and many other traditional beliefs and practices have responded to the challenges posed by the HIV and AIDS scourge among the Shona people in the Chipinge District. However, before delving into that topic, it is essential to establish the current state of HIV infections and the AIDS epidemic in the Chipinge District in Zimbabwe.

2.4 A résumé of the HIV and AIDS epidemic in the Chipinge District

The state of the HIV and AIDS epidemic in the region reflects the national statistics. It is a microcosm of the macrocosm. What makes the situation worse is the fact that some of the leading transit roads to South Africa through Beitbridge and to Mozambique through Mt. Selinda border post traverse the Chipinge District. Therefore, the district is prone to diverse influences that might speed up the spread of HIV and AIDS. Factors that may play a role are cross-border sex, unrestricted immigration and related health problems.

Related to this is the location of one of the largest and most overcrowded refugee camps in the District – Tongogara, which holds up to over 300 000 Mozambican refugees. In addition, the camp also houses Somalis and Democratic Republic of Congo refugees and others from war-torn countries (Taylor 2007:232). Taylor further reported that the refugee camp has one of the highest rates of HIV infections in the district, and possibly in the country. This could be because female and under-age refugees are vulnerable to all forms of abuse, including unprotected sexual intercourse. Jackson (1992:18) corroborated the above factors by pointing out that long-distance truck drivers, migrant labourers, refugees and commercial sex workers top the list of the riskiest groups in Zimbabwe.

The haphazard implementation of the fast-tracked land reform programme instituted in 2000, and the *Murambatsvina* (Operation Restore Order) of 2005, contributed a fair share of problems to the HIV and AIDS landscape. Garbus and Khumalo-Sakutukwa (2002:32), citing the South African AIDS Information Dissemination Service (SAfAIDS), noted that significant population mobility and household units' reorganisation characterised the chaotic fast-tracked land reform exercise. Tibaijuka (2005) substantiated this fact in a United Nations (UN) special report on Zimbabwe, where she indicated that the *Murambatsvina* operation displaced about 2.4 million people from Zimbabwe's towns, cities and even growth points. These large-scale movements of humans, uncontrolled immigration, the over-crowded Tongogara refugee camp, and exposure to new sexual networks, increased their vulnerability to HIV infection. Therefore, poverty and economic insecurity, a result of underdevelopment caused by years of neglect by the central government, and challenges of *Murambatsvina* and the chaotic fast-tracked land reform programme,

are catalysts of the rapid transmission of HIV and AIDS in the Chipinge District (Simmons, 2012:3).

From the literature reviewed so far, the researcher may conclude that researches done hitherto at national, provincial and district levels, are inundated with the HIV infection and AIDS pandemic prevention messages focused on knowledge improvement. These are ostensibly directed at cultural factors in the context of practice, and none at all in the domain of belief. It is, therefore, prudent to carry out a study, where traditional chiefs, healers, elders and local authorities participate in order to establish the interface between traditional beliefs and practices and HIV and AIDS. This information might be useful in the development of effective HIV and AIDS intervention programmes by the relevant stakeholders (Burnett *et al.* 1999). Perhaps, people might change their attitudes and behaviour towards matters of sexuality for the betterment of their lives. It is, therefore, the assumption of this study that traditional beliefs and practices have been less responsive to the HIV and AIDS pandemic and many victims have perished because of their cultural mores. The next section briefly reviews the theory that underpins this study.

2.5 Theoretical framework

The phenomenological theory, whose background is in the study and interpretation of religious phenomena, undergirded this study. In its broadest terms of reference, phenomenology is a theoretical point of view that advocates the study of direct experiences taken at face value. The approach sees behaviour as determined by the phenomena of experience rather than by external, objective and physically described reality (Cohen *et al.* 2007:22; English & English 1958).

The history of the phenomenological movement dates back to the times of the transcendental phenomenology of Husserl, the founding father of phenomenology. Husserl focused on investigating the assumptions of the day-to-day life of people. The research catchphrase, “Back to the things!” guided him in his studies as he sought to find out how phenomena appear directly to us, rather than through the socio-cultural interpretation of data and symbolic structures. In the same vein, de Vos *et al*. (2011:316) stated that the intention of the phenomenological approach is to understand the phenomena under study on its terms, and describe human

experiences in a study the way participants experience them. Husserl advised that people should look beyond the details of life to the essences or *noumena* underlying them. He argued that people could achieve this by bracketing out the world or "free[ing] ourselves from our usual ways of perceiving the world" (Cohen *et al.* 2007:23).

The terms *phenomenon* and *phenomenology* stem from the Greek word *phainomenon*, which means 'that which shows itself, *or* that which appears [sic]' (Douglas 2005:186). Thus, the aim of the phenomenological approach, as Cohen *et al.* (2007:23) and Hughes (2010:297) citing Polt (1999:14) stated is:

> …to focus and describe that which shows itself to us, noticing how it displays itself and relates to the contexts in which such displays occur.

The idea of an accurate and objective description of the phenomenon, as it shows itself, is of paramount importance. The interviews and the open-ended questions on the questionnaire enabled the researcher to make an attempt at accurate descriptions of the phenomenon, as it revealed itself, and to intuit or decode critical meanings (Douglas 2005:189).

The tenet of *epoché* made this approach suitable for this study. It relates to an unbiased and direct way of examining religious phenomena and being able to perceive or experience it, as the subjects under study understand and experience it (Blum 2012:1033; de Vos *et al.* 2010:316). The phenomenological approach seeks to "unravel the essences through 'empathy"(*Einfühlung*) (Chitando 1997:3). Alternatively called phenomenological reduction, *epoché* is bracketing the world, or suspending judgement about it, or the researcher's convictions about what does or does not exist, what words mean, and what fundamental essences are, thereby getting pure appearances without noumenal connections (Douglas 2005:189; Weininger, Lecture notes on: 'Hermeneutics and Phenomenology', 30 November

1999)[43]. In concurrence with Weininger (1999) and explaining the objectives of the approach, Chitando noted that epoché helps the researchers to refrain from:

> …evaluating truth claims made by religions, while enjoining researchers to be sensitive to the adherent's point of view. It upholds a positive perspective on religion, attacks unbridled subjectivism, as well as seeking to promote religious tolerance (Chitando 2001:184).

Therefore, by the application of the principle of *epoché,*[44] the researcher placed himself in the shoes of listener and did not judge the phenomena under study according to preconceived beliefs and impressions (Bleeker 1959:99).

According to Cox (1992:15) and Chitando (1998), the approach provides a means of exploring the way people come to know reality, or what Giorgi (1997:230, 240) and Shoko (2007) citing Bleeker (1963), referred to as the *eidos* – the kernel or 'whatness' of religious phenomena.[45] Since the study was concerned with examining the interface between the traditional practices and beliefs and HIV infection and the AIDS pandemic among the Shona people in the Chipinge District in Zimbabwe, predicating it on a phenomenological vantage point, enabled the researcher to engage in the study with an unclouded mind. The approach allowed the researcher to enter sympathetically into the worldview of participants in the study, and their involvement in HIV and AIDS mitigation efforts with ease, after the expunction of his prejudices, presuppositions and value judgments.

The strength of the phenomenological approach in this study lay in the fact that the traditional healers, teachers, traditional leaders and community elders were the primary source of data for this study, and the researcher carried out the study *sui generis* (Marashe 2014:3). Therefore, while the researcher was able to operate at

[43] David Weininger lecture notes available on: http://people.bu.edu/wwildman/WeirdWildWeb/courses/wphil/lectures/wphil_theme19.htm#Phenomenology

[44] Douglas (2005:189) indicated that the term *epoché* is an adoption of a Greek term that means 'abstention' or 'suspension of judgment', and phenomenologists regard the approach as a method of 'bracketing.'

[45] Bleeker (1959:99) explained *eidos* as the essentials of the *noumena*, thereby distinguishing the sacred or religious from the spurious.

almost the same perceptual and spiritual levels, for instance, regarding traditional medication and HIV and AIDS, the study participants in the study were, as Shoko (2007) stated, "…understood, respected and credited …" as value-judgements by the researcher were expunged. As Arthur (1988:63) noted, the approach:

> ...is a means of passing over to someone else's [traditional] religious world so that we may try to see how things appear, when viewed from that perspective. It is an attempt to place us, so far as this is possible, in the other person's shoes, so we might stand there and walk with them, observing and feeling what occurs with a closeness, which would be impossible for an 'external' descriptive study, where we stood rooted to the spot and made no attempt at passing over beyond the mere turning off an already judgmental gaze in the direction of the phenomena concerned.

The pilot study and the subsequent fieldwork the researcher conducted for this study allowed him to have a feel for what Arthur (1988) stated. The observation of some of the traditional practices, the reality of issues as articulated during the interviews and the accompanying experience were 'really out of this world'. Thus, the approach necessitated:

> …not only the description of what is visible from the outside, but above all their experience born of what can only become a reality after it has been admitted into the life of the observer himself (Arthur 1988:64).

The triangulation of raw fieldwork data from interviews, and the open-ended questions on sections of the questionnaire enabled the researcher to have a feel for, and gain an insight into some of the study participants' traditional beliefs and practices, and the way they relate to the AIDS scourge and HIV. Through *epoché*, the researcher became attentive to the internal structures of the data from fieldwork and was able to recognise, explain and deduce its meaning about the objectives of the study.

The advantage of using the phenomenological approach to the study was that it is 'discovery-oriented' (Giorgi 1997:243). Therefore, to realise the meaning of the data collected, the researcher adopted an attitude open enough to let the unexpected meanings emerge. Giorgi (1997) referred to this researcher character as 'professional sensitivity and spontaneity function', and through it the *noumena* intuits. Thus, with the aid of free imaginative variation, it was possible to describe the essential structures of the real and lived experiences from the perspective of the participants, and the traditional religious discipline (Giorgi 1997:243).

Notwithstanding its weaknesses, most notably, the feasibility of executing *epoché* in the study, the researcher adopted the approach because some scholars successfully used it and achieved credible findings. Cox (1991:64, 1996:162) used the method in studying the Shona traditional religion in Zimbabwe. The method allowed Cox, through empathetic interpolation, to comprehend the essential characteristics of the participants' traditional religion in terms that adherents could confirm (Chitando 2005:306; Cox 1996b:162). Furthermore, Chitando (2005:306) citing Pobee (1979:21) endorsed the phenomenological process as "…the method for collecting data of African religion". McKenzie (2002:116-119) successfully used the method in a study of the Yoruba religion. Commenting on the findings derived from the utilisation of the method, Chitando (2005:307) stated that it "identifies its emphasis on getting as close as possible to the believers, categorising religious phenomena and recognition of the integrity of African Traditional Religions as enduring values". The researcher found the method suitable for the current study of traditional beliefs and practices of the Shona people of Chipinge as these are cardinal aspects of their traditional religion for which Chitando recommended its usefulness.

The researcher aimed to discern the roles of traditional practices and beliefs, in containing HIV transmission, and the AIDS plague, from within a traditional medico-religious worldview, and reach credible conclusions and recommendations. The researcher utilised the phenomenological theory because it enabled him to differentiate between the *noumena* [things as they are] and the *phenomena* [things as they are perceived] (Cox 1992:15; Marashe 2014:3). The researcher hoped that results from the fieldwork in the impoverished rural Chipinge District would, therefore, mirror the perceptions and understanding of the study participants, and

exposes the same to sound interpretation, or hermeneutics. By using this approach, the researcher aimed to complement knowledge already available on the role of traditional practices and beliefs in the fight against the HIV transmission and AIDS pandemic and perhaps add new insights into the Shona traditional practices and beliefs' corpus.

2.6 Conclusion

Chapter 1 introduced the whole study. It provided background information and presented the research topic and the justification for the study. Chapter 2 followed that up by presenting a review of the related literature to determine and delineate what researchers in the discipline have done to date, and what they have not been able to achieve.

The study is an examination of the Shona traditional practices and beliefs in light of the HIV and AIDS pandemic, and the study's primary objective was to determine if there are traditional practices people have discontinued or modified due to HIV infections and the AIDS epidemic. Chapter 2 deliberately began with a review of the central tenets of the Shona traditional religion. It is from the Shona people's traditional religion that traditional practices and beliefs find expression and meaning. The chapter highlighted the beliefs in witchcraft, sorcery and spirit mediumship. It explained some of the traditional marriage practices such as *kuputsa, barika, chimusamapfiya* and others. The objective of highlighting these marriage practices was to determine if, by following them, people were not possibly exposing themselves to HIV infection.

After a delineation of traditional practices and beliefs, the chapter also briefly explained the state of HIV and the AIDS pandemic in Zimbabwe. It gave some statistics of the pandemic from the national level down to the districts. While there is an understanding and appreciation of the epidemic in towns and cities, there is little knowledge at rural community levels, and this study aimed to address the lack of information in the impoverished rural and remote areas of the Chipinge District. Statistics of HIV infection in Zimbabwe are frightening. However, there is some level of optimism, when reports indicate that HIV prevalence is falling.

The chapter also identified the theoretical framework the researcher used in the study – the phenomenological approach. The researcher chose this method because it advocates accuracy in description, respect for the integrity of the phenomenon under study, and upholding the believers' point of views for their religious experiences (Chitando 1997:12). The phenomenological approach allowed the researcher to describe or explain the phenomena under study − the traditional beliefs and practices of the Shona people in the Chipinge District, the state of the HIV and AIDS epidemic, as the study participants perceive them. In the next chapter, the researcher presents and critically explains the research methodology and the research procedures.

CHAPTER 3

RESEARCH METHODOLOGY

A descriptive survey research deals with "conditions that exist; practices that prevail; beliefs, points of view or attitudes that are held; processes that are going on; effects that are being felt; or trends that are developing. At times, descriptive research is concerned with how what is or what exists is related to some preceding event that has influenced or affected a present condition or event" (Cohen et al. 2007: 205).

3.1 Introduction

This chapter introduces and justifies the research methodology that steered the research journey, which sought to examine the Shona traditional beliefs and practices in the light of HIV and the AIDS pandemic and its ramifications for mitigation and care. The chapter describes, among other things, the research design, population of the study, sampling procedures and sample size. It discusses the data collecting instruments, the questionnaire and the non-scheduled structured interviews, and several other sources of data used in this research. Gall, Borg, and Gall (2007), cited by Dudu (2013:88-89), stated that mixing the research paradigms has the advantage of providing a more precise comprehension of the phenomenon under investigation since mixing has an inherent characteristic of being pluralistic, creative and complementing one another. These research instruments provided the researcher with rich data for analysis and discussion about the research topic.

3.2 Research design

A research design is a programme that leads the researcher throughout the research process. It provides a lead in the collection, analysis and interpretation of data. Nachmias and Nachmias (1981:75) referred to it as a manifesto of a study that enables the researcher not only to draw inferences concerning causal relations among the variables under investigation, but also come up with solutions to identified problems. This study utilised the descriptive survey research design in the Chipinge District, in the Province of Manicaland, Zimbabwe.

The researcher used the descriptive survey design because, as Cohen *et al.* (2007:205) asserted in the epigraph, it helped him, among other benefits, in describing and classifying data. By using the descriptive survey approach, the study placed Shona people's traditional beliefs, practices, the HIV and AIDS epidemic in a

broader cultural milieu for better comprehension. The researcher used the descriptive survey approach in the exegesis of relevant journal articles, textbook information, newspaper reports, UNAIDS and WHO reports (Hatendi, 2001). The researcher examined this literature, like Cohen, Manion, and Morrison (2007) described it, for what they had and did not have on the study topic.

Furthermore, the descriptive survey design was concerned with the collection of data from a sample of participants through the administration of a questionnaire and through interview (Dooley 1995:234; Hradyck & Petrinovich 1975:41). The study used the descriptive survey design because of its "ability to produce a representative distribution, or a cross-section of the "target" population" (Gray *et al.* 2007:122). This research design, like any other belonging to the qualitative paradigm, is concerned primarily with the process rather than the product. It looks at meaning, that is, how people interpret their experiences. It views the researchers as the main data-gathering instruments in the field as they pose questions and intermingle with study participants, and it is descriptive as well as inductive (Creswell 1994; Glesne & Peshkin 1992:6; Merriam 1988). The focus on the process and the interpretation of the participants' responses work perfectly with the phenomenological framework this study utilised.

As the primary data-gathering instrument, the researcher immersed himself at grassroots level as it were, through fieldwork, to 'study real-world situations as they unfold naturally...' (Bogdan & Biklen, 1982:28), and witness the goings-on first hand, *Sitz im Leben.* The researcher undertook several research visits to the custodians of Shona customs such as chiefs, village heads and the elderly in the society to gather the necessary data. When information is finally gathered, the qualitative paradigm demands a detailed descriptive account of what the researcher observed before making inductive conclusions. The goal of qualitative research is "to portray the complex pattern of what is being studied in sufficient detail *so that one who has not experienced it can understand it*" [emphasis added] (Ary, Jacobs & Razaviel 1990:445).

The study used this research design because it was less costly, and the researcher collected the data personally without the services of research assistants.

Furthermore, it is a tried and tested design, especially in the Zimbabwean context. Moyo (1992) used it in a study about voting, democracy and electoral politics in Zimbabwe and his results were both reliable and valid. The value of the descriptive survey design rests in the provision of valuable insights and contribution to research, if it is conducted appropriately, particularly in environments where our knowledge is limited (Punch 2009:123).

Besides, the research design affords a multi-perspective analysis of data, where the interface between information from a cross-section of participants, and their context is reviewed (Nieuwenhuis 2007a). The researcher organised data from chiefs, headmen, village heads, teachers, nurses and the elderly from the Chipinge District. For instance, the researcher transcribed data from each set of participants, considering the research topic and sub-questions. Before this organisation, the researcher took the necessary precautions to ensure that the study used the appropriate participants. The researcher drew the participants from the population of study.

3.3 The study population

According to Doodley (1984:245), a population of the research study refers to "… the collection of all elements to whom survey results are to be generalised". Litt (2010:1052), Rosnow and Rosenthal (1996:188) observed that the population is a more significant pool [of entities], from which the researcher extracts information from a fraction [sample] of that pool and inference is drawn. The significance of the study population is that it sets the boundaries of the research. It includes only individuals who possess information or specific characteristics that are of interest to the researcher. This study is an examination of the interface between Shona customs (traditional practices and beliefs) and the HIV and AIDS pandemic. The population for the study, therefore, included members of a cross-section of the Shona society in the Chipinge District, who had the kind of information relevant to the research topic. Thus, the study population for this research comprised health professionals[46], traditional leaders[47], traditional healers[48], educators[49] and the elderly

[46] Health professionals included both qualified nurses and trainee nurses at different levels in their training programme.

in the communities of the Chipinge District. An estimate of the total number of people who fit in the above categories, and therefore likely to have participated in the study is around 300.

It was not feasible to question every member of the population in the study because of time and resource constraints. Accordingly, the researcher proceeded by selecting a sample, which exhibited approximately the same general characteristics of the Shona people in the impoverished rural Chipinge District.

3.4 Sample

A sample is a small collection of units or a subset of study participants selected from a much more significant study population. This is such that the researcher can study the sample to generate accurate generalisations or forecast the prevalence of new data, situations or conclusions about the study population (Kumar 2011:193; Neuman 2006:219). A unit in this context were individuals who participated in the survey (Fink 2003:50). The sample size for this study was 72[50], drawn from several rural communities in the Chipinge District. Of these 72 participants, 15 were health professionals, comprising both qualified and trainee nurses; 7 were traditional healers; 37 were educators from both primary and secondary schools; and 13 were from the traditional leadership group (consisting of chiefs, headmen, village heads, elders in the chief's court and local authorities from the Chipinge District Administrator's (DA) office). The study participants were selected through both purposive or judgmental and snowball sampling, where the researcher selected the study participants based on the prediction of who might best provide relevant data for the research question (Creswell 2007; Denzin & Lincoln 2000:370; Kumar 2011:207). The identified participants, acting as informants, identified other participants from the study population, and this process was repeated until there were enough participants for the study (Welman, Kruger, & Mitchel 2005:69). The sampling methods were appropriate for this study, which aimed to gain a deeper

[47] Traditional leadership included chiefs, headmen and village heads.
[48] The traditional healers group comprised of both male and female diviners, herbalists and diviner-herbalists.
[49] Educators included senior teachers from both Primary and Secondary/High Schools.
[50] The researcher ended up working with 70 participants, 2 traditional healers withdrew their participation midway through the interviewing session, and for this reason, the researcher did not consider their responses in this report.

comprehension on the interface between the Shona traditional beliefs and practices, and the HIV and AIDS pandemic (Neuman 2006:222). The sampling methods ensured that participants, old and knowledgeable in the people's customs, participated in the study. It was the researcher's belief that the elderly were more knowledgeable in the people's traditional beliefs and practices, than the young.

The participants in this study were mature or the elderly in the traditional societies of the Chipinge District. Their ages ranged from 30 to 55 years. Most of them were able to read and write, while answering the questionnaire because of the high literacy rate in Zimbabwe. The researcher chose the elderly – teachers, nurses, traditional leaders, and others − to participate because of the belief that they were the custodians of the Shona cultural beliefs and practices. Their wisdom, knowledge and experience on the research topic were rich and credible and, as envisaged, beneficial to the study (McMillan & Schumacher 2001). For this study, and in agreement with Welman, Kruger and Mitchell (2005:71), 70 mature research participants were reasonable and large enough a number to obtain reliable and valid results. The sample size was more significant than the total percentage of the entire population that it represented.

Armed with an introductory letter from the study promoter at the University of Pretoria, the researcher sought permission to collect the necessary data for the study from both the traditional and political leadership, under whose jurisdiction the area of study fell. To access traditional leadership, teachers and nurses, permission[51] was sought from the traditional leaders' section under the Zimbabwe Ministry of Local Government, Public Works, and National Housing, Ministry of Education, Sport and Culture (now called Ministry of Primary and Secondary Education), and the Ministry of Health and Child Welfare (now called Ministry of Health and Child Care), respectively.

[51] It took quite some time to get the necessary permission to carry out the research. The researcher posted the application for permission in April 2011, but got no response. The researcher had to travel to Harare in December 2011, where the Ministry of Education, Sport and Culture granted him the permission to carry out the study. The researcher only got permission from the other ministries later on, which delayed the whole research process.

3.5 Data collection procedures and strategies

Data collection proceeded in stages. It involved conducting a pilot study for data collection instruments, after which the researcher administered the questionnaire and conducted interviews to gather data for the study. The researcher also used a fieldwork diary to register salient non-verbal and visual information that participants failed to express orally. In addition, the researcher consulted relevant books, journal articles, and online articles, a process Marshall and Rossman (2011:66) referred to as triangulation of data sources as shown in Figure 3.1 below.

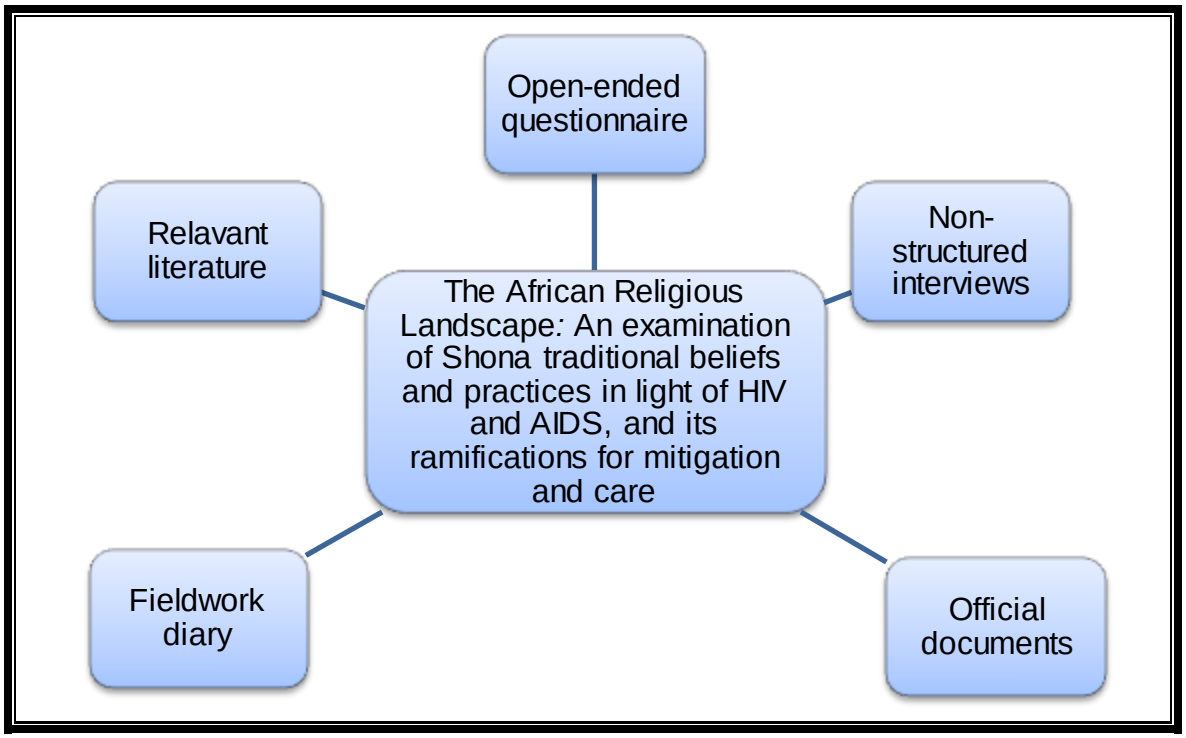

Figure 3.1: Triangulation of Sources of Data

However, before data collection procedures commenced, the researcher needed to have approval and permission to conduct fieldwork. The next section highlights the details of the clearance process.

3.5.1 Research approval and ethics clearance

The nature of this study involved human subjects to participate. It was, therefore, important that the researcher obtain ethics clearance, and permission to carry out the study (Thomas 2009). The researcher applied for an ethics clearance and research permission from the University of Pretoria, Faculty of Humanities' Postgraduate Committee and Research Ethics Committee. The researcher applied

for clearance and permission to proceed with the study by submitting a research proposal that indicated the proposed participants of the study. It also included an interview guide and copies of a questionnaire that the researcher was going to administer. In addition, the proposal dossier included copies of letters to the Permanent Secretaries of the Ministries of Health and Child Welfare, Education, Sport, Arts and Culture and Local Government, Rural and Urban Development in Zimbabwe. The researcher wrote to the Permanent Secretaries of the afore-mentioned ministries, applying for permission to conduct research involving health workers in hospitals and clinics, teachers and headmasters in schools, traditional leaders and the elderly citizenry, respectively, in the Chipinge District. Lastly, the proposal included a copy of a letter to the President of the Zimbabwe National Traditional Healers' Association (ZINATHA). The contributions of traditional healers were indispensable in this study, and it was prudent that the researcher seek permission to engage them from their national association President. Many bogus traditional healers have mushroomed everywhere in Zimbabwe generally, and in the Chipinge District in particular. Therefore, asking for research permission from the relevant association was a way of ensuring that the researcher gathered data from registered traditional healers, thereby safeguarding data validity and reliability. The Postgraduate Committee & Research Ethics Committee approved that the researcher proceed with the study as shown in Appendix A.

Ethics clearance was vital in this research. Besides it being *sine qua non* in qualitative research, the ethics clearance was an indication of the researcher's desire to ensure the autonomy of every participant, treat all respondents as fellow human beings in their socio-political and professional milieu (Mugweni 2012:116). The study was beneficial to the study participants in that findings on the interface between the Shona traditional beliefs and practices in light of HIV and the AIDS pandemic might arm the participants, and the generality of Chipinge residents with tools that might enable them to retain practices that do not endanger their lives by exposing them to HIV infection.

Participation was voluntary, and the researcher assured the study participants of their freedom to withdraw from the study without any harm, physical, psychological or otherwise. The researcher maintained confidentiality and the right to privacy by

ensuring that participants did not write their names on the consent forms (the researcher used pseudonyms instead) (Christiaan 2006; Cohen *et al.* 2000:61). Moreover, all research materials – fieldwork diary, audio records with interview data and completed questionnaire, were only accessible to the study promoter and the researcher. In line with treating study participants as human beings, the researcher commenced interview sessions by explaining the aims and objectives of the study (establishing rapport) to participants. Subsequently, the researcher asked them, if they were willing to be involved in the study without coercion (Kvale & Brinkmann 2009). They read a consent letter (Appendix B) and signed a consent form (Appendix C), which had clear instructions. The researcher structured the questionnaires in such a way that each section started with a comprehensive introduction and instruction so that respondents found it easy to answer the questions without difficulty. The introductions were necessary, considering the nature of the study – asking for information about the Shona traditional beliefs and practices, and HIV and the AIDS pandemic from a community in a remote and impoverished rural Chipinge District. The data gathering process was, perhaps, laced with an ethical dilemma (Clasquin-Johnson 2011:93).

Armed with an ethics clearance from the Postgraduate Committee & Research Ethics Committee, the researcher posted the application letters requesting permission to carry out the research to the relevant ministries (Appendices D1 to D4). The responses were extremely delayed in coming, and when the researcher made a follow-up, the Secretary in the Ministry of Local Government, Rural and Urban Development responded first. He demanded a written confirmation of the researcher's doctoral candidature at the University of Pretoria, and the study promoter duly provided it (Appendix E). As a result, he granted the researcher the permission (Appendix F) to carry out the study. The Secretary of Education, Sport, Arts and Culture, though late, approved that the researcher could carry out the research in December 2012 (Appendix G), and other authorities followed suit. The researcher obtained the consent of the Provincial Education Director (PED) and the District Education Officer (DEO) of Chipinge to access schools, without which principals and the generality of teachers might not have participated in the study. In keeping with the research ethics, the researcher used pseudonyms in this research

to guarantee confidentiality and anonymity (Kanari & Millar 2004:753). While waiting for permission from the Ministries concerned, the researcher conducted a pilot study, a precursor to the central section that addressed methodological rigour matters, a *sine qua non* endeavour in any research task.

3.5.2 Pilot study

The researcher conducted the pilot study at Chikore Mission and environs, Murenje, Dzika and Muzite communities from 3 January 2011 to 31 March 2011 to pre-test data collection instruments before implementing them during the fieldwork. As a result of the pilot study, the questions and categories were re-developed and refined. Clumsy, redundant, double-barrelled and wordy questions were re-worded; others were deleted from the questionnaire altogether, following recommendations from participants in the pilot study areas and further research on questioning and questionnaire construction (Nachmias & Nachmias 1981:211,213). This exercise was beneficial in more ways than one. It helped to unearth some of the challenges the researcher was likely to encounter in the ultimate research beforehand, as well as improve on reliability (Cohen *et al.* 2007:58; Marshall & Rossman 2011; 1995:64). The researcher also used copies of the refined interview schedules and questionnaire to apply for clearance to carry out the study from the relevant ministries and departments.

3.5.3 Research instruments

The primary data gathering techniques were the questionnaire with both closed and open-ended questions, the non-scheduled structured interview and the fieldwork diary. It was essential to use all these data collection techniques in recognition of "… the limitations of a single method …" (Kincheloe 2001:681). Thus, the interweaving of these techniques reflected a search for the nodes or the interconnections between knowledge bodies and between knowing and understanding (Lincoln 2001:693-694). The researcher personally administered the questionnaire to the sampled literate participants and conducted the non-scheduled structured interviews. With the study participants' consent, the researcher audio-recorded some of the interviews for further analysis and identification of common themes. Interviews were significant because they provided opportunities for the researcher to collect first-hand information that was hard to get with questionnaires (Bless & Smith 1995). The

sections below shed more information on the questionnaire, non-scheduled structured interviews and the fieldwork diary.

3.5.3.1 The questionnaire

According to Nkuna (2001:9), Best and Khan (1993:229), questionnaires are data gathering instruments, through which the study participants answer questions on a form or respond to the statements in writing. The questionnaire afforded the respondent the chance to either choose pre-determined answers or write answers in the spaces provided or both. In this study, the questionnaire was administered to the elderly in the Chipinge District in consideration of their literacy; the raison d'être being to obtain information and opinions on the interface between the Shona traditional beliefs and practices, and the HIV and AIDS scourge. As such, they were able to interpret the questionnaire and provide the required data since they were knowledgeable, and experienced as custodians of the Shona cultural beliefs and practices under examination.

The questionnaire comprised a broad spectrum of both closed and open-ended questions. The researcher designed and administered open-ended questions because, as suggested by Mathison (1988) and cited by Mugweni (2012:130), data gathered was detailed and had a clear status as qualitative research. The researcher modified some of the questions after a pilot study revealed, for instance, that the questioning diction ought to agree with particular groups of participants. Although many questions were similar across the research participants' divide, some were specific to a particular group of the study participants. For instance, some questions were peculiar to traditional healers and others to traditional leaders, who were literate. Others were suitable for the study participants from the health professionals' sample such as nurses. The researcher designed questions in both English and ChiNdau (a Shona dialect and mother tongue for the Ndau people who live in the Chipinge District). The translation of the questions into English was in recognition of what Cooper and Schindler (2008:338) referred to as a shared vocabulary.

In this study, shared vocabulary is whereby participants develop and share an innate understanding, and agreement to what the questions mean in reality and practice. The translation helped the study participants, who might have had problems in

understanding the issues asked in English, to comprehend them entirely; and subsequently, gain reliable and valid data. Some of the questions sought to determine the study participants' comprehension and perceptions of HIV and AIDS (asking them the causes of, and defining the terms), and others asked for their professional training, diagnosis and cure of HIV and AIDS and precautions they take in order not to be infected, while in the line of duty. Other questions assessed, for instance, in the case of traditional healers, the efficacy of traditional medicine in HIV control, and if their healing practices did not facilitate the spread of HIV in the Chipinge District, or even endanger their own lives. The virtue of open-ended questions was that it did not force participants to choose preconceived answers (Nachmias & Nachmias 1981:211). The participants were at liberty to express their thoughts, out of their volition and in their language (Silverman 2010). The focus on designing the questionnaire in such a way was to show how the study participants use their language, the primary carrier of culture and express their attitudes and feelings, among others (Nyoni, Marashe, & Nyoni 2011:280). The researcher viewed whatever the respondents produced such as written work in response to the questions, as transcripts of their minds. According to Neuman (2006), questionnaires have a high degree of anonymity for they do not ask participants to identify themselves in any way. Furthermore, the instrument was quick and economical to administer.

The researcher administered the questionnaires in two crucial ways. Among some participants, the researcher administered the questionnaire to participants and waited for their completion, and among others, the researcher administered the survey questionnaires, explained the completion and left. The researcher then collected them after some days or even weeks. The situation found on the day of approaching participants determined whether it was prudent to leave the questionnaires or to wait for their completion. For instance, if the respondents did not have the time to complete the questionnaire because of work commitments or other engagements, the researcher would leave them to be completed when they had the time and agreed with them on the time and date to collect them. This arrangement was the researcher's experience with participants from schools, hospital/clinics or even from the community. The first strategy allowed for an immediate address to any

ambiguity or query on the questionnaire and ensured a high response rate. Above all, it enabled the researcher to check if respondents completed all sections correctly (Cohen *et al.* 2007:344). The second strategy had its advantages, too. It allowed the participants to complete the questionnaire when they had time, in the comfort of their offices or homes and without the pressure of the presence of the researcher (Cohen *et al.* 2007). However, the questionnaire as a data-gathering instrument and irrespective of the manner of its administration, has limitations.

For questionnaires completed in the presence of the researcher, it was difficult for the researcher to establish whether they were not hurriedly completed, which may have affected the validity of data collected (Cohen *et al.* 2007:344). The most significant challenge concerning the questionnaire, if the researcher left it behind for completion was that the researcher was not able to address any queries or ambiguities that participants might have faced. Furthermore, and as Cohen *et al.* (2007:344) argued, there was no time to check for sections or items that participants might have omitted and failed to contact the researcher for clarification. The researcher's absence might have led to a loss of valuable data. Though the questionnaire might not have been perfect, subjecting it to a pilot test, and the subsequent modification of the same, provided a safety net for some of the challenges that participants might have faced. On that account, the researcher took adequate measures to ensure that the collected data was as reliable and valid as possible.

3.5.3.2 The non-scheduled structured interview

The researcher commenced making appointments for interviews with possible research participants in October 2011, and both interviews and administering of the questionnaire lasted until May 2012. An interview session was, on average, approximately 15 to 20 minutes long. Using an interview guide with questions written in both English and ChiNdau (a Shona dialect mostly spoken and understood in the Chipinge District) (Appendix H), the researcher interviewed participants such as the traditional leaders in their local language since, for one reason or another, they were unable to answer the questionnaire (Nachmias & Nachmias 1981:189). The virtue of the non-scheduled interview was that it focused on the subjective experiences of the interviewees regarding their traditional beliefs and practices and knowledge about

the HIV and AIDS pandemic. This type of interview was favoured because, although the interview process was structured and the significant aspects of the study elucidated, the interviewees had considerable autonomy in expressing their opinions about their traditional beliefs and practices. Even though the interview guide was in English, the researcher conducted the interviews in ChiNdau, a dialect of the Shona language spoken by the participants. The study used the native ChiNdau dialect so that the participants and the researcher understood the questions from the same language continuum (shared vocabulary). Moreover, as Nyoni, Marashe, and Nyoni (2011:28) and Duffy (2005:25) expressed, it is through language that participants reveal their culture, beliefs and attitudes (Marashe 2014). As such, the interview was a befitting data-gathering instrument for this study, whose primary focus was to '*examine the interface between the Shona traditional beliefs and practices in light of the HIV and AIDS epidemic'.*

The researcher conducted the non-scheduled structured interview to enhance communication between the researcher and the interviewees (Cohen & Manion 1989). The one-on-one interview allowed the researcher to solicit more information through probing what participants indicated by both verbal and non-verbal expressions. Furthermore, the non-scheduled interview allowed the interviewer to probe further for ideas, and investigate motives and feelings or specific emotions (Nachmias & Nachmias 1981:189).

In addition to being flexible and adaptable, enabling the researcher to modify his line of inquiry, the researcher used the non-scheduled structured interview to gather data because it was like a checklist. According to Aberbach and Rockman (2002), interviews allow for a better comprehension of participants' perceptions and interpretations of phenomena. Gall, Borg, and Gall (1996) supported structured interviews in the sense that they help the interviewer not to forget some of the important points during the conversation. In corroboration with Saunders and Thornhill (2000) and Thomas (2009), the researcher noted particular gestures and clues of participants' feelings on the research topic during the interviews. Furthermore, the non-scheduled interviewing technique ensured a high response rate. With the consent of the participants, the researcher jotted down and audio-recorded their responses during the interview. The interviewer was particularly alert

and sensitive to inconsistencies and omissions of valuable data, especially those that had a bearing on answering the research problem.

Jotting down fieldwork notes and audio-recording the interviews was necessary. It was useful in the subsequent processing and analysis of data to identify common themes and discussion points. Thus, voice recording of a description or elaboration on traditional processes or practices was advantageous in that the researcher was able, when the need arose, to play the recording several times for a better understanding, clarity and microanalysis (Glesne & Peshkim 1992:76), notwithstanding the fact that recorded interviews present a decontextualised account of the proceedings (Seidman 2006). It lacks non-verbal communication visuals such as gestures, nuances and interviewees' body language (Mugweni 2012:109). However, the voice recording allowed the researcher to interpret the responses more accurately, especially in cases, where significant traditional events, for instance, *muthimba* (traditional wedding), were held at the time of the interviews. Such an important ceremony might have influenced the interviewees' responses (Nachmias & Nachmias 1981:192) on one of the questions that sought their knowledge on traditional marriage practices they knew and practised in their community.

The researcher interviewed different sets of participants, depending on their professional and social status in the community and their natural working or community settings. The study targeted the elderly who were willing to share their cultural wisdom and their rich and untapped knowledge reserves of the Shona traditional practices and beliefs. Furthermore, the researcher also interviewed heads of sections in their relatively quiet and non-distractive offices, clinics or hospital offices. They were often too busy to find time to respond to questionnaires, and the way to tap into their knowledge of traditional practices and beliefs was through interviews. The researcher resorted to interviewing them because, despite their willingness to participate, they hardly found the time to complete the questionnaire. Though the researcher interviewed different groups of participants, some questions, seeking information on their knowledge of traditional practices and beliefs, the HIV and AIDS pandemic were similar across the sample divide. The researcher designed the questions that way because of the realisation that the data required was not a preserve of any particular group in the sample. Some of the issues in the interview

questions explored participants' knowledge about the Shona traditional practices and beliefs in general, and those, which they thought fuelled HIV transmission and AIDS epidemic. The researcher ended the interview by asking for solutions to the problems that participants would have highlighted.

The researcher assured the interviewees of the confidentiality of data collected to avoid suspicion and boost their confidence. When the researcher guaranteed them confidentiality, the response rate significantly increased. Perhaps, this was because, as stated by Nachmias and Nachmias (1981:193l), the researcher quickly reached and interviewed participants, who included those who had difficulties in reading or writing, or those who did not fully understand the language or merely those who were not keen to take their time to participate.

3.5.3.3 Fieldwork diary

In addition to the data collected through both interview and questionnaire, the researcher kept a field diary, where he recorded personal impressions (thoughts), spontaneous discussions, non-verbal behaviour, observations, feelings and reflections of observed gestures and mannerisms during the course of the fieldwork (Lincoln & Guba 1985:327; Wilkinson 2000:228). The researcher also recorded flashes of ideas related to the research question that crossed his mind during fieldwork, as well as unclear arguments that needed clarification on issues the study participants might have raised or those yet to be raised (Bogdan & Biklen 1992:122). The molar approach guided the choice of what to record in the fieldwork diary, that is, focusing on significant elements of behaviour as determined by the research problem – the interface of Shona traditional beliefs and practices in light of the HIV and AIDS pandemic.

The fieldwork diary was critical to the study. It enabled the researcher to access data that the study participants had failed to communicate orally. Accordingly, the information gathered indicated the *who*, *what*, *where* and *how* of the study context (Mosia 2011:74). The fieldwork diary notes complemented data from the questionnaires and interviews, as the researcher noted during data analysis. The notes and other data thus increased the credibility of the study's conclusions and recommendations.

3.6 Data presentation and analysis

Qualitative data collected through the questionnaire and from interviews were analysed using Atlas.ti 4.2 qualitative data analysis software for Windows. The researcher used Atlas.ti 4.2 in data reduction because it was able to manage large volumes of transcribed data. It also provided a useful tool, with which to measure the Shona people's customs and make inferences about their beliefs and traditional practices (Sarantakos 1998). In essence, Atlas.ti 4.2 was helpful in organising the large volumes of data the researcher had gathered. Data analysis involved several processes – data preparation, transcription, uploading the primary documents (PDs) into Atlas.ti 4.2, and coding.

Initially, and well before data transcription, the researcher prepared for data analysis by ensuring that each participant had a unique identity. For instance, N identified all responses from health professionals, and those from the traditional healers were labelled T. Thus, N1 or T1 referred to the first research participants from that particular group of people or sample of participants. The next stage was the transcription.

The researcher transcribed a sum of 70 questionnaire and interview responses into open Word documents. After the transcription, the researcher arranged data in order of the questions and grouped all Question 1 responses for all participants so that it became easy to code. The researcher also ordered all questions in all PDs in descending order (as shown in Table 3.1) before uploading them into Atlas.ti. In Table 3.1, ID#, for instance, T1 was the pseudonym for the first traditional healer interviewed, while Q# was the number of the question answered, and Response denoted the participants' answers. Asking in ChiNdau, a Shona dialect, the question that resulted in these replies was:

1. – *Chinombozwi mukondombera kana kuti 'edzi' chiinyi*? – (What is HIV or AIDS?)

Table 3.1: Transcription of Traditional Healers' Responses on Question 1

ID#	Q #	Response
Section A: Knowledge and perceptions about HIV and AIDS		
T1	1	Is a result of a mixture of many sicknesses, for example, having sex with a woman who has just given birth or who is menstruating.
T2	1	It is illnesses that befall men and women – from sexual intercourse.
T3	1	It is a mixture of sexual diseases that would not have been attended to for a long time.
T4	1	HIV & AIDS is runyoka.
T5	1	Prostitution; richirana – to have sex with a woman who has a small child, even fingernails pull off, and hair becomes thin and slippery; you cough incessantly and become thin.

The researcher then uploaded the transcribed data or primary documents (PDs) into Atlas.ti 4.2 qualitative data analysis software, which assisted the researcher in the coding process. The researcher used open coding and systematically broke down data into codes that took cognisance of the research question and sub-questions. After completing the coding, the researcher then requested the system to produce a code-quotations output. The output showed, for instance, the frequency a particular code occurred and the corresponding quotation from which the code originated (Table 3.2). Table 3.2 shows three examples of participants only to save space. The question asked participants to state the primary causes of AIDS. They identified prostitution as one of them, and it recurred seven times.

Table 3.2: Atlas.ti Codes-Quotations Output

Code: AIDS causes::prostitution {7-0}
P 1: Participants' responses.txt - 1:746 [B 12 2 Prostitution and wife i..] (1533:1533) (Super)
Codes: [AIDS causes::prostitution] [wife inheritance]

B 12 2 Prostitution and wife inheritance

P 1: Participants' responses.txt - 1:754 [C 36 2 The socio-economic stat..] (1545:1546) (Super)
Codes: [AIDS causes::prostitution]

C 36 2 The socio-economic status of a country causes women to indulge in promiscuity. Women, in general, want to make quick bucks.

P 1: Participants' responses.txt - 1:760 [G 28 2 Poverty leading to girl..] (1558:1563) (Super)
Codes: [AIDS causes::prostitution] [blood transfusion] [unfaithfulness]

G 28 2 Poverty is leading to girl child becoming a sex worker. Teaching on the proper use of contraceptives back in some families. Negligence and weak morals of involved persons. The infected person has the feeling that...

[**Key to Table 3.2**: P 1 meant Primary document (PD) 1; PD name - Participants' responses; 1:746 - PD 1, code number 746. B12 was the study participant, and 2 was the number of the question the research participant answered. The figures in brackets denoted the lines within the transcription from which the code originated, and Super is a default identifier of the author who coded the transcriptions].

Related codes then formed code families, and associated code families formed super codes. These code families and super codes subsequently formed categories and themes (Friese 2012) that the researcher discussed in the study report.

Categories and themes that emerged from the coding process, such as knowledge about Shona traditional beliefs and practices, attitudes and traditional beliefs about HIV and AIDS, formed the backbone of the study report on the findings and analysis, and eventually led to deductive or inferential conclusions. The researcher discussed the research data about the emerging themes drawn from interviews and questionnaire responses, and explained any notable trends and patterns from the data codes.

3.7 Validity and reliability of the study

Every research endeavour must be valid and reliable, if its outcome is to be valued in the research landscape. Cohen *et al.* (2007:133) noted that "If a piece of research is invalid, then it is worthless". According to Altheid and Johnson (1994), quoted by Whittemore *et al.* (2001:523), reliability is the extent to which the research outcome is stable, and validity mirrors the truthfulness of research outcome. Creswell and Miller (2000:124) corroborated this idea and added that in qualitative research paradigm, validity should be seen as the degree of accuracy of the research findings' reflection on the realities of the participants' social phenomena. Thus, trustworthiness (a trait of validity) implies credibility, transferability, dependability, conformability and authenticity of both the research process and output (Creswell & Miller 2000:126). All these features are hallmarks of a sound study. Research validity is, therefore, a prerequisite in any research venture. It is difficult to attain 100% validity in research that is taking a variety of forms. This means that validity should then be perceived as an issue of degree, and not expressed in absolute terms (Gronlund 1981). However, in agreement with Winter (2000) cited by Cohen *et al.* (2007:133), this study attempted to achieve this feat "… through the honesty, depth, richness and scope of the data achieved, participants approached, the extent of triangulation and …" the objectivity of the researcher. In this study, the researcher used triangulation, and debriefing peers or peer reviews in order to assess validity.

Creswell and Miller (2000:126) defined triangulation as a validity process, wherein the researcher looks for convergence from several sources of data. The current study achieved this feat by using participant triangulation. The researcher consulted stakeholders who had the requisite knowledge regarding the research problem. These included traditional chiefs, traditional healers, headmen, health personnel and

the elders in the communities, where the researcher conducted fieldwork for the study. In exploring the same issue, and checking for data accuracy (Patton 1999), the researcher asked different groups of participants the same question. For instance, the researcher asked them whether the practice of wife inheritance causes HIV infection.

The researcher used methodological triangulation. The use of the questionnaire and non-scheduled structured interviews to gather data for the study from groups of the study participants ensured research output validity. It is worth noting that experts in the Shona language translated interview questions into ChiNdau. On their own, these instruments drew valuable and informative information. Other sources of rich data were the Traditional Medical Practitioners Act (2002, Chapter 27:14), the Traditional Leaders Act (2000, 29:17), the African Charter on the Rights and Welfare of the Child (Chapter 1, 1999) and reports from the National AIDS Council (NAC). The Traditional Medical Practitioners Act (2002, Chapter 27:14) regulates the conduct of traditional healers and use of traditional medicines in Zimbabwe, while the Traditional Leaders Act (2000, 29:17) stipulates the roles of traditional leaders in Zimbabwe. The Charter champions the rights of African children, and NAC reports provide insights into the HIV and AIDS pandemic statistics in various provinces and districts of the country. By interviewing participants using their language, involving the elderly in the community, traditional leaders and nurses, this study achieved, to some extent, what Cohen *et al.* (2007:139) referred to as cultural validity.

Cultural validity entails appreciating cultural values of the study participants, and the appreciation involved:

> … identifying and understanding salient terms as used …; reviewing appropriate target language literature; … checking interpretations and translations of data with native speakers; … (Cohen *et al.* 2007:139).

In support of Morgan's (1999; 2005) idea, Cohen *et al.* (2007:139) perceived cultural validity as the “degree to which a study is appropriate to the cultural settings, where research is to be carried out”. This study thus strove to achieve cultural validity by involving research participants who were, perhaps, knowledgeable in their cultural

practices and beliefs. The nature of the research question is such that there was no way in which the researcher could avoid ploughing through cultural issues in the quest to find relevant information. It was enriching to interact with the elderly, the chiefs and traditional healers and gather valuable information from them, especially as the fieldwork took a considerable amount of time to complete. The researcher does not regret the amount of time spent conducting interviews and asking participants to answer questionnaires as it was beneficial to both the interviewees and the interviewer. In the initial stages of the fieldwork, participants used to think that the researcher was an agent of a Non-Governmental Organisation (NGO) registering for assistance only those who agreed to participate in the study. However, with time, and after interacting with them, he established a good rapport. They appreciated the study. In turn, the researcher was able to tap into the rich vein of their wisdom and data (Burck 2005) that benefitted this study in more ways than one.

The researcher engaged some peers (peer debriefing), well acquainted with the area of study, to review the research process (Creswell & Miller 2000). For instance, the researcher consulted a Zambian national who had recently graduated with a doctorate for her contribution and advice on this study. The researcher sought her guidance and input because of the similarities between her work and this study, although the peer's primary focus was on the Zambian context. Her comments and suggestions were helpful. The researcher also asked a fellow PhD student at the University of Witwatersrand conversant with Atlas.ti software to code some of the transcriptions, and compared his codes to the codes generated for this study. His coding was a revelation to the researcher who had minimal training in the use of the software. Nevertheless, in the end, the codes matched most of the times. The researcher also sent data transcriptions and original codes to the co-supervisor, an expert in empirical research in his own right, and was advised to reduce the number of codes since they were too many. His advice helped in fine-tuning data coding. Overall, the researcher involved peers in the study to ensure data accuracy, culture-fairness and cultural sensitivity, all elements of validity and reliability.

3.8 Limitations of the study

The researcher faced numerous challenges in this research, especially during the data collection stage in the field. The research problem was: *The African Religious Landscape: an examination of Shona traditional beliefs and practices in light of HIV & AIDS, and its ramifications for mitigation and care*. Therefore, while respondents were conversant with questions regarding cultural beliefs and practices, they were sceptical of others that required them to demonstrate knowledge about HIV infections and the AIDS pandemic. Perhaps, this was because matters of sexuality, HIV and AIDS are sensitive and influenced the study participants' attitudes, behaviour, personal taboos, beliefs and emotions (Kachingwe, Norr, Kapondal, Norr, Mbweal & Magai 2005:1). Some potential respondents were reluctant to share their views on issues bordering on sexuality, an issue the study could hardly avoid, if it were to do justice to the primary research problem. Their reluctance was perhaps due to the environment, in which the fieldwork took place – predominately rural and remote communities, where it is a taboo to talk openly about sexuality, especially to strangers. Maybe, the researcher worsened the situation when, as a male researcher, he interviewed female research participants whose cultural and social upbringing meant that issues of sexuality were sacred, and, therefore, not appropriate for public discussion, especially with men. However, some of them opened up later during the fieldwork as they were satisfied with the genuineness of the study.

The other challenge was the delay in questionnaire completion. For instance, the researcher left several questionnaire copies at a school, having agreed with the study participants on a date on which to collect them. Quite often, the researcher would get back to the school only to find that some research participants had not finished completing the questionnaire. Some of these would ask the researcher to come back later, or feeling remorse, offer to complete the questionnaire hastily. Concerned about the quality of such responses, the researcher usually agreed to come back later. This arrangement worked out very well as the rate of reply, though delayed, was sound and pleasing. However, the ripple effects of such unforeseen delays were that the whole research process was considerably delayed, and the researcher missed set target dates.

The use of Atlas.ti software in the coding process had its fair share of problems. Having minimal training in its use, the researcher had to rely on online classes and podcasts from Germany. These depended much on the strength of the internet, either in the library, computer laboratory or in the halls of residence. Listening to, and participating in some of the lessons was challenging. The researcher was at the mercy of library or computer laboratory users since taking part in the online lectures could disturb them, while at the same time, it was not possible to change to set times. The researcher managed to participate in some of these lectures after having secured a cubicle in the library or begging others to bear with him during the time of the lecture – usually lasting an hour.

The coding process was not easy either. Using data analysis software, installed onto the University computer system, was a major challenge. First, being a novice in using Atlas.ti, the researcher produced too many codes. However, the study co-promoter advised that the codes be reduced. The researcher merged many similar codes and, as a result, remained within a manageable number.

Second, at the turn of 2013/2014, the researcher lost all the codes done in the past eight months because the University computer system was upgraded and/or cleaned. Efforts to recover them from the Information and Technology (IT) Department were in vain, and that futility confirmed the researcher's greatest fears – the gruelling task of re-coding. The researcher had no option, but to re-code all the transcriptions again. Notwithstanding the fact that the re-coding process was a bit faster than the first time, the whole exercise stalled the researcher's progress on the thesis report writing, and once again, like the delay experienced during the data collection stage, as highlighted above, the researcher missed the thesis completion deadlines in a significant way. The researcher had to endure the unpleasant experience of applying to the responsible Faculty to have his doctorate candidature extended. Eventually, the researcher completed the re-coding exercise, and proceeded to the thesis report writing.

3.9 Conclusion

Research methodology, as discussed in this chapter, is the backbone of this thesis. This chapter discussed the descriptive survey research design used in the research

on the examination of Shona traditional beliefs and practices in light of the HIV and AIDS epidemic and its ramifications for mitigation and care in the Chipinge District, Zimbabwe. It discussed purposive and snowballing sampling methods. The study consulted 70 participants who, among others, included health professionals, traditional healers and traditional leaders in their ranks. Non-structured interviews, questionnaires and a fieldwork diary provided rich data for this study, and were coded using Atlas.ti software for qualitative data analysis. Furthermore, the chapter examined ethical issues since the study involved human participants and, therefore, a necessity if the research outcomes would be valued in the research landscape. It also addressed validity and reliability concerns. The researcher instituted several measures to ensure that the whole research process had a measure of cultural validity and reliability. Some of the mechanisms included were a triangulation of data sources and refining the codes and themes. The researcher asked colleagues to generate codes from the same data transcriptions, a mechanism employed to seek a second opinion from colleagues. After executing the research methodology and, consequently, ending up with data that the researcher reduced to several codes, the study now presents the findings of the fieldwork in the next chapter.

CHAPTER 4

RESEARCH FINDINGS AND ANALYSIS OF DATA

"Qualitative data analysis involves organising, accounting for and explaining the data; …, making sense of data in terms of the participants' definitions of the situation, noting patterns, themes, categories and regularities"(Cohen et al. 2007:461).

4.1 Introduction

The literature review in Chapter 2 interrogated relevant literature from various platforms – books, refereed journal articles (both hard and online copies), internet materials and disciplines such as the socio-cultural and African traditional religious traditions. This interrogation identified and raised several research questions, which the study systematically set out to answer. At the same time, Chapter 3 set the stage for the study. It provided the means and instruments for the research's *modus operandi* and delimited the parameters for the study. Grounded in the phenomenological approach milieu, Chapter 3 identified the descriptive survey as the research design within the qualitative research paradigm, with the questionnaire and the semi-structured interview as the instruments for gathering the necessary data from a sample of carefully selected participants. Chapter 1 sub-sections 1.9 and 1.10 provided introductions to both the literature review and the methodology of the study. Therefore, the aim of the current chapter is to build on those introductions and provide the necessary assurance that the survey followed proper research etiquette.

From the onset, it is worth noting that this chapter concurrently presents and analyses the findings of the study. The researcher presents data and its analyses in juxtaposition to avoid the likelihood of repetition and monotony by reporting on the study findings in one section and analysing similar data in another. Adopting a thematic approach, the study presents and analyses themes that emerge from the transcribed, coded and categorised data. It first identifies topics for discussion and the corresponding questions in round-edged rectangle graphics, and thereafter, the analysis follows below. The Chapter commences by presenting the demographic data of the traditional leaders, which is part of a journal article by the researcher, entitled, '*The African traditional religious landscape: An examination of the role of*

traditional leaders in the fight against HIV and AIDS in Chipinge, Zimbabwe.[52] The study will then proceed by presenting the demographics of the rest of the participants. After the demographics section, the researcher organised the chapter around major themes concerning the perceptions of the participants on the HIV and AIDS pandemic, followed by themes regarding the participants' perceptions of the traditional beliefs and practices of the Shona people in the Chipinge District. Since some of the findings of the study have already been published in a journal, *Verbum et Ecclesia*, with a note on the article explicitly indicating that the published work is part of this study[53], the researcher has reproduced some participants' views, opinions and inferences therefrom as they appeared in the published journal article or in truncated forms. The chapter concludes by highlighting in summary form, the main findings of the study.

4.2 Demographic data

Presented below is an extract of the demographic data of a sample of the traditional chiefs in the Chipinge District as published in an online refereed journal, *Verbum et Ecclesia* (Marashe 2014:4-5).

4.2.1 Traditional leaders

The study reveals that the study participants in the traditional leadership sample are all males.

This is probably, because traditional leadership positions were mostly, until in the new millennium, a preserve of the male members of the community. Traditional leadership has been male-dominated since time immemorial, and the *status quo* remains intact in the Chipinge District. This situation may be a consequence of the socialisation of children in African rural societies.

Rusere (2011) aptly summarised it thus:

[52] The published article is a part, derived from the data of the current study and research report.

[53] Marashe, J. 2014, 'The African traditional religious landscape: An examination of the role of traditional leaders in the fight against HIV and AIDS in Chipinge, Zimbabwe', *Verbum et Ecclesia* 35 (1), 1-8, http://dx.doi.org/10.4102/ve.v35i1.871

> It is not by design that women find themselves in such marginalised areas of everyday lives, but the African society has socialised them into believing that they are subordinated to their male counterparts.
>
> However, now there are female chiefs in some parts of Zimbabwe's Matabeleland South and Mashonaland East provinces (Mpofu 2008). This is diametrically opposite to the widely held traditional principle of male primogeniture. In Zimbabwe, there are 268 chiefs of whom 5 are women and only 4 out of 474 headmen are women, which suggests 'a slight appreciation of the dynamic nature of culture' (Rusere 2011).[54]

Furthermore, traditional leaders in Chipinge are the elderly in society. Most of them are above 50 years, while the rest are within the 40 to 50 years range. This implies that traditional leadership is the office of those who have 'seen it all'; those who can use their life experience to advise others and discharge their duties; and those who have learnt the traditions of the people they lead over the years. This aspect is quite significant in the study that sought information concerning traditional practices of the people, which the elderly could answer best.

While all participants are married, the most interesting finding on this aspect is that there seems to be a shift in marriage preferences. In the past, chiefs valued and married many wives and fathered many children. This has changed as few participants are in polygamous marriages, while the rest are in monogamous marriages. This is a positive development in the fight against HIV infection, and the AIDS pandemic − developments in which chiefs are leading by example.

[54] In an article entitled, 'Africa's women grab fair share in leadership' Rusere (2011) showed how African women are faring not only in political leadership positions, but also in traditional positions. Further details are on www.africanews.com/site/list_message/3.

In terms of religion, the study reveals that the majority practise African Traditional Religion (ATR), while a few are Christians. The fact that the majority of the participants practise ATR is important for this study, which is premised on the Ndau traditional beliefs and practices in light of HIV and the AIDS scourge. In any case, traditional leaders are the principal religious functionaries in African Traditional Religion, from which the study examined some traditional practices in relation to their role in the transmission of HIV.

The study shows that all study participants are literate; the majority attended school up to Standard 6. Some went up to the secondary school level, and one of them holds a degree. That participants are literate is significant – their social status is high, and for the study − they are able to read, understand and complete (though slowly) the questionnaires given to them.

Of all the participants in the study, the majority are gainfully employed, entrepreneurs or engaged in some form of work, while only a few are unemployed.

For the study, this meant that it was difficult to find time to engage with them in the research, as the researcher had to fit within their tight schedules. Weekends were their busiest days. Quite often, they would be presiding over traditional courts, dealing with various issues in their communities, except in a few instances, when they were free to attend sessions for this research. The economic status of the participants is, therefore, good for the study since they willingly participated without expecting any remuneration. While this may be contested, providing data out of genuine willingness to share an opinion imbues it with unparalleled credibility compared to data given based on what one gets from it, which risk that they are given to please the researcher.

This section shows that traditional leadership in the Chipinge District is predominately patriarchal and involves elderly men in the society, even though in some provinces of the country, there are now female chiefs and headwomen. Most respondents are monogamously married with a few still involved in polygamy. This

shift in marriage patterns by the elderly in society is a strong message in the fight against HIV infection. Sticking to one faithful marriage partner keeps one safe from HIV infection, and there could be no better way to spread the message to the youth than to be exemplary in the elders' conduct and marriages. The fact that all participants have completed school, albeit at different levels, meant that they were able to read and complete the questionnaires, which, for purposes of communicating with them and being fully understood, were translated into the Ndau language. The majority still practise ATR, which renders further value to this study as the Shona traditional practices are the bedrock of this study, especially when viewed through the HIV and AIDS pandemic lens. Above all, the demographic information, especially the socio-economic status (SES) of the participants was helpful in the study. It ensured that the right participants participated, and data collected was in and from the proper context (Marashe 2014:4-5).

4.2.2 Demographic data for the rest of the participants

This section is an extension of the one presented above. The section presents findings on the demographic information of the remainder of the sample of participants. They include health professionals, educators, traditional healers and the elderly in the communities, where the researcher carried out the research. This section, however, presents only findings different from the ones presented above, to avoid repetition.

4.2.2.1 The participants' age

The study shows that most of the participants are mature. Their ages range from 25 years to well above 46 years. Like in the traditional leaders' category, male participants are more than their female counterparts in number. The reasons for this gender imbalance are multi-faceted. A considerable number of prospective female participants were too busy with their daily chores to spare time either for interviews or completing a questionnaire. For instance, female traditional healers' low turnout was because of their demand for payment before participating in the study. They argued that participating was wasting valuable time they could otherwise be busy with a paying client, and not in research that 'benefits you alone'. The researcher had not made any provision for paying interviewees or questionnaire respondents in the research budget. Furthermore, the researcher did not want to compromise on

acceptable research standards; study participants had to participate willingly and not because they expected a reward.

Other female would-be participants were sceptical about the researcher's presence in their communities at a time, when there was so much tension in the political landscape. Political parties were campaigning in preparation for the harmonised presidential and parliamentary elections of 31 July 2013. They were afraid that political activists might victimise, assault and harangue them for interacting with a 'stranger in the guise of a researcher'.

A lot more were not interested in participating, when they learnt that the researcher was just a University of Pretoria student carrying out a study on cultural practices and beliefs, and not registering anyone for 'division'[55] or a food-for-work programme. Thus, they preferred to attend political gatherings, where the attendance register thereto also served as a food[56] distribution list by the ZANU (PF) activists who had assumed the role of social welfare officers.

4.2.2.2 Participants' marital status

Comparable to the traditional leadership section above, the study shows that most participants, except traditional healers, are married and very few of them were either, still single, widowed or divorced *by the time the researcher carried out this research*[57]. Most traditional healers are living in polygynous marriages, and one of them, in the Chisungunye village to the south of Zuzunye area under Chief Muzite, has as many as 13 wives[58]. Perhaps, this finding is significant in the study that aimed to examine the Shona traditional practices and beliefs at a time when HIV infections and AIDS pandemic are wreaking havoc generally in Zimbabwe and specifically in

[55] 'Division' is a corrupted term derived from World Vision, a Non-Governmental Organisation that gives food handouts in the impoverished communities of the Chipinge District. Most elderly people in the communities could not pronounce the full name and just called it 'division'.

[56] Food included but was not limited to maize, sugar beans, *Matemba* or *Kapenta* fish, and soya beans, cooking oil or mealie-meal from either the Government of Zimbabwe or Non-Governmental Organisations. The local ZANU (PF) officials normally hijacked the food distribution exercise and used the occasion to campaign for votes, and discriminate against opposition party members getting any food at all.

[57] Emphasis added in recognition of the fact that participants who were single then may be married by now, and widow(s) or divorcees may have remarried, or nothing changed at all.

[58] The traditional healer had 36 children of whom 17 were females, and the rest were boys. He admitted not knowing all children by name and got the correct names from the mothers when the researcher probed him, if he knew all his children by name.

the impoverished rural communities in the Chipinge District. As a socio-cultural institution, marriage is sacrosanct, and consequently, the Shona people in the communities, where the researcher carried out the study in the Chipinge District, treat married men and women with respect. Many societies regard the institution of marriage as a socially recognised rite for the genesis of the family unit – another important social institution responsible for churning out socially and morally upright citizens as well as perpetuating family lineage. The fact that the majority of the participants are either in monogamous or polygynous marriages demonstrates that the marriage institution, as a socio-cultural practice is alive. As such, the researcher may argue that marriage in itself may be one of the ways at the disposal of the communities to minimise the possibilities of HIV infection. This argument remains valid, provided the partners in marriage remain *religiously faithful to each other throughout their whole lives* (e.a.)[59]. The researcher argues so in recognition of the fact that extramarital and unprotected sexual relationships, among a host of other factors, in either monogamous or polygynous marriage, expose the couples to HIV infection.

4.2.2.3 Participants' literacy levels

Analogous to the section on traditional leadership above, the study indicates that all participants are literate. A few and the most elderly among them attained education ranging from the basic Standard 1 to Standard 6. The majority of participants had studied for either a certificate or a diploma in their areas of speciality (educators, school administrators, doctors and nurses), while a considerable number were degreed university graduates. This moderate to high level of literacy is significant in this study.

The study participants' ability to read and understand the questionnaire as well as writing were crucial to the data-gathering process of this study, which sought to examine the interface between the Shona people of the Chipinge District's traditional beliefs and practices, and the HIV and AIDS epidemic. Reading, understanding and writing were cardinal in responding to the questionnaire, while comprehension of questions was important in extracting the best answers out of the interviewees.

[59] a.e. ~ emphasis added.

Above all, the research participants' ability to express themselves either in writing, in response to questionnaire tasks, or orally during the interview sessions, made it easy to categorise information during data transcription and coding exercises. Thus, the research participants' moderate to high literacy levels were significant to the success of data gathering process, coding and categorisation. They made coding and categorisation of data tasks easy to accomplish.

4.2.2.4 Religious affiliation

Unlike in the traditional leadership section discussed above, where most participants indicate that they practise African Traditional Religion, the rest of the respondents, as the study reveals, are practising Christians. This divine attribute gives the study the right impetus and sound grounding as it sought to unravel the stamina of the traditional practices and beliefs of the Shona people in the Chipinge District in a socio-cultural terrain that the HIV menace has, and is continuously invading. Most participants, even Christians, have had an experience in the traditional practices of the people and shared some of the beliefs. One elderly cleric at Chikore Mission, run by the United Church of Christ in Zimbabwe (UCCZ) concurs (personal communication 12 December 2012):

> *Tsika nemagarire echiandhu kana ChiNdau tinomaziya. Takakuriremwo, apana chitsva chetisingazii. Takatozozvisiyawo hedu taone kuti kuna Jesu mwanakomana waMwari mupenyu uye wakafire zvishaishi zvedu pamuchinjiko.*
>
> (Translation: We are knowledgeable in the Ndau cultural mores. We grew up practising them, and there is nothing new. We left for Christianity after realising that there is Jesus, the Son of the Living God, who died for our sins on the cross.)[60]

[60] Consider this revelation from a member of the UCCZ church in relation to another discussion with a traditional healer further in this chapter, who indicated that his clientele base included government ministers, pastors and elders of different churches, who consult him for strength and consolidation of power in their positions of authority.

Perhaps, this citation summarises the influence of the Shona traditional mores on some members of the Christian community in the Chipinge District, and elsewhere in the country. This implies that all participants in the study, Christians and non-Christians, had the requisite background knowledge about Shona traditional practices and beliefs necessary for this study. The researcher had assumed prior to conducting the study that participants have some knowledge about HIV transmission and the AIDS pandemic. Information on these twin dangers cuts across the religious divide, and is available and accessible to all.

The study shows that the demography of the participants is appropriate for this study. Their socio-cultural and religious background mean that they have a firm grounding to provide precious and valuable data on the Shona traditional beliefs and practices, and the influence of the HIV and AIDS pandemic on the same. Having discussed the appropriateness of the study participants by unlocking the details of their demographics, the report now presents the findings on their perceptions concerning the causes of the HIV menace.

4.3 Perceptions regarding the causes of HIV transmission and the AIDS pandemic

This section presents information gathered on the misconceptions (if any) the Shona people in the Chipinge District have on and insights about the HIV and AIDS pandemic. This information is significant because it influences the conclusions and recommendations of the study.

4.3.1 Definitions and causes of HIV and the AIDS pandemic

Using the questionnaire and the interview, the survey asked a set of questions to garner information regarding participants' knowledge about HIV, the AIDS scourge and their causes. These questions were significant in that the researcher was able to infer the impact of the Shona traditional beliefs and practices regarding societal health matters, and indigenous thought patterns, embedded in traditional or indigenous knowledge systems. This report evolved the questions hereunder into a theme, definition and causes of HIV, and the AIDS scourge because data shows that, in defining or explaining what HIV or AIDS are, some participants highlight the causes of both the virus and the disease. Thus, their definitions and the causes are inextricably intertwined. Other responses, however, show a clear distinction of the

issues at stake, and the researcher presents them accordingly. The questions the researcher asked were:

- What is HIV?
- What is AIDS?
- What do you think are the major causes of HIV and AIDS in your community?

The participants give different definitions of HIV and AIDS. Not paying particular attention to the differences between the virus and the disease, some of the participants, mainly traditional healers, traditional leaders and most elders define AIDS as *richirana* or *runyoka*[61]. *Richirana/runyoka* is a type of a sexually transmitted disease believed to affect a man who has sexual intercourse with a woman who has just given birth. One traditional female healer puts it succinctly:

> *Mukondombera*[62] *chirwere chinonzwi richirana, zvinoronze kupindire mukadzi une mwana mudoko; nendwara dzinobva, nebvudzi rinoerera; kana kuti wadusa pamuiri woata naye usikazvizii; unokotsora weisefeka*.[63]
>
> (Translation: AIDS is a disease got by having sex with either a woman who has just given birth; even fingernails pull off, and hair becomes thin and slippery; or unknowingly, having sex with a woman who has had an abortion; you develop a bout of a severe cough and lose weight).

[61] Runyoka is a chronic sexually transmitted disease that people believe is caused by traditional charms or magic. Men use the charms or magic to 'fence' their wives against extra-marital sex without their knowledge (Dewah & Mutula 2014:215). If the woman has sexual intercourse outside marriage, she and the man's genitals get stuck and lock, and the two love-birds will not be able to separate until the rightful husband comes to 'unlock' them. In some cases, the man would have his genitals or stomach swollen, lose weight and eventually die, if he fails to seek traditional medication.
[62] Simmons (2009:233) defined it as a "stubborn disease that will not let go once it gets hold of you".
[63] P 3: Traditional healers.txt - 3:5 (11:13) (GUEST) Codes: [HIV/AIDS definition: richirana | a disease caused by prostitution]

The other respondents define it as an assortment of sexually transmitted infections (STIs) left untreated for a long time[64], or a collection of many diseases due to deficiency of body soldiers.[65] These perceptions and understanding are similar to Simmons' (2009:233) "*bumbiro rezvirwere"* (a group of different diseases that begin to manifest themselves at the same time), which he established in a study about traditional healers' understanding of indigenous names of HIV and AIDS in the suburbs of Harare, the capital city of Zimbabwe. Some erudite participants such as teachers and the health personnel correctly define AIDS as Acquired Immuno Deficiency Syndrome.[66] They define HIV as a human immune virus,[67] while most elders refer to it as 'a virus that causes AIDS'.

Regarding the causes of HIV infection, some of the participants claim that sexual intercourse with an 'unclean woman' is the cause of HIV infection or transmission. One participant states HIV is a consequence of:

> …having sex with a woman who has just given birth, is menstruating or has aborted….She will be unclean, and that causes this kind of diseases.[68]

Thus, the Shona people in the Chipinge District believe that women are 'dirty' during their menstruation and, therefore, too 'unclean' to engage in sexual relations. Once people break this prohibition or taboo, the result is infection by a disease that is hard to cure, and accordingly, they think it is HIV. The concept of 'uncleanliness' is linked to what Moyo (2009:40), corroborating Simmons (2009:232), refers to as 'pollution'. It is 'pollution' because it causes sickness as a result of dirt or impurity. In the traditional worldview, people perceive 'pollution' as a source of illness. They link 'pollution' to ritual impurities that are customarily associated with death, the

[64] P 3: Traditional healers.txt - 3:3 (8:9) (GUEST) Codes: [HIV/AIDS definition: assortment of STIs not treated for a long time]
[65] M 20 1(b) AIDS is a collection of many diseases due to deficiency of body soldiers. In full, it is Acquired Immuno Deficiency Syndrome.
[66] Code: AIDS definition: acquired immune deficiency syndrome {20-0}. Note, the number, 20 denotes the frequency participants define AIDS as such.
[67] Code: HIV definition: human immune virus {13-0} Note: the bracketed number, 13, denotes the frequency with which the code is mentioned by participants.
[68] P 3: Traditional healers.txt - 3:7 (14:16) (GUEST) Codes: [Causes of HIV/AIDS::sex with an 'unclean' woman].

reproductive system, the violation of sexual prohibitions and the breaking of taboos. Therefore, the people abstract and catapult the concept of 'pollution' in relation to time and space, to address contemporary health concerns. Since 'pollution' was a cause for sexually related problems of yesteryear, the Shona people in the District of Chipinge, are, by association, attributing the HIV infections and AIDS to it.

4.3.2 The role of witchcraft and ancestors in HIV transmission and the AIDS pandemic

The premise of this sub-section was the dominant Shona philosophy bordering on the belief in witchcraft and the malevolence of ancestral spirits expressed in the proverb, *chiripo chari uraya, zizi arifi ngedutu,*[69] (translated literally: something has killed the owl, it cannot just be the wind). Accordingly, nothing in the lives of humankind happens without a cause. Guided by this Shona maxim, and aiming to determine the interface between the participants' beliefs in witchcraft and the malevolence of ancestral spirits in light of the HIV menace and the AIDS scourge, the study asked the following questions:

- Some people believe that HIV & AIDS is a punishment by angry ancestors. What is your comment on this belief?
- Other people believe that witches can infect people with HIV through witchcraft. What is your opinion on this claim?

The study reveals that ancestral spirits' malice does not cause AIDS.[70] One of the participants responds thus:

> It is not a punishment; it is all about behaviour: If one is unfaithful and has affairs with more than one person, having sex with these people, maybe one of the people is infected and might cause all to be affected too, so it is not a punishment, it is all about behaviour.[71]

[69] *Dutu* is an Ndau word meaning 'wind', and its *Zezuru/Karanga* equivalent is *mhepo.*
[70] Code: AIDS and ancestors: do not cause AIDS {33-0}.
[71] P 1: Participants' responses.txt - 1:836 [G 8 4 It is not a punishment...] (1707:1710) (Super) Codes: [AIDS and ancestors: do not cause AIDS] [results from promiscuity].

The citation above clearly demonstrates the belief that unfaithfulness and having multiple sexual partners exposes people to the risk of contracting HIV, and later on AIDS. Other participants, also maintaining that there is no cause-effect relationship between angry ancestral spirits and HIV transmission and AIDS, argue that AIDS is acquired – thus, one takes an initiative that results in one being infected. Because of this, ancestral spirits have no role in somebody getting HIV infection. Furthermore, other participants state that it is unlikely that ancestors cause HIV infection as they did not know it, and neither could they invent the virus. While in agreement with the assertion of ancestral spirits' malevolence, one participant states, "…. Ancestral spirits may punish by other means, *not by AIDS* [infection]," (my emphasis).

However, a few participants believe that ancestral malice causes HIV infection. The few participants state:

> Angry ancestors cause someone to have sex licentiously, and without taking great caution for prevention against sexually transmitted diseases, and be infected.[72]

Another participant corroborates the expressed perception by adding that:

> …our strict tradition asserts that there is always a cause for misfortunes befalling anyone in a family. They believe the avenging ancestors lead you into that trap of HIV and AIDS. Why do you get HIV and not others?[73]

However, the majority of the study participants point out that "having sex with an infected sexual partner"[74]causes HIV infection. For instance, 16[75] research participants single out unprotected sex as the reason for infection, and 6 of these are more specific than others. They state unprotected sex with infected persons, among

[72] P 3: Traditional healers.txt - 3:10 (21:22) (GUEST) Codes: [Causes of HIV/AIDS::ancestor's malevolence]
[73] P 1: Participants' responses.txt - 1:822 [B 33 4 Of course, our strict t..] (1678:1681) (Super) Codes: [AIDS and ancestors::lead people into a trap of HIV infection]
[74] P 3: Traditional healers.txt - 3:9 (20:20) (GUEST) Codes: [Causes of HIV/AIDS::sex with an infected partner]
[75] Code: AIDS causes::unprotected sex {10-0} and Code: AIDS causes::unprotected sex with infected person {6-0}. Note, the bracketed numbers indicate the frequency the codes recurred.

others, is the chief cause of HIV infection and transmission. One such research participant summarises the responses by others by stating that:

> The primary causes of HIV and AIDS are unprotected sex with an infected partner, low male circumcision, and low use of condom in long-term relationships, cultural and religious practices and spousal separation.[76]

This statement shows that there are several other causes of HIV transmission, though minor in degree.

On the role of witchcraft in HIV infection, the study results indicate that respondents feel that witchcraft has no role in the spread of HIV infections or the AIDS pandemic. The majority of participants dismiss entirely the insinuation that witchcraft might have a hand in the spread of HIV as stated hereunder:

> This is not true, for HIV/AIDS is acquired, and therefore, a witch cannot cause AIDS. One can be given an evil spirit to drive him/her to be in situations that one gets HIV/AIDS.[77]

A few participants observe that while witchcraft might not directly cause HIV infection, it acts as a spell, and leads people to choose sexual partners who would infect them with HIV. In this line of thinking, witchcraft acts as a catalyst to HIV infection and not as an agent of causation as indicated in the participants' collective statement, "Witches cause misfortunes, for instance, if there are 10 women, why not choosing the uninfected from the 10?"[78] The role of witchcraft in this instance is latent and not defined. Thus, while it may not be responsible directly, it presents an environment in which, under the spell of witchcraft, people themselves may indulge in inappropriate behaviour, and get the HIV infection.

[76] P 1: Participants' responses.txt - 1:756 [C 9 2 The major causes of HIV ...] (1549:1551) (Super) Codes: [AIDS causes::unprotected sex with infected partner] [spousal separation]
[77] P 1: Participants' responses.txt - 1:818 [S 30 3 This is not true for HI..] (1668:1670) (Super) Codes: [AIDS and witches::witches do not cause AIDS]
[78] P 1: Participants' responses.txt - 1:815 [S 26 3 Witchcraft does not inf..] (1661:1662) (Super) Codes: [AIDS and witches::witches do not cause AIDS] [cause misfortunes]

The study also identifies sexual promiscuity by the youths, the unmarried and the widowed, and unfaithfulness in marriages as the primary drivers of HIV infections and the AIDS pandemic. Participants, particularly traditional leaders, identify the proliferation of beer-halls at the Growth Points dotted around the Chipinge District, and at business centres such as Mundanda, Chako, Pfidza, Tanganda Halt, Chibuwe, Rimbi (Chibunji), Checheche and Chisumbanje, and the high consumption of *chikeke* (locally brewed beer)[79] as some of the causes for the spread of the HIV. They argue that when drunk, people forget their morals and indulge more freely in immoral activities, including sexual promiscuity. Therefore, alcohol abuse and drunkenness are responsible for sexual promiscuity, which may subsequently lead to infection and spread of HIV. Besides, and as mentioned above, the likelihood of infection is high when one of the sexual partners is HIV seropositive, and then engages in unprotected sex.

It was apparent during the interviews that the participants view alcohol abuse or drunkenness as one of the major reasons for unfaithfulness in marriages and relationships in general. They premise their argument on the assumption that once people get drunk, they are bound to cheat on their spouses or sexual partners, irrespective of whether they are married or just dating. A sizeable number of interviewees point out:

> *…kana vadakwa vanonga vaanechidengu, zvekuti vanonga vasikachakheti wekuata naye; chero wevandoona*[80]
>
> (Translation: …When drunk, they [people] will have a high libido, such that they will not choose sex partners; they will have sex with anyone who comes their way.)

[79] The problem with locally brewed traditional beer is that its alcohol content is unknown.
[80] Fieldwork Diary notes at Headman Chindezwa's court, in Muzite village, which falls under Chief Gwenzi's jurisdiction, 15 January 2012.

Another aspect of unfaithfulness highlighted during the interviews is that of extra-marital affairs, caused by long periods of spousal separation. Probed to explain why this is a serious issue in the impoverished rural communities of the Chipinge District, the study participants cite working in South Africa as a contributory factor:

> *maJoni-joni*[81] *anosiya vakadzi uneno, vopetuke Joni kwaakuriyarwa kuti vakasiye vakadzi. Ngendaa yenzara yekude vamuna, vakadzi vanopedzisira voohura nevamuna, vamweni, vatori nemizi yavo*.[82]
>
> (Translation: The young men work in South Africa and leave their wives behind when they go back to work and stay away for a long time without coming home, forgetting that they left their wives. Because of the desire for sex, the wives end up having sexual relations with men - some of whom have their families).

At face value, the issue of extra-marital affairs should not be the major cause for HIV infection. However, with both the HIV and the AIDS scourge wreaking havoc in society and sparing no one, it may be justified to suggest that extra-marital affairs are a recipe for disaster. With the women's lack of capacity to compel condom use during sex, perhaps because of the way they are socialised when growing up, they are vulnerable and at high risk of infection. Thus, they risk contracting not only sexually transmitted infections (STIs), but also the HIV, which they pass on to their husbands, some of whom only come home from South Africa once a year − if they come at all. Alternatively, because of their extended stay away from home, which constitutes spousal separation, the men are even more likely to engage in extra-marital affairs, having one or several 'girlfriends' where they work and contract STIs or HIV, which they pass on to their unsuspecting wives when they come back home,

[81] *Joni* is a term that refers to South Africa, and *maJoni-joni* refers to young men who go to search for and work in South Africa.
[82] Fieldwork Diary notes, 18 December 2011, at Headman Murenje's *dare* (court), in Chief Musikavanhu's chiefdom.

especially during the Easter or Christmas holidays, or the annual shut-down in December.

Thus, while the participants identify unprotected sex with an infected sexual partner as one of the major causes of HIV infection, it is worth recognising that there are peripheral causes too. Viewed holistically, the study shows participants' perceptions about the causes of HIV and the AIDS scourge. In their view, and for various reasons, *chihure* (sexual promiscuity), which results from unfaithfulness in relationships (pre-marital) or extra-marital affairs (post-marital), with an infected sexual partner, causes the deadly HIV infection. This is important to note considering the fact that approximately 90% of HIV infections in Zimbabwe occur through heterosexual contact (UNAIDS & WHO 2002 cited by Duffy 2005:23).

4.3.3 Symptoms of AIDS

To understand the perceptions of the Shona people of Chipinge regarding specific features of AIDS infection, the study posed the following question:

- What symptoms are shown by someone suffering from AIDS?

Many participants identify loss of body weight[83] and vulnerability to opportunistic infections[84] as the major symptoms exhibited by a person who has AIDS. Some of the symptoms stated by participants are:

> Skinny bodies, red lips, frail and thin hair, loss of appetite, demoralisation … [and] … poor healing of the body, constant physical pains and weakness of the body."[85]/[86]

[83] Code: AIDS symptoms::loss of body weight {14-0}
[84] Code: AIDS symptoms::vulnerable to diseases {3-0}
[85] P 1: Participants' responses.txt - 1:1117 [S 16 10 Skinny bodies, red lip...] (2144:2145) (Super) Codes: [AIDS symptoms::loss of body weight] [appetite loss] [falling hair
[86] P 1: Participants' responses.txt - 1:1097 [C 35 10 Poor healing of the body...] (2110:2111) (Super)

This finding is significant when viewed within the context of a traditional society, whose traditional beliefs on spirit possession are intact, and whose spirit mediums exhibit similar symptoms before possession. This study argues that the belief in spirit possession and mediumship may have a bearing on how the community responds to HIV infection, mutation, transmission and the AIDS pandemic.

4.3.4 Diagnosis of HIV and AIDS, and other diseases

Related to the symptoms of HIV infection and the AIDS scourge is the diagnosis. The researcher asked participants, especially traditional healers, the following question:

- How do you diagnose that a patient has HIV or AIDS, and other diseases?

The responses on this issue yield some interesting results. Some of the responses border on nostalgia, and perhaps, the mythical. Some of the participants (traditional healers) indicate that they diagnose the presence of HIV, AIDS or any other illnesses by casting lots, and it is 'revealed' to them after an invocation to the alien or ancestral spirits who possess them. One traditional healer states:

> *Pakutshaye hakata zvinobuda, uye kuringidza. Ndinoronzere murwere kuti aende kuchibhedlera. Uye vazhinji vanobhuya vega kuti vanehosha.*[87]
>
> (I diagnose by casting lots and inquiring, or revelation from ancestors. I then refer the patient to go to the hospital. Furthermore, most patients disclose their illness to me).

Interestingly, other traditional healers point out that they diagnose the illnesses by examining the patient using their naked eyes and experience:

[87] P 3: Traditional healers.txt - 3:24 (45:47) (GUEST) Codes: [Diagnosis::casting lots | consulting ancestors] [referring patient to hospital]

Tinoone view *yake – madziso anotsvuka, kurambe kurya; unonga eidakarire chingwa nehuku, asi aaryi. Tsvina yake inenge iri yelo uye nhengo dzemuiri dzakakosha dzinenge dzeirwadza.*[88]

(Translation: We examine [the patient] closely – eyes are red, loss of appetite; the patient may desire to eat bread or chicken, but does not eat. His /her faeces are yellowish and has painful genitals).

The implication of this quotation is that traditional healers reinterpret what they see to determine the nature of sickness one might have. They make use of the 'unusual body appearance' (symptoms of illness; for instance, red eyes, loss of appetite and so forth) as well as their experience and knowledge of symptoms of illnesses, gained over the years, to determine the nature of sickness one has.

4.3.5 Cure for HIV, AIDS and other illnesses

The questions for cure or treatment of AIDS were as significant as the ones on symptoms and diagnosis. The researcher asked the questions on AIDS cure with the aim of establishing the Shona people's beliefs and the trust they had on the traditional health delivery system in general and mainly if they believed that AIDS was curable. The researcher asked the first question to the traditional healers, who are the guardians of the traditional health delivery system and the second and third ones to the general people in the research sample, who, perhaps, occasionally received health services from traditional healers. The questions are:

[88] P 3: Traditional healers.txt - 3:27 (52:54) (GUEST)
Codes: [Diagnosis::red eyes] [loss of appetite] [painful genitals]

- How effectively can your healing methods cure AIDS?
- Headaches and stomach pains are curable. Do you think HIV or AIDS is curable?
- In what ways may traditional healers help a person who has AIDS?

These questions, though asked to different sets of participants in the sample, were, in fact, asking for the same information, that is, the availability of a cure for AIDS. The researcher did not ask participants a direct question such as "Is there a cure for AIDS?" the rationale being the need for them to elaborate their answers, rather than giving short "Yes/No" responses.

Most traditional healers believe and expressly state that they could cure HIV or AIDS, though with difficulty. Probed further on a related question about the availability of a cure for HIV or AIDS, one traditional healer explicitly says:

> *Mushonga uriyo – mushonga wacho ibinda-wapinda, nenjuzu yemugato – zvinonyanye kushandiswa ngeveZINATHA*[89]*.*
>
> (Translation: There is medication - *binda-wapinda* (getting in anyhow) and *njuzu yemugato* ('mermaid' of the thicket) mostly used by healers in ZINATHA).[90]

However, some of the participants unequivocally refute the above-stated claims of an HIV or AIDS cure by their colleagues. One of the most popular traditional healers in Chisungunye area (near Zuzunye village) points out:

[89] P 3: Traditional healers.txt - 3:17 (30:32) (GUEST) Codes: [Cure for HIV and AIDS:: yes, some traditional herbs can cure AIDS]

[90] ZINATHA is an acronym for Zimbabwe National Traditional Healers Association – a body that represents traditional healers in Zimbabwe, and to which all traditional and faith healers must be affiliate members (Rutherford 1999: 93)

Akusati kwaane mushonga unorapa, asi vechiyungu, ngekuti vanemichini inoongorora ropa.[91]

(Translation: There is no medication yet; maybe in hospitals, since they have the machinery to test blood).

Thus, as the study shows, and in harmony with similar contemporary medical studies globally, HIV and the AIDS scourge are not yet curable. However, the pathogens could be stopped from multiplying, if anti-retroviral treatment (ART) is administered.[92]

Nonetheless, a handful of the participants believe that there used to be a cure for AIDS in the past, when the youth used to listen to their elders' instructions. However, it has become more difficult to contain since the society in general and the youth, in particular, are behaviourally wild, morally bankrupt and disobey elders' instructions. A concerned elderly participant laments:

Siki ineyi pamazuwa apera yairapika ngekuti vana vaiya nenzee; zvinezvi avachina naimwe, saka kupera kwayo kunonesa.

(Translation: In the past, this sickness used to be curable because the youths were amenable and obedient to advice; nowadays the current generation of youths are arrogantly adamant in their lost ways such that curbing the spread of HIV is an insurmountable task). [93]

This perception of the HIV and AIDS menace demonstrates a clear misunderstanding of the nature of the virus and the disease that HIV and AIDS are. It is a misconception because HIV and AIDS were never a problem in the past, until in 1985, when the Zimbabwe Ministry of Health and Child Welfare confirmed the first AIDS case. Therefore, to say that 'it used to be curable' is a myth and a misrepresentation of what HIV and AIDS are. It might be a mental projection of a

[91] P 3: Traditional healers.txt - 3:14 (26:27) (GUEST) Codes: [Cure for HIV and AIDS:: no cure yet | hospitals do blood tests]
[92] P 1: Participants' responses.txt - 1:872 [Diseases are not curable as it…] (1764:1766) (Super) Codes: [Curability::incurable]
[93] P 3: Traditional healers.txt - 3:18 (33:35) (GUEST) Codes: [Cure for HIV and AIDS::not curable]

once problematic outbreak of a sexually transmitted disease, which the traditional healers managed to cure, and not the current strand of HIV ravaging the communities under study. However, what is significant in their wrong perception is the realisation and conclusion that the pandemic is not curable. This inference might, perhaps, make the community and particularly those who are more at risk to be more morally vigilant when it comes to issues related to HIV and AIDS.

On the question of whether traditional healers themselves could provide medication for the pandemic, most participants affirm that they cure AIDS, while a few admit that they cannot treat the disease. One traditional healer admits unequivocally thus:

> *Tinombotseya-tseyawo ngemitombo kuti aone kugume kuchibhedlera".*[94] (Translation: We prop up by our herbs to enable the patient to get to the hospital).

The study established that traditional healers do not cure AIDS. A sizeable number of participants point out that the best traditional healers could do is to provide herbs or medicines that reduce pain.[95] Some of the participants state that traditional healers help:

> …by treating diseases, the person suffers from and administering herbs that reduce signs and symptoms of illness and pain.[96] However, it does not help for long. Many diseases attack the person every time, and no one can treat a person at such a rate …; they cannot cure the disease for real.[97]

Therefore, the outcome of the study does not support claims by some traditional healers about their ability to cure HIV and AIDS. Such a finding resonates very well with similar studies elsewhere.

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[94] P 3: Traditional healers.txt - 3:33 (60:61) (GUEST) Codes: [refer to hospital] [Treatment::Yes]
[95] Code: Traditional healers and AIDS::provide herbs, which reduce pain {15-0}
[96] P 1: Participants' responses.txt - 1:953 [M 22 7 By treating diseases, t...] (1909:1911) (Super) Codes: [Traditional healers and AIDS::provide herbs, which reduce pain]
[97] P 1: Participants' responses.txt - 1:951 [M 14 7 Traditional healers may...] (1906:1907) (Super) Codes: [Traditional healers and AIDS::provide herbs, which reduce pain]

4.3.6 Traditional healers' methods of treating other diseases

Within the HIV and AIDS traditional healing milieu, the study sought to establish, if traditional healers did not expose themselves to HIV infection. To access this information, the researcher asked a question that required traditional healers to explain the process of healing other diseases in general and *chitsinga*[98] (magical projectile) in particular. Their detailed responses are full of clarity and freshness of immediate experience. Some of the study participants states that they remove *chitsinga* (magical projectile) by *a* process called *kubvita* (extraction) thus:

> *Tinobvisa ngenyara – tinodzodze mushonga pandau yakhona, tocheka ngechisingwana, kwaakutodusa chitsinga.*[99]
>
> (Translation: We remove by hand – we smear medicine on the body part, we cut with a razor blade, and then extract magical projectile).

The study also reveals that few traditional healers use bloodletting or biting out, the tennis-ball or the *kurumika* process to extract *chitsinga* implanted into a patient's body, perhaps, through witchcraft. One of the participants describes the process thus:

> *NdinoGenzise murwere ngemvura inodziya. Ndotore mushonga unozwi munyamharadza kana dindimuziri. Ndinomudzodze mafuta eshato nemunyamharadza uya. Chitsinga chinoende kumhiri kwaakurumika. Kana kucheka ngechisingwana, kwaakukwee chitsingacho ngechithenisi.*[100]
>
> (Translation: I bath the patient with warm water. I smear the patient with a medicine called *munyamharadza* [i.e.

[98] Maxwell (1995:331) stated that *chitsinga (*plural - *zvitsinga)* refer to bones or charms placed inside someone's body by witches.

[99] P 3: Traditional healers.txt - 3:42 (80:82) (GUEST) Codes: [Chitsinga extraction::kurumika] [tennis-ball]

[100] P 3: Traditional healers.txt - 3:41 (75:79) (GUEST) Codes: [Chitsinga extraction::apply medicine] [kurumika] [tennis-ball]

one that destroys or annihilates], and oil extracted from python fat. The magical projectile goes to one side of the body and is extracted by *kurumika.* Alternatively, I cut an incision using a razor blade, and then extract projectile using a tennis ball).

An exegesis of some of the medicines traditional healers in the Chipinge District use led to a subtle finding, particularly as it relates to the healing of other illnesses. The word *munyamharadza*, one of the medicines used in the extraction of *chitsinga* (magical projectile) means 'destruction or annihilation'. Thus, its use is significant as it indicates the complete obliteration or removal of *chitsinga* (magical projectile) or the 'foreign object' that causes pain in the body. Perhaps, the application of yet another medicine known as *dindimuziri* (i.e. that which numbs) ensures that the patient feels less pain during the healing or 'operation' process since it has anaesthetic properties, which numbs the wound caused by incisions. Python-oil, extracted from python fat, possibly soothes the wound and prevents it from over dryness, thereby preparing it for quick healing. According to the Ndau people, a python is a sacred limbless reptile, usually associated with *mandlozi* (alien spirits of Zulu origin), which usually bestows their medium with hunting or healing skills. Perhaps, the use of python oil on a patient is an indication of good health after treatment.

4.3.7 Consistent consultation of traditional healers despite failures

The study further sought to determine the major reasons why people living with HIV or those sick with AIDS, and those who look after them, continue to consult traditional healers, even after consulting medical doctors. To find out more, the researcher asked the study participants the following question:

- Why do people living with HIV and AIDS continue going to traditional healers, even after consulting medical doctors or hospitals?

The study shows that the participants believe that people continue to consult traditional healers to try their luck for the cure of HIV infection or any AIDS-related

disease. Traditional healers reason that the visits are inevitable since hospitals and clinics sometimes only give patients sick with HIV and AIDS painkillers such as Panado or Aspirin because of the shortage of drugs. Such patients go for traditional healers' services also because they believe that they have been bewitched, or that they are under a spell of evil spiritual forces. They believe traditional healers could exorcise the evil spirits or the evil spiritual forces. Other respondents indicate that people consult traditional healers because of the fame some healers have in the communities where they reside. One participant reports that people continuously visit traditional healers because:

> *Vanonga veizwe mbiri yekupona kwevanonga varapwa pano*.[101] (Translation: They would have heard the reputation of the healer and how he cures the illness of those from those who would have come).

The sick and their caregivers consult famous traditional healers for a second opinion on a deadly health condition. The belief in witchcraft and negative spiritual forces drives the sick to seek the services of traditional healers, particularly in the belief that modern medical methods cannot treat witchcraft-induced sickness.

An online platform entitled “Culture of Zimbabwe”, affirmed the usefulness of traditional healers and traditional medicines. It argued that traditional herbs are used extensively for minor ailments and that traditional healers are highly esteemed "for their counselling skills, especially in treating psychological and psychiatric problems …."[102] Moreover, it is believed that there is no better time to seek traditional healers’ services than when they have a relative who has been discharged from the hospital, but who remains noticeably sick.

Accordingly, even after doctors introduced modern medicine, people did not stop consulting traditional healers. As Simmons (2012:10) described it, people consult traditional healers "to make sense of the changing and often unpredictable circumstances they find themselves in". Citing Chavunduka (1998), Simmons

[101] P 3: Traditional healers.txt - 3:59 (108:109) (GUEST) Codes: [Consultation after hospital::fame of healer]
[102] http://www.everyculture.com/To-Z/Zimbabwe.html [accessed 4 July 2013]

(2012:5) observed that scores of Zimbabweans in rural or urban settings still visit traditional healers "to ameliorate various afflictions – physical, psychological or spiritual". In fact, a sick person may first consult the traditional healer before going to the clinic or hospital, and when sickness continues, the ill person may go back to the traditional healer for medication. Barker (1959), a medical doctor who worked among the Zulu in South Africa, once conceded that when modern medicines fail to cure a sick person:

> …fond relatives [are prompted to] leave no avenue unexplored, which might lead to last-minute restoration of their sufferer's health (Barker 1959:104).

A healer of note, Philemon Matakura[103] (personal communication, 20 December 2011) adds that Christians and prominent people in society visit traditional healers clandestinely. Therefore, traditional healers are a vital cog of culture and society in the impoverished rural Chipinge District. They are the leading providers of healthcare in most of the rural and remote areas of the District, wherein they also reside.

The study has so far discussed the role of traditional healers and traditional medicine in the mitigation of HIV and the AIDS pandemic. It now turns to describing the role of traditional leaders in combating the HIV and AIDS scourge among the Shona people in the Chipinge District. The reason for this focus is that traditional leaders are significant stakeholders and custodians of traditional practices and beliefs, whose very existence is threatened by the HIV and AIDS pandemic. To this end, the next section highlights the roles of traditional leaders in combating the spread of HIV among the Shona people of the Chipinge District. It reproduces a section of the researcher's article published in *Verbum et Ecclesia* 35(1), (2014:6-7).[104]

[103] Matakura is an abridged form of Matakuran'ombembudziihata, which means one who can carry a/n cow/ox and use a goat as a cushion. Perhaps, the name signified the greatness of the healing power he possessed.

[104] Marashe, J. 2014, 'The African traditional religious landscape: An examination of the role of traditional leaders in the fight against HIV and AIDS in Chipinge, Zimbabwe', *Verbum et Ecclesia* 35 (1), 1-8, http://dx.doi.org/10.4102/ve.v35i1.871

4.3.8 Traditional leaders' role in the fight against the spread of HIV and AIDS

The following question was asked to establish the traditional leaders' roles in combating the spread of HIV and the AIDS disease:

- As custodians of culture, what do you encourage your community to do to avoid infection by HIV and AIDS?

The responses to the question show that the majority of traditional leaders encourage their communities to change their behaviour in order to win the battle against HIV infection and other STIs. What is clear from the focus group discussion (FGD) is that encouraging safe sex by using condoms has its problems, including a lack of knowledge on how to wear them, and that it is misconstrued as encouraging sexual indulgence among the youth. Furthermore, the FGD recommended:

> … *kudzibata mukurumba, ndookuti chirwere cheshuramatongo chiite chishomani. Vabude muzera vasasaamba ekuroorana vasikazi koozemenwa ngazi veshe.*
>
> (Translation: Avoiding prostitution reduces the spread of HIV and AIDS. Those who want to get married should have a blood test first.)

The traditional leaders point out that they often take advantage of crowds that are present at agricultural field days, traditional court sessions or when they are receiving food aid to warn them of the dangers of HIV and encourage them to be faithful to their spouses or sexual partners. To the youths, the leaders first encourage abstinence from any sexual activity before marriage and the use of condoms, if they are unable to abstain or control themselves.

Furthermore, Chief Mapungwana communicated that using his government-donated vehicle, he drives rape victims from his community to the hospital as soon as he receives a report of the crime so that the victim receives medical treatment immediately [ART] (Personal communication, 4 March 2012). He subsequently

ensures that his 'policemen' arrest the culprit with the assistance of the whole community before handing him over to the Zimbabwe Republic Police (ZRP) for incarceration.

Regarding the same issue, before sending the culprit to the ZRP, a headman of Chibuwe village orders him to pay reparation in the form of '*mwombe nemwana wayo'* (i.e., two head of cattle) to the family of the victim (Headman Mutorwa personal communication, 18 March 2012). The full wrath of traditional law is also unleashed on men who engage in extra-marital affairs. They pay the same compensation to the offended party. The headman argued that these measures are deterrent to would-be offenders because their families would ensure the youths and men are careful in whatever they do as '*mwombe nemwana wayo*' are beyond the reach of many in these remote, rural and impoverished communities.

Thus, the study shows that by being vigilant, assisting sexually abused victims and enlisting the help of, or by helping the ZRP to minimise sexually related crime; and encouraging abstinence and safe sex, traditional leaders are supporting their communities in trying to minimise the spread of HIV and the AIDS pandemic (Marashe 2014:6-7)

4.3.9 Participants' advice to people living with the HIV and AIDS pandemic

After establishing participants' perceptions regarding the causes of HIV and the AIDS pandemic, symptoms, diagnosis and cure of AIDS, a survey of traditional healers' healing methods, and repeated consultation of traditional healers' services, the study sought information regarding participants' advice to people living with HIV. The researcher asked the following question or its variants across the study sample:

- What is your advice to people living with HIV and AIDS in your society?

The rationale for asking this question was in recognition of the fact that after consulting a medical doctor or nurse at a hospital or clinic set-up, the latter gives the patient instructions on the times and frequency of taking the medication and what to or not to eat and drink. For instance, when patients are under antibiotic medication,

doctors strongly advise them against alcohol consumption, and fatty foods or milk. Invariably, doctors or nurses advise patients on how to take care of themselves during the period they are under medication and beyond. Thus, the above-cited question probed participants to explain the kind of advice they render to people whom doctors diagnose to be HIV seropositive or those sick with AIDS.

The study reveals that all sections of the respondents caution the sick to avoid alcoholic beverages, stop smoking, and desist from engaging in casual and unprotected sexual intercourse, especially with infected partners. Furthermore, the study participants caution married men, in particular, to exercise self-control and not engage in extra-marital sexual affairs. They state:

> *Vanhu ngavazvibate. Vaisa vanofanire kugutsikana ngevakadzi vavo; vakadzi vadoko kana vezera doko ava vanokupe eidzi.*[105]
>
> (People must exercise self-control. Men must be satisfied with their first wives; young women infect you with AIDS).

Above all, they warn men to be wary of young women, who could infect them with HIV. Most participants believe that younger women have a higher likelihood of infecting men with the virus that causes AIDS.

A sizeable number of traditional healers indicate that after exorcising evil spirits from the sick, they advise them to go to the hospital for further clinical treatment. The study further indicates that participants implore the sick to take their '*Mwari ndouyeyo'* medication (anti-retroviral [ARVs] drugs) regularly and at specific times. They advise that:

> *Ngaarambe echimwe maMwari ndouyeyo*[106] *aanenge apuwa, nguwa dzeshe …* [107](Translation: [Patient] must always take prescribed ARVs, and at the set times …).

[105] P 3: Traditional healers.txt - 3:63 (116:117) (GUEST) Codes: [Advice::exercise self-control] [no extra-marital affairs]
[106] '*Mwari ndouyeyo'* literally means 'God I am coming there'

'*Mwari ndouyeyo'* literally meaning 'God I am coming there', is a pseudonym given to anti-retroviral (ARV) drugs. As a *nom de guerre*, *'Mwari ndouyeyo'* conceals from the public the real identity of the medication prescribed by the doctor. In like manner, it conceals the reality that someone is on antiretroviral therapy (ART)[108]. This fictitious name may influence people infected with the virus or living with AIDS. On the one hand, the infected people may perceive the pseudonym as some form of ridicule. This kind of perception carries with it the ripple effect of stigmatising people who are living with, and affected by HIV and AIDS. Consequently, many people who may be in similar situations may not seek medication early, until it is too late for meaningful remedy. If they are brave to seek medication, they might hide it such that no one ever knows that they are on ART. They isolate themselves and conceal their statuses even from their family members. Consequently, the effect of such a scenario could be lack of family social and emotional support since family members might not know that one of their members is sick.

On the other hand, some people living with HIV or AIDS may access and use anti-retroviral (ARV) drugs without stress or shame. Riding on the power of euphemism, the people living with the virus or the disease may take advantage of the pseudonym to escape from the feelings of shame and embarrassment. In such cases, the pseudonym may perhaps work to the benefit of the people who are sick from AIDS or infected with HIV. In that jocular and social milieu, they might take their medication regularly, and at specific times. This could work to their advantage health wise. Therefore, depending on the perception a person living with HIV or sick from AIDS has, the pseudonym, *Mwari ndouyeyo*[109] might either make one isolate oneself in shame, and not take medication as prescribed, or might promote one to take the anti-retroviral medication on time and without any feelings of shame. The next sub-section presents the study's findings on participants' advice to members of the community affected by the HIV and AIDS pandemic.

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[107] P 3: Traditional healers.txt - 3:62 (114:115) (GUEST) Codes: [Advice::take medication on time] [no sex with infected partner]

[108] According to the World Health Organisation, the standard antiretroviral therapy (ART) comprises a combination of three antiretroviral (ARV) drugs that maximally suppress the HIV and stop the subsequent progression of HIV disease.

[109] Invariably, known as *Jehovah ndouyeyo*, i.e., God I am coming!

4.3.10 Participants' advice to people affected by the HIV and AIDS pandemic

In addition to participants' advice to people living with HIV and those sick with AIDS, the study probed their advice to the people affected by the presence of individuals living with HIV and AIDS in their families. The affected people among the Shona people of the Chipinge District include close family members and the relatives who take care of the sick. The study shows that the majority of participants advise those who are affected to take great care of their kith and kin that are living with either HIV or AIDS,[110] and not to discriminate or 'ill-treat' them. One of the participants states that:

> They should care for those who have HIV and AIDS as they do to other sick people who are not suffering from the HIV infection and AIDS.[111] …, and should not ill-treat the sick.[112]

Caring for people living with HIV infection and AIDS comes in several ways. As established by the study, the caregivers:

> …must take them to shows, games so that they feel comfortable… they must make sure that they are having energy-giving foods; they must help in the washing of clothes [*sic*].[113]

The suggestion given indicates the community's realisation that the affected should not only feel sorry for the people living with HIV infection and AIDS, but should spring into action to help them. They could do so by ensuring that they feed the sick, entertain them or take them to places of entertainment,[114] and give them nutritious foods. They could also help them with domestic chores such as laundry. Above all, they should collect their ARV drugs from the hospital, if they are bedridden. The

[110] Code: Advice to the affected::care for the sick {18-0}
[111] P 1: Participants' responses.txt - 1:1250 [M 22 13(b) They should care for…] (2416:2418) (Super) Codes: [Advice to the affected::care for the sick]
[112] M 6 13(b) They should take good care of the sick, and should not ill-treat the sick.
[113] P 1: Participants' responses.txt - 1:1247 [G 8 13(b) They must take them ...] (2407:2409) (Super) Codes: [Advice to the affected::care for the sick] [healthy diet]
[114] 'Shows' and 'games' are genres of entertainment.

issue of ‘shows' and ‘games' identified in the citation above borders on the realm of entertainment, which comes in various forms in the rural and poverty-stricken Chipinge District. The ill could attend sporting competitions in the schools nearby, traditional dance competitions or agricultural field day shows. In other words, the study suggests that the caregivers, as the affected, should be approachable, respectful and should provide a supportive family network. After the presentation of the findings and discussion on participants' advice to the concerned members of the community, the study focuses on how information about the HIV and the AIDS epidemic reaches them. The study addresses this concern in the next section.

4.3.11 HIV and AIDS information dissemination

The survey sought data for this part from a cross-section of participants that included the elderly, the traditional leadership in the community and health professionals. The study utilised multiple sources of data to ensure reliability, validity and richer data as well since two or three data sources are better than one. The survey asked two questions that were complementary to each other. From the sample, the researcher asked health professionals the question:

- How do you reach out to the community with information about HIV and AIDS?

To the rest of the participants, who included traditional leaders and the elders, the researcher asked thus:

- How do you get information about HIV and AIDS?

The study shows that responses from the two data sets complement each other in a great measure. The health professionals take advantage of the patients who visit the clinic for different medical reasons or related issues. Most of them explicitly state that they cascade the information about HIV infection and AIDS disease during:

> [The sick people’s] hospital visits; patients usually receive [HIV and AIDS epidemic] education before they get to the

> purpose of their visits. We also disseminate information during outreach sessions for anti-retroviral treatment supplies and extensive immunisation programmes.[115]

Thus, the health professionals target patients who visit the healthcare institutions for medical help and teach them about HIV and AIDS disease. The other set of participants corroborate the health professionals' submission. They indicate that they get information about HIV and AIDS "through trained personnel in hospitals, clinics and from magazines."[116] Alternatively, they get the information about the HIV and AIDS pandemic from the "health workers who visit the community"[117] on outreach programmes. Extended immunisation programmes are when nurses from the hospital or clinic move into the communities, on dates specified by the government through the Ministry of Health and Child Welfare to vaccinate children against diseases such as bilharzia, polio, tetanus and diphtheria. In each case, the community members either gather at schools, at the shops or mobile clinic venues for a variety of reasons, some of which are vaccination of children, baby clinics or receiving of food rations from donors. The health professionals take advantage of these gatherings to spread the information about HIV transmission and the deadly disease, AIDS, to patients.

Furthermore, the study shows that the health professionals make use of several other methods to reach out to the communities with information about the HIV and AIDS in the Chipinge District. Figure 4.1 provides a summary of some of the significant ways the health professionals use to cascade the information about HIV infection and transmission. Figure 4.1 also presents other means by which HIV information reaches the communities, and not necessarily through the health professionals.

[115] P 5: Health professionals.txt - 5:217 (478:481) [N13 8] Codes: [health education during outreach programmes] [Information dissemination::talk to patients who visit clinic]
[116] P 1: Participants' responses.txt - 1:1167 [C 35 12 Through trained person...] (2253:2253) (Super) Codes: [Access to HIV/AIDS information::hospitals] [clinics] [magazines]
[117] P 1: Participants' responses.txt - 1:1181 [M 34 12 Health workers visit t...] (2279:2279) (Super) Codes: [Access to HIV/AIDS information::health workers]

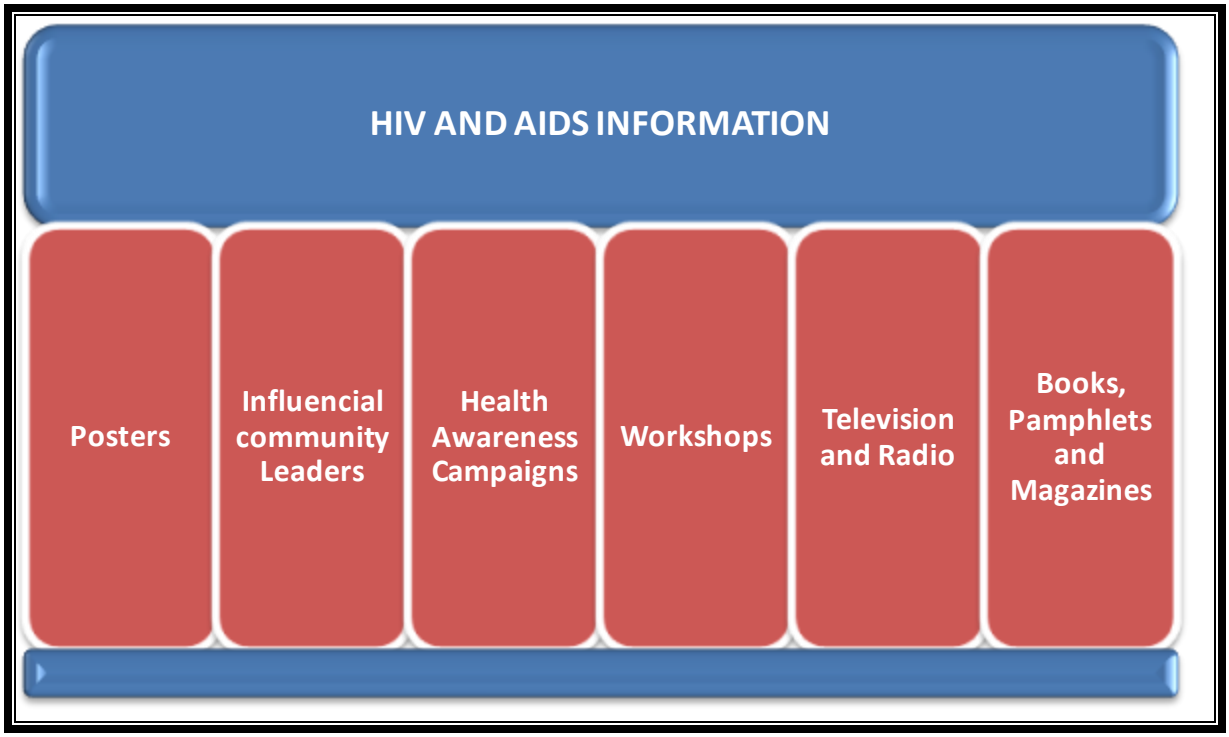

Figure 4.1 Ways of disseminating information about HIV infection and the AIDS epidemic

Depicted like a stack of books in a library shelf and red in colour[118], under a suitable section entitled HIV and AIDS INFORMATION, Figure 4.1 highlights some of the different ways ('books') by which information about HIV transmission and the AIDS disease reaches the Shona people of Chipinge. The means ('books') of cascading the information, which the study discusses hereunder include, but are not limited to posters, influential community leaders, health-awareness campaigns, workshops, and both electronic and print media.

4.3.11.1 Posters

Posters are a common feature at all the health institutions in the district, business centres and schools. In the context of this study, the posters the study refers to fall within the information category (Nunyenge & Esena 2013). They contain valuable information about the prevention of HIV infection and care, as Figure 4.2 shows.

[118] The colour of the 'books', red, taken after the colour used in HIV and AIDS awareness campaign materials. Therefore, like 'books; in a library shelf, anyone can borrow them and read on how HIV information reaches the people of the District of Chipinge.

Figure 4.2 Picture of a poster on HIV and AIDS prevention

The poster (Figure 4.2) contains information on the prevention of HIV and AIDS by encouraging faithfulness in sexual relationships.[119] The other posters champion the message of the prevention of the spread of HIV amongst the youth by encouraging them to avoid pre-marital sex, while others contain general facts about HIV and children as well as ways of preventing HIV infection (Appendices K and M). The posters show an overlap of information in HIV and AIDS prevention. Above all, other

[119] Related messages about HIV and AIDS prevention and care are shown in Appendices I and J. The use of condoms is emphasised in a dramatic manner (Appendix I), while peers or friends are given a voice to discourage husbands (and indeed wives) from being involved in extra-marital sexual relationships in order to curb HIV infections (Appendix J). The researcher used examples of posters from Mt. Selinda Mission Hospital in this discussion.

posters contain information about the benefits of taking HIV tests as shown in Figure 4.3 below.

Figure 4.3 Picture of a poster encouraging couples to test for HIV together

The picture of a poster (Figure 4.3) is significant. By encouraging couples to test for HIV together, it inculcates a sense of spousal unity, a culture of responsibility and self-respect. These aspects are a guarantor for the survival of future generations, and perhaps reducing new HIV infections to manageable levels by 2030 (UNAIDS 2014:6), one of the 8 key United Nations Millennium Development Goals (MDGs). The health professionals use posters because of their visual appeal. Posters are visually attractive to onlookers and capture their attention (Gobind & Ukpene 2014:741). Moreover, a large number of people from all walks of life can see them

(Nunyenge & Esena 2013:1). Perhaps, this is why some of the participants state that posters are highly visible:

> Health education to everybody who visits the clinic or hospital, whether HIV seropositive or not, and they use posters that are dotted everywhere around the clinic or hospital.[120]

Taken at face value, posters thus promote the communities' healthcare. They capture people's attention because of their clear pictorial messages and the manner in which authorities display them. Posters are a visual medium of communication, which means that people may remember the message vividly for a long time, in line with the adage that a picture is worth a thousand words.

4.3.11.2 Influential community leaders

Influential community leaders are those knowledgeable in the affairs of their communities. These community leaders have influence and power bestowed on them by their people in the communities. Normally, the influential community leaders act as contact persons between the community and the 'outside world' – government officials, NGO representatives and health professionals. Quite often, they are respected members of their communities who can mobilise people for various developmental projects in their communities. The community leaders invariably include traditional leaders,[121] traditional healers, councillors, village health workers and chairpersons of different community developmental projects, retired and in-service school headmasters and at times, local business persons.[122]

The study shows that the health professionals work closely with community leaders to disseminate information about HIV. The community leaders mobilise people in their communities to gather at business centres or schools, and the health professionals educate them about HIV transmission and the AIDS pandemic among

[120] P 5: Health professionals.txt - 5:206 (450:451) (GUEST) Codes: [Information dissemination::talk to patients who visit clinic] [use of posters]
[121] In the context of this study, traditional leaders include the Chiefs, headmen and village heads.
[122] The use of business persons as agents of HIV information chroniclers may be true to some degree. Communities work well with business people of good moral standing, and therefore, they shun those who may be directly or indirectly involved and implicated in ritual killings.

other health-related issues. The data-sets of the health professionals and those of older adults of the community concur in highlighting this finding, which is summarised in their affirmation, that those health professionals:

> Conduct awareness campaign workshops; mobilise the traditional leaders to play an active role in preventing HIV and AIDS through making some cultural practices illegal.[123]

In addition, the study discovered that traditional leaders, who, through the Traditional Leaders Act (2000) Chapter 29:17 are communities' leaders, and have the responsibility to transmit information about the dangers of HIV in their communities. This view is corroborated by the health professionals who submit that traditional leaders:

> Address people in churches, at gatherings where they would be getting food rations from Non-Governmental Organisations or at political rallies, if given a chance.[124]

Naturally, the health professionals take advantage of the traditional leaders' charisma and their ability to mobilise people in their communities to deliver health education lessons on various topics, such as on HIV, STIs and AIDS education.

In addition, some church denominations have health slots, health expos and health seminars in their churches. In a personal communication with a participant from the Seventh Day Adventist Church (SDA), the researcher established that the SDA church allocates slots to health professionals so that they talk about health-related issues. HIV and AIDS issues dominate most of these presentations. A week of health seminars follows the health slots. In health seminars, the professionals discuss different health concerns with congregants throughout the week. Once more, HIV and AIDS issues are emphasised. Health expo summarises the health seminars. During the health expo, invited professionals offer free health/medical check-ups on

[123] P 2: Local Authorities.txt - 2:39 (87:89) (GUEST) Codes: [Cascading information on HIV/AIDS::awareness workshops] [Mobilising leaders to play active role]
[124] P 2: Local Authorities.txt - 2:39 (87:89) (GUEST) Codes: [Cascading information on HIV/AIDS::awareness workshops] [Mobilising leaders to play an active role]

both non-SDA members and members of the church.[125] In a personal interview, the researcher conducted in the field, a participant highlights information about these health expos. He points out that health expos are full-fledged or a complete mirror of a hospital set-up at the micro level. There is a reception, where a nurse captures the patients' health/sickness histories, checks and records their weight and blood pressure, from where the person proceeds to 'consultation rooms', where qualified and well-experienced nurses and sisters engage patients about their illnesses. Depending on the nature of the diseases, the nurses refer patients to medical doctors for further examination.

Furthermore, the health professionals are lobbying for the abolition of some of the Shona traditional practices that expose people to HIV infection. This is in recognition of the fact that traditional leaders are the custodians of culture. If there is any lobbying to abolish some of the traditional practices that are detrimental to the communities, then it has to begin by consultation with the traditional leaders.

4.3.11.3 Workshops

Related to the use of influential community leaders as agents to cascade down information about HIV infection, is the use of the workshops platform. An online *American Heritage Dictionary of the English Language* defines a workshop as:

> …an educational seminar or series of meetings emphasising interaction and exchange of information among a usually small number of participants.

As the study reveals, health professionals conduct seminars not only with the aim of educating the research participants, but also to brainstorm solutions to the challenges they identify. This aim is in line with the overall objectives of the whole concept of holding workshops, where community representatives participate. Participants obtain information about HIV transmission and are involved in the search for solutions to the AIDS pandemic.

[125] Personal Communication with Hazel Ngiphelipenda [pseudonym for ethical reasons] on health programmes in the SDA church in Chipinge and elsewhere, 16 June 2013.

The study discovered that in some instances, the communities send representatives to attend workshops, and participants would, in turn, share the knowledge they gained therefrom with their communities. Most study participants' views are summed up in the affirmation that:

> We send village health workers to workshops about HIV/AIDS, and these [*village health workers*] take the message about HIV and AIDS door-to-door.[126]

The communities' leadership thus select members to attend workshops either at Mt. Selinda Hospital, Chikore Mission Hospital, and Chipinge District hospital or at any other place that hosts the workshop. It would then be the duty of the participants to give feedback to the communities. Perhaps, this could be why some participants state that they get information about HIV transmission or the AIDS pandemic "through trained personnel, hospitals, clinics and magazines."[127] The study indicates that village health workers would move from one homestead to the next, imparting their new-found knowledge on HIV infections and its transmission.[128]

4.3.11.4 Health awareness campaigns

The study reveals that in addition to disseminating information on HIV infection and transmission through workshops, health professionals pass their knowledge on through health awareness campaigns. One of the participants points out that they disseminate information about HIV by:

> …conducting health education campaigns at gatherings in the community and at schools as well as giving health education during community immunisation programmes, and to individuals who visit the clinic daily [*sic*].[129]

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[126] P 2: Local Authorities.txt - 2:41 (91:93) (GUEST) Codes: [Cascading information on HIV/AIDS::train village health workers who take information to community members]

[127] P 1: Participants' responses.txt - 1:1167 [C 35 12 Through trained personnel...] (2253:2253) (Super) Codes: [Access to HIV/AIDS information::hospitals] [clinics] [magazines]

[128] Code: Information dissemination::talking to people at gatherings {3-0}
P 5: Health professionals.txt - 5:207 (452:454) (GUEST) Codes: [health education to schools] [Information dissemination::talking to people at gatherings]

[129] P 5: Health professionals.txt - 5:212 (463:466) (GUEST) Codes: [Information dissemination::health education on outreach] [talk to patients who visit clinic]

The elderly participants from the community corroborate this view by stating, "Nurses and village health workers (VHW) teach people about HIV and AIDS."[130]

Furthermore, they state that:

> We get the information from different organisations like Family AIDS Caring Trust (FACT) or Batsirai Group, World Vision and through behaviour change facilitators.[131] They give voluntary testing and counselling (VCT) and lessons on HIV/AIDS.[132]

These submissions reveal that health professionals and NGOs complement each other in providing the communities of the Chipinge District with information regarding HIV infections and the AIDS scourge. NGOs, in partnership with government and local authorities, or by themselves, assist the communities in the district to mitigate the impact of HIV, amongst other social responsibilities. Detailing the activities of the NGOs in this regard is beyond the scope of this study and requires different research altogether. Suffice to say, the greatest challenge, which these organisations face, is that there is no medical cure yet that has been developed for HIV and AIDS.

4.3.11.5 Television (TV) and radio

Some communities in the Chipinge District access information about HIV infection or transmission and AIDS in other significant ways. The study shows that both electronic and print media play a pivotal role in transmitting information about HIV and AIDS. Under the electronic media stable, TV ranked the highest, followed by radio. A substantial number of study participants state, "… we get information [about HIV and AIDS] through the television and the radio …."[133] It is indeed a surprising and exciting revelation that people access information from the TV more than they do on the radio. One would expect that by virtue of the high costs of TV sets, radios

[130] P 1: Participants' responses.txt - 1:1184 [M 6 12 Nurses and village heal...] (2282:2282) (Super) Codes: [Access to HIV/AIDS information::nurses] [health workers]
[131] P 1: Participants' responses.txt - 1:1170 [C 9 12 We get the information...] (2256:2258) (Super) Codes: [Access to HIV/AIDS information::NGOs]
[132] P 1: Participants' responses.txt - 1:1161 [B 33 12 Through Non-Government...] (2244:2246) (Super) Codes: [Access to HIV/AIDS information::NGOs][VCTs]
[133] Code: Access to HIV/AIDS information: TV {10-0}. P 1: Participants' responses.txt - 1:1172 [G 11 12 We get information through...] (2260:2261) (Super)Codes: [Access to HIV/AIDS information::TV] [radios] [workshops]

would be more accessible to these communities. Perhaps, this scenario results from poor radio signal reception such that even though people have radios, they hardly listen to them for information from the national broadcaster, Zimbabwe Broadcasting Cooperation (ZBC). Quite often, they use their radio sets to play different genres of music from cassette, compact discs (CDs), or memory sticks because of inadequate radio wave transmission. There is inadequate TV reception as well, but as a mitigatory measure, people use free-to-air decoders that enable them to watch several TV channels free of charge.

Additionally, one important subtle observation is that the study findings indicate the different residential backgrounds of the research participants. The majority of the participants, who indicate that they get information about HIV transmission from the electronic media, are those who either live at schools or at clinics situated in rural areas or mission schools and hospitals that have electricity.[134] It is the researcher's assumption that the rest of the participants have no access to either the radio or television due to their silence about the electronic media as a source of information about the AIDS menace and HIV infection and transmission.

An NGO distributed solar-powered Short Wave (SW) radio receivers to most rural households in the Chipinge District, and indeed in other districts as well. The distribution coincided with the period leading to the 2013 harmonised general elections in Zimbabwe. The Government of Zimbabwe was extremely incensed about this development since people accessed not only information in general, but information that was very critical of government, mainly on the rampant human rights violations and political violence. The Government of Zimbabwe, through the security agents, confiscated the radios,[135] alleging that an organisation linked to the MDC-T, the main opposition political party, had distributed them. The government also

[134] Some of the schools located in the rural areas, where the researcher conducted this study, include Dzika Primary, Gwenzi Primary and Secondary, Chibuwe Primary and Secondary, Mt. Selinda Primary and High and Chikore High and Bigtree Primary. The clinics and hospitals include Gwenzi Clinic, Mt. Selinda Mission Hospital, Chikore Mission Hospital, Kondo and Chibuwe clinics. The nature of the locations of the study gave way to the identity of participants as well – school and hospital administrators as well as teachers and nurses, and their relatives in their care.

[135] See reports on the clampdown of the solar-powered radios by Violet Gonda, on http://africajournalismtheworld.com/tag/shortwave-radios-confiscated-in-zimbabwe ; Brian Hungwe's on http://www.bbc.com/news/world-africa-21829815, and The Guardian's on http://www.theguardian.com/global-development/2013/feb/27/zimbabwe-police-ban-radios-elections

alleged that the radios broadcast Voice of America's (VOA) Studio 7 and the British Broadcasting Corporation (BBC) stations that were very critical of the government. The stations broadcast, among other issues, topics on HIV and the AIDS pandemic, news about the deteriorating socio-economic and political situation in Zimbabwe during the run-up to the harmonised general and presidential elections. The government perceived this as 'peddling lies and meddling in the internal affairs of a sovereign and democratic state'.[136] Consequently, without the solar-powered SW radios, there was also an absence of any alternative source of information regarding HIV transmission and the AIDS scourge.

4.3.11.6 Books, pamphlets and magazines

The print media that include books, pamphlets (leaflets) and magazines are essential in disseminating information in general, and on the spread of HIV and AIDS in particular. The study shows that books, pamphlets and magazines are crucial in disseminating information about HIV and AIDS. Some of the participants indicate that they access the information through "reading books, magazines and leaflets that have information …."[137] These are not just ordinary books or pamphlets, but ones that have information about HIV transmission and the AIDS pandemic. While people may buy books and magazines from bookshops or book dealers, nurses bring leaflets or fliers to the communities or people access them directly from the clinics/hospitals.[138]

However, while books, pamphlets and magazines are indeed valuable sources of information, it depends on the reading culture of the people for books to have a positive impact and outcome. With the assumption that the interest to read seems to dwindle as the distance from education facilities like schools and colleges increases, we should accept the results of the study about the contribution of books, leaflets and magazines with caution. This idea comes from the backdrop of and the

[136] BBC's Focus on Africa programme and Voice of America's Studio 7 highlighted some of the gross human rights violations perpetrated by ruling party youths on opposition political activists, and the economic meltdown of the years 2000-2008. Most people in the rural areas accessed this information through the solar-powered radios, and the government swiftly stopped this source of information.
[137] P 1: Participants' responses.txt - 1:1176 [G 8 12 Reading books and leaflets...] (2269:2271) (Super) Codes:[Access to HIV/AIDS information::books] [magazines] [pamphlets] [radios] [TV]
[138] P 1: Participants' responses.txt - 1:1189 [S 25 12 Via pamphlets, booklet...] (2291:2292) (Super) Codes: [Access to HIV/AIDS information::pamphlets] [hospitals] [NGOs] [posters]

assumption about people being pre-occupied with trying to make ends meet, especially with the 2015-2016 El Nino-induced droughts in most rural communities of Zimbabwe, and the Chipinge District in particular. Thus, to an extent, and as the study revealed, participants who reside within and at the periphery of educational or health institutions/establishments access information from books, leaflets and magazines. It would also indicate that health practitioners and educators would probably have greater access to such material and a need to remain up-to-date. These materials are readily and freely available in the school or hospital libraries or storerooms from where members borrowed them and read. As one moves further away from the schools/hospitals, people are less inclined to borrow non-fiction books or other reading material. If they get a newspaper from the school or from a teacher/nurse who may have brought it from town, all they want is to use it to prepare a *chimonera* (hand-rolled cigarette) with coarsely ground tobacco leaves, or as a substitute for toilet paper. Resultantly, its contribution as a source of information vanishes.

However, this critique does not mean that books and magazines are useless as information carriers. They are valuable indeed in transmitting information, but the people in the rural communities in the Chipinge District are so impoverished that they cannot afford to read them. The reading culture could be the lowest of their priorities.

Furthermore, the study reveals the interrelatedness of the manner in which information about HIV reaches the communities as well. Behaviour change facilitators, as agents lobbying for sexual behavioural change, may be a sub-theme that runs across all the ways (Figure 4.1) in which information on HIV infection reaches the communities in the Chipinge District. There could be nurses at the hospital or clinic, or out in the community on outreach or immunisation programmes, peer educators or village health workers (VHW) imparting their new-found knowledge to the community members. The principal objective of cascading information about HIV transmission and the AIDS pandemic is to encourage behaviour change among the target audience in the Chipinge District.

As the study findings in this sub-section demonstrate, information about the HIV and AIDS scourge reaches the people in the Chipinge District in a variety of ways, and it

is readily available. The chief agents in the dissemination of this vital information are the health professionals who, before attending to patients at the clinic or hospital, teach them about HIV infections and the AIDS epidemic. Healthcare personnel also share HIV information when they go out into the communities on immunisation programmes or mobile baby-clinics, armed with leaflets and posters pregnant with messages on the HIV – AIDS epidemic. Both print and electronic media also play a role in information dissemination, albeit on a limited scale. The media is helpful to healthcare professionals and those with access to electricity and TV/radio transmission. How the people respond to the information they get from posters and several other ways discussed above is a subject of further research.

The study, up to this point, has examined the perceptions regarding the causes of HIV, its symptoms, diagnosis and the not yet available cure. It has also examined the advice to both the infected and the affected, and the various ways in which health professionals and other stakeholders disseminate information about HIV infection and the AIDS pandemic. The study report hereafter discusses the participants' perceptions regarding the state of the Shona traditional beliefs and practices in the era of the HIV and the AIDS menace in the Chipinge District.

4.4 Perceptions regarding the traditional beliefs and practices of the Shona people in the Chipinge District

This section sought to determine traditional beliefs and practices of the Shona people of Chipinge District as well as establish those that were discontinued or modified due to the impact of HIV infection and the AIDS epidemic. The researcher aimed to utilise the information to lobby for culturally appropriate practices, especially those that could help in minimising the spread of HIV.

The people's beliefs in spirit possession and spirit mediumship are still high, despite the infiltration into the community's moral fabric by the non-curable human immune virus, and the AIDS pandemic. The study sought to establish the extent to which beliefs in spirit possession and spirit mediumship might be dangerous in a community where HIV has infiltrated into the community's cultural and moral fabric. Since HIV and AIDS are a sexually transmitted virus and sickness, the study also investigated traditional practices that had a bearing on human sexual intimacy. The

study scrutinised the traditional practices within the marriage institution of the Shona (Ndau dialect speakers) people of the Chipinge District.

4.4.1 Beliefs in spirit possession and spirit mediumship

Spirit mediums are the hosts of the departed ancestral or alien spirits. The spirits communicate with the living through the mediums. To get an insight into the people's belief in the spirit mediumship realm, the researcher asked the following question:

- Briefly, explain how a person becomes a spirit medium?

Responses to this question are intriguing. There are variations in the manner different participants describe the process of spirit possession. However, out of most participants' explanations, one theme emerges. The process, graphically depicted in Figure 4.2 is usually threefold.

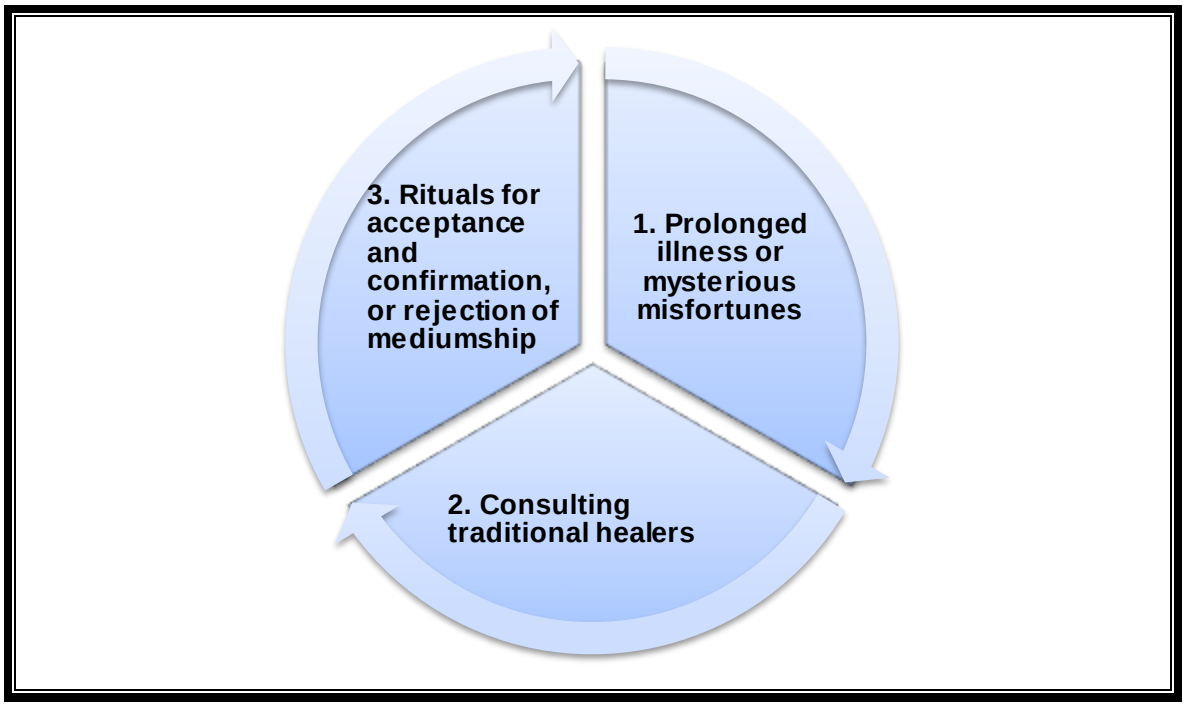

Figure 4.4 Spirit mediumship process

The study shows that the spirit, alien or ancestral, chooses its host, and once targeted, the would-be mediums suffer prolonged and strange illnesses or mysterious misfortunes. Quite often and surprisingly, the sickness of this nature takes ages to heal. The caregiver/guardian might take the sick person to the clinic or

hospital several times, but without improvement being achieved. After a series of futile visits to the hospital, the sick person or caregiver might then consult traditional healers[139] to find out the cause. Traditional healers might tell them that the chief cause of the sicknesses or misfortunes is a spirit[140] that wants a place to reside. He might then ask them to conduct rituals to accept the spirit for a cure. A participant aptly sums these ideas up by stating that:

> One who is to become a medium becomes sick and then consults traditional healers who inform him/her that an ancestral spirit wants to take possession of him/her.[141]

A séance, under the guidance of senior mediums, is organised. Senior family members brew traditional beer for the occasion. On the occasion of the ritual, usually running throughout the night into the early hours of the following day amid song, dance and appropriate rituals, senior mediums who are in a trance 'induce' spirit possession so that the spirit possesses the chosen person as the new medium. The spirit, through the medium, introduces itself and speaks to the gathering after the medium has been possessed. If it is an alien spirit that once possessed a deceased member of the family, senior family members confirm it by subjecting the spirit to an interview, testing its knowledge about the household. The senior family members also subject the medium of an ancestral spirit to the same confirmation interview. If for one reason or another, the chosen people or their families do not welcome the spirit, traditional healers exorcise it at their request.

The belief in spirit possession and the process leading to becoming a medium could be possible challenges to HIV mitigation and care efforts as the next section shows.

4.4.2 Difference between spirit possession 'illness' and AIDS

Literature and preliminary findings of this study reveal that illness is the gateway to becoming a spirit medium. It is not just an ordinary sickness, but one characterised

[139] It is not enough to consult one traditional healer. So several healers, usually three, are consulted, and remedial action is taken, if any two of them have a similar diagnosis.

[140] The actual identities of the spirit that require a medium differ – it could be an ancestral spirit or an alien spirit.

[141] P 1: Participants' responses.txt - 1:482 [M 20 3(a) When grandfather was...] (988:991) (Super) Codes: [Spirit mediumship::host becomes sick] [traditional healer is consulted]

by not being diagnosable by, and unresponsive to, modern medication and, therefore, taking longer to heal. These characteristics of being unresponsive to medication and the prolonged illnesses seem to be the norm in individuals who have AIDS as well. This background provides one of the premises for undertaking this study. To find out more on the issues raised herein, the researcher asked the question:

- What is the difference between a person who is ill because the spirit chose him to be a medium and one who has AIDS?

The results of the study indicate that there are no major differences regarding the sicknesses, and both show similar symptoms as shown in this citation:

> General physical deterioration; persistent ill health; diarrhoea and anaemia in some cases; often vomits, falling hair, red lips and loss of appetite.[142]

Most participants express the view that the causes of the sickness are different and that the cause of illness of a would-be spirit medium is the spirit, while in the other case, the HIV infection is the cause. Participants also note that because of the differences in the causes of the illnesses, the remedies also differ as the summary of the responses state:

> If ever an HIV and AIDS patient gets medication on the possible diseases associated with HIV and AIDS, he/she may recover … temporarily …. However, this is different from a spirit medium host. Until a ritual to accept the spirit is held, he/she will not recover. If the ritual is carried out, the host will recover forever.[143]

[142] P 1: Participants' responses.txt - 1:562 [S 16 3(c) The former looks healthy...] (1201:1202) (Super) Codes: [Difference HIV/Medium::medium healthy] [HIV sickly] [strong]
[143] P 1: Participants' responses.txt - 1:536 [B 12 3(c) An HIV/AIDS patient ...] (1125:1130) (Super) Codes: [Difference HIV/Medium::HIV lose weight] [medium recover after …ritual accepting spirit]

The citation means that while HIV infection or AIDS pandemic are manageable with the administration of antiretroviral drugs, the same cannot be said of sicknesses caused by spiritual forces, especially if one has been chosen to be a spirit medium. Spiritual remedies are the only ones that can manage and treat spiritually-induced illnesses.

The degree to which the sicknesses exhibit the same symptoms makes the management of HIV infections and AIDS difficult. People might delay going to the clinic or hospital with the thought that a spirit has chosen that sick person as host, especially with the belief in the communities that sicknesses of this nature require traditional and spiritual remedies.

The Shona people of the Chipinge District's belief in spirit possession may perhaps fuel the spread of HIV, if people think that the sick are experiencing hard-to-heal sicknesses because a spirit has elected to possess them, and yet they might be ill from opportunistic infections caused by a weakened immune system. This study argues that because of a traditional belief in spirit possession, the delay in promptly seeking proper medical care in hospitals poses the greatest danger. It subsequently causes delays in the diagnosis of HIV and the commencement of anti-retroviral treatment (ART). The delay in commencing ART allows the virus to weaken the immune system further such that by the time ART commences, the degree of deterioration and sickness would be beyond the capabilities of the clinics or hospitals to offer any meaningful assistance.

4.4.3 The Traditional Shona (Ndau) marriage practices

As discussed earlier on, 90% of the cases of HIV transmission and AIDS result from human sexual intimacy. Thus, by examining some of the marriage practices of the Shona (Ndau) people of the Chipinge District, the study aimed to determine the practices that, perhaps, expose people to HIV infection, and those that are culturally appropriate. To gain an insight into the traditional marriage practices of the Shona (Ndau) people in the Chipinge District, the researcher asked participants questions

regarding different marriage patterns. The researcher has reproduced the results of his article published in *Verbum et Ecclesia*[144], as shown hereunder:

4.4.3.1 Barika (polygamy)

- "In light of HIV and AIDS, what is your opinion on the practice of *barika* (polygamy)?"

The majority of respondents indicate that *barika*[145] is discouraged in most of the areas under study. The FGD supported these findings, as there is consensus when participants speak boldly against *barika.* The most vocal discussants in the FGD are at Headman Munamba's homestead in Gwenzi Village. They argue that nowadays life is too expensive to support a big family − let alone in a *barika*:

> *Kuroora vakadzi vakawanda kwonesa mazuwa ano. Chinonyanye kunesa isapoti … madzimai nevana vanonga vechide chekurya, chekupfeka, kubhadhare mare yechikora yegurumwandira revana … iii, azvichakoneki. Zvasiyana nekudhaya ngekuti kwainga kuchaibva, uye madzimai vaiendawo kooshanda kwaTondoro kana ku*Jersey.[146]

(Translation: Marrying many wives is problematic nowadays. The greatest problem is support … wives and children need food, clothing, and paying school fees for a team of children … mmm, it is no longer possible. It is different from the past, when there used to be plentiful harvest and women went to work at *Tondoro* [nickname for Smalldel Coffee Estate] or Jersey Tea Estate).

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[144] Marashe, J. 2014, 'The African traditional religious landscape: An examination of the role of traditional leaders in the fight against HIV and AIDS in Chipinge, Zimbabwe.'

[145] *Barika* is a Shona word that means polygamy

[146] Fieldwork Diary notes, at Headman Munamba's homestead, which falls in Chief Gwenzi's chiefdom, 23 January 2011.

This seems to suggest that the discontinuation of polygamy (as corroborated by the findings on traditional leaders' biographical data in Section 4.1 above) is because of extenuating circumstances, such as poverty, poor harvests due to perennial low rainfall patterns and the high cost of living, rather than the people's choice. Therefore, the study reveals that cases of polygamy − as a type of marriage − are becoming less popular for a variety of reasons, which include men's fear of contracting HIV and developing AIDS (Marashe 2014:6-7).

While the FGD and traditional leaders have played down the prevalence of *barika*, the health professionals identify it as one of the living practices of the Shona people of the Chipinge District when most of them concede "… one man may marry as many as 10 or 15 wives".[147] This seemingly contradictory finding perhaps is caused by the fact that few individuals who visit the health centres, and upon taking down the patients' personal details, realise that most are from polygamous marriages. This tends to cloud the evaluation of the holistic picture as findings from the FGD and traditional leaders suggest. The study made further inquiry about another marriage practice as explained herein, and extracted from the researcher's published article.[148]

4.4.3.2 Kuputsa (forced marriage)

Another form of traditional marriage practice besides *barika* is *kuputsa* (pledged or forced marriage), discussed in the sub-section hereunder:

- In the light of HIV and AIDS, what is your comment on the practice of *kuputsa* (pledged or forced marriages)? (Marashe 2014:6)

Most of the traditional leaders who participated in the study are unanimous in their view that the practice of *kuputsa* has decreased significantly in the areas under their control, while a few maintain that *kuputsa* is still practised. During the FGD,

[147] P 5: Health professionals.txt - 5:112 (253:254) (GUEST). Codes : [HIV & AIDS causes : polygamy]
[148] Marashe, J. 2014, 'The African traditional religious landscape: An examination of the role of traditional leaders in the fight against HIV and AIDS in Chipinge, Zimbabwe.'

participants voiced their concern about the trauma the young girls' experience when pledged for, or even forced into a marriage without their consent. The argument made was that the practice is not only out-dated, but also against children's rights as enshrined in the Africa Charter on the Rights and Welfare of the Child,[149] a charter, that the Government of Zimbabwe upholds. Moreover, the Government of Zimbabwe discourages the practice. At Murenje village, to the southeast of Chikore Mission, Headman Murenje commented:

> *Iyi tsika aichanyanywi kuitwa mundau munomu, chezvinoita ngechekuti, dai yechinyaitwa, inoitwe muchihware-hware ngekuti Mambo Musikavanhu wakambaaronza kuti hurumende aizvidi, uye kuti unonga abatwa unosungwa...*[150]
>
> (Translation: This practice is no longer done in this area; however, even if it continues, it is done clandestinely because Chief Musikavanhu announced that the government is against it, and whoever is caught practising it would be arrested) (Marashe 2014:6).

The affirmation that some households practise *kuputsa* clandestinely is surely a cause for concern. It demonstrates that the practice lives on, notwithstanding the danger and threat of HIV infection the practice might pose on the innocent girl-child.

In the Dzika area, which is in the village of Tauya to the west of the Chikore Mission, under the chieftaincy of Musikavanhu, Headman Mbonyeya corroborates Headman Murenje's view. He opines that sometimes families in the community surreptitiously practise *kuputsa* to save the lives of family members who may be under a spell of *ngozi* (avenging spirit) (M. Mbonyeya [Headman] personal communication, 5

[149] African Charter on the Rights and Welfare of the Child, Chapter 1, Article 1, Subsection 3, discourages - among others - traditional practices that are inconsistent with the Charter, and Article 16 discourages both physical and sexual abuse of children. OAU Doc. CAB/LEG/24.9/49 entered into force on November 29, 1999.

[150] Fieldwork Diary notes, at Headman Murenje's court in Chief Musikavanhu's jurisdiction on 19 December 2011.

February 2012)[151]. *Ngozi* (avenging spirit) is the spirit of a person who died with a grudge over an injustice suffered during his life or that of a murdered stranger. What forces a parent to give up an innocent girl is the devastation that the *ngozi* leaves in its trail. The attack by the *ngozi* is capricious as well as perilous, and as Bourdillon (1976: 163) and Mutekwa (2010: 153) conceded, it often leads to a series of deaths, often in quick succession, in the family of the one responsible for the murder. The only remedy is to appease the spirit.

When mysterious deaths and misfortune wreak havoc in a family and traditional healers identify *ngozi* as the cardinal cause, the father gives up the innocent girl-child to pay the restitution. The family sometimes gives away the young and innocent girl at no cost at all or a ridiculously low price.[152] As Marashe (2014:6) noted:

> In such circumstances, the young and innocent girl, used to appease the avenging spirit, becomes a homicide bride and a sacrificial lamb for the survival of her family.[153]
>
> The dangers of such a practice is that the benefactor - the husband − would force the young girl to have sexual intercourse before she is mature enough, and exposes her to sexually transmitted infections (STIs) or the deadly HIV infection; she would be too young to either consent to, or negotiate for safe sex. While it was difficult to correlate *kuputsa* with the prevalence of HIV in Chipinge District, qualitative data from the sample, in conjunction with information from the FGD, seem to suggest that

[151] Marashe, J. 2014, 'The African traditional religious landscape: An examination of the role of traditional leaders in the fight against HIV and AIDS in Chipinge, Zimbabwe'

[152] UNICEF (2000:134) reported of an instance in Chiredzi, in the south-eastern low-veld of Zimbabwe, where 'a girl was sold for ZW$1500 to a person who needed a girl for a family he had wronged to make peace with vengeful [*ngozi*] spirits.'

[153] Young girls are married to wealthy men to avert starvation especially in times of poor harvest. The practice mushroomed in other districts too, for instance, in Nyamajura to the east of Harare; a girl of 14 years was married to a 65-year old mangeriatric, to save the family from starvation. More details on http://mg.co.za/article/2006-05-17-hunger-forces-zim-girls-into-forced-marriages

> although the practice is declining, it carries a high risk of infection.[154]

Perhaps, the risk of infection alluded to above could be as a result of her powerless position immaturity and vulnerability and his previous exposure to potential infection, which he would then transmit to her any children to be born. The next paragraph examines yet another marriage practice found among the Shona people of the Chipinge District.

4.4.3.3 Kugara nhaka (wife inheritance) and the threat of HIV infections

Kugara nhaka (wife inheritance) is another traditional marriage type practised by the Shona people in the Chipinge District. This practice is whereby the widow of the deceased is 'married' or inherited by the deceased's agnatic brothers or any patrikins. The researcher posed the question below to get more insight into the practice:

[154] Marashe, J. 2014, 'The African traditional religious landscape: An examination of the role of traditional leaders in the fight against HIV and AIDS in Chipinge, Zimbabwe.'

- In light of HIV and AIDS, what is your comment on the practice of *kugara nhaka* (wife inheritance)?

The responses were as varied as the participants themselves were, and ranged from approval of the practice to its outright condemnation, while others advised people to be cautious and shared their wisdom on it vis-à-vis the HIV and AIDS pandemic as shown in Figure 4.3 below.

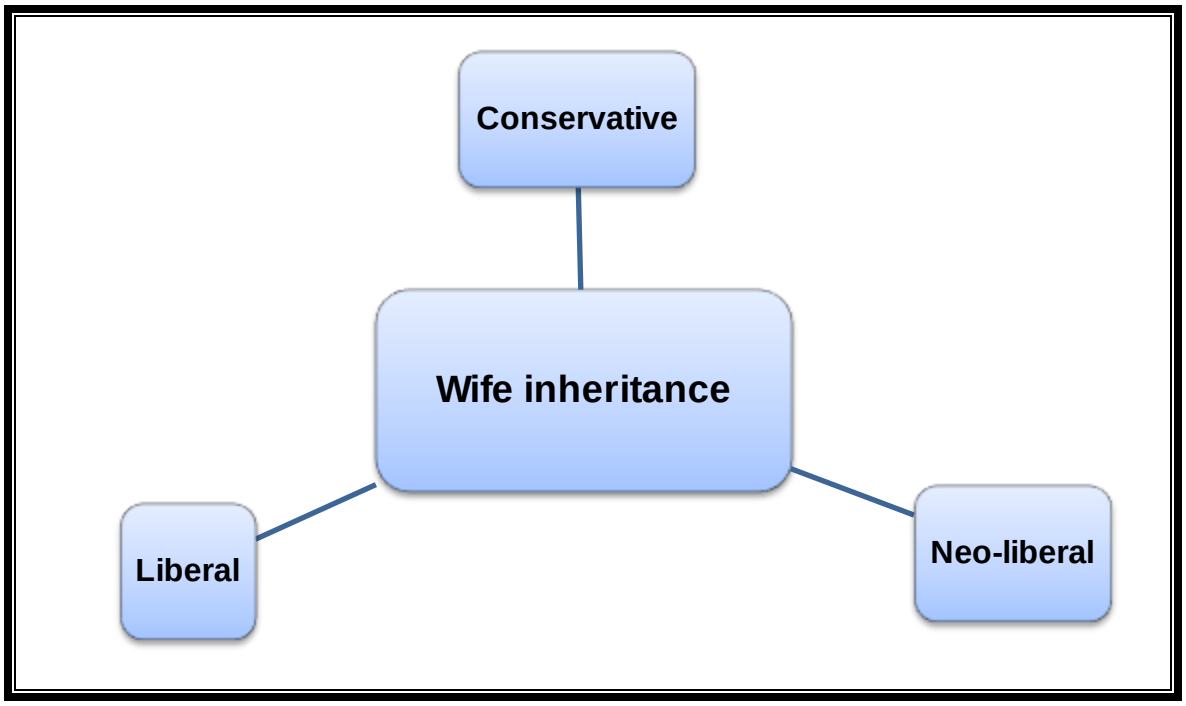

Figure 4.5: The study participants' perception of wife inheritance

The study unveils two clear and opposing views or themes – the conservative and the liberal viewpoints, and a third view that is more inclined to the liberalists than to the conservatives. Most conservative participants do not see anything wrong with the practice although they lace it with conditions. Most male participants and a few women indicate that the practice is as old as humankind. They argue:

> Since time immemorial, if there was death in the family, they selected someone to take care of the family. The

> widow would fetch water and give it to the man of her choice.[155]

The occasion referred to in the citation above is the day on which the family of the deceased conducted the ceremony of *kugara nhaka*, usually a year or so after the burial of the deceased. Relatives of both the widow and the deceased and the local traditional leaders attend the ceremony to witness the event. With all suitable would-be inheritors present, the widow would offer a gourd or a dish filled with water to either a man, an aunt of her choice or her first male child. In turn, the chosen inheritor "…washes his face and drinks the water. This shows that the heir has agreed to take the widow as his wife."[156] The drinking of water and washing of the face by the inheritor symbolises acceptance of his new role, and the relatives would ululate in approval. Henceforth, the inheritor assumes full responsibility for the deceased brother's family.

Other research participants, whom the researcher prefers to call neo-liberals, corroborate the idea of the perpetuation of the practice with scepticism or caution. They explicitly state:

> There is nothing wrong [with *kugara nhaka* practice],[157] provided the deceased did not die of HIV/AIDS. The surviving partner should also give his/her consent, after an HIV/AIDS test.[158]

Thus, the new conditions for those who are in support of the continuation of *kugara nhaka* practice are evident. The deceased should have passed-on through natural causes and not by the AIDS pandemic. Furthermore, the bereaved widow should consent to the practice of *kugarwa nhaka* (widow being inherited by a man). Lastly,

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[155] P 1: Traditional Leadership.txt - 1:64 (191:192) (Super) Codes: [Wife inheritance:: to care for the family]

[156] P 1: Participants' responses.txt - 1:382 [M 34 2(b) If the husband passes...] (739:743) (Super) Codes: [washing and drinking means acceptance of offer] [Wife inheritance procedure::widow gives water in a dish and a cup to male relative of the deceased]

[157] Words in brackets are my emphasis.

[158] P 1: Traditional Leadership.txt - 1:63 (178:180) (Super) Codes: [Wife inheritance:: nothing wrong if death is not by AIDS] [Wife inheritance:: should go for blood test] [Wife inheritance::widows consent required]

both the grief-stricken widow and the would-be inheritor should first undergo a blood test to determine their HIV status before they engage in sexual intimacy.

Those whose viewpoints the researcher thinks are liberal argue that:

> The practice was important yesterday, but it is not fashionable these days. People are against the practice.[159] It is no longer acceptable. If someone dies of AIDS, then if you inherit her, you also get an infection. ....[160]

Thus, from the liberal perspective, there is no need for people to engage in a practice that endangers the lives of the people. It is a practice that was important yesteryear, but one that should also evolve and adapt to the current developments in the area of the people's health. To the liberal study participants, being nostalgic about yesteryear's traditional practices and beliefs should be treated with caution.

Responses to a follow-up question on the *kugara nhaka* practice corroborate this idea. The probe aimed to determine if, by continuing with the practice as expressed by the conservative voices amongst the participants, the community was not, in fact, endangering the same lives of the families the *kugara nhaka* practice intended to preserve. The question the researcher posed was:

- What risks of HIV infection (if any) may be associated with the *kugara nhaka* practice?

Most participants[161] in the study pointed out that the practice of *kugara nhaka* posed a high risk of spreading HIV, especially if the deceased husband succumbed to AIDS. In Atlas.ti software for qualitative data analysis the idea, coded and expressed

[159] P 1: Traditional Leadership.txt - 1:68 (200:201) (Super) Codes: [Wife inheritance:: people do not like it nowadays.]
[160] P 1: Traditional Leadership.txt - 1:62 (174:177) (Super) Codes: [Wife inheritance::encouraged to go for blood test if one likes it] [Wife inheritance::fear of contracting HIV] [Wife inheritance::not practised anymore]
[161] Code: Wife inheritance risks::high chances of HIV infection {23-0}

that ‘wife inheritance risks::high chances of HIV infection', was so common that it reached data saturation point before the researcher even completed coding the question. Therefore, one of the most important revelations of the study is that there seems to be a move by the community to promote a culturally safe widow/wife inheritance practice, perhaps as a response to the AIDS scourge. The community could achieve the safe wife inheritance practice by encouraging both the widow and the would-be inheritor to take an HIV test and the latter to seek a voluntary and ‘honest' consent from the widow.

Furthermore, another cardinal safety net on the wife inheritance practice includes widows giving the gourd/dish of water to either their son or an aunt from the late husband's side. While most participants welcome this development or adaptation as a way of minimising the spread of HIV, the conservative participants are very sceptical about its success. Most of the study participants argue that:

> *Kana mvura ikapuwa atete vanonga vakatoroorwawo, vanozouya ere koopfumbe mbatso inonga yoobvidza? Vanobadhara mare yechikora yevana vanonga vakasiiwa ndinyamufa ere, kube nguwa dzimweni navoo vanonga vane vana vanode kubhadharirwawo? Vangazviita havo ngekude kurambe nhaka yemene, asi mangwani zvoonesa apana unozodetsera ngekuti vanonga vakatorambe nhaka yemene-mene yeChiNdau chedu.*[162]
>
> (If the widow gives water to an aunt who is married, will she come to thatch for her a leaking house? Will she pay children’s fees, even if she may be struggling to pay fees for her children? They may do it [giving the aunt the water] as a way of rejecting a proper wife inheritance practice, but when trouble comes, no one will help because they would have refused a proper Ndau inheritance practice).

[162] P 1: Traditional Leadership.txt - 1:68 (200:201) (Super) Codes: [Wife inheritance:: people do not like it nowadays.] […give water to aunt] [Give water to son ….]

While the wife inheritance by the aunt/son could be a welcome development or modification of the long-held practice vis-a-vis HIV infection mitigation, it is hard to accept for the hard-core traditionalists, who view any modification to the Shona traditional practices as the hallmark of Western cultural influence. It is worth noting that despite the negative perception by the traditionalists, the modified version of the wife inheritance seems to be gaining momentum for fear of contracting HIV. If this assessment has some measure of truth, then it means that HIV and AIDS have an impact on some of the traditional practices and beliefs of the Shona people of the impoverished rural Chipinge District. The fear of HIV infection is possibly leading to some of the modifications and adaptations to the wife inheritance practice as revealed by this study.

4.4.3.4 Chimusamapfiya (replacement-wife)

The study proceeded by making an inquiry into the practice of *chimusamapfiya* (replacement-wife) found among the Shona people of the Chipinge District. *Chimusamapfiya* is

> *Mukadzi unopuwe mukwambo ndiana sezara kana wekutanga atamika* (a wife given to a man by his in-laws when his first one passes on) (J. Gwenzi, personal communication, 21 July 2012).

The father-in-law normally offers the widower the deceased wife's younger sister as a new wife. In other cases, the widower's brother-in-law gives his daughter to the widower (J. Mapara, personal communication, 22 April 2016) In these two instances, the main objectives of the practice are to replace the deceased wife as well as ensure that the children are well cared for by a close relative of their mother and not a stranger. One more reason for the practice ias for the:

> *Chimusamapfiya auye koobase muriro echibikire vana pamapfiya padzime muriro. Ticherechedzezve kuti kubase muriro pamapfiya zvinoronze kuite mukadzi wababa*

mukuru ngekuti mwevanoata mwotondhora (J. Mapara, personal communication, 22 April 2016).[163]

(Translation: The replacement wife is to make fire and cook for the deceased's children at her fireplace as the fire would have burnt out. We should also remember that to 'make fire' symbolised to become the widower's wife since his bedroom would be cold).

Furthermore, the *chimusamapfiya* marriage practice was done, as one participant states, "… to cement relationships."[164] This meant that *chimusamapfiya* revived and rejuvenated the family of either her deceased sister or aunt. It ensured the continuity of the family. The practice did not involve any strangers. *Chimusamapfiya* would mother the children of the widower as well as be his new wife. Against this background, the researcher probed the study participants with the question:

- In light of HIV and AIDS, what is your opinion on the practice of *chimusamapfiya* (replacement-wife)?

The study shows that the practice is 'dying a natural death'. Most participants state that the *chimusamapfiya* practice is no longer encouraged, while a few claim that it had been stopped a long time ago. Most participants affirm that the Shona people in the Chipinge District discourage the practice of *chimusamapfiya* because of the ravaging influence of the HIV and AIDS pandemic, and caution those who may want to do it to be cautious. The study participants are diplomatic when they state "It is practised, but we do not encourage it because of the AIDS disease. We encourage those who want it to take a blood test."[165]

[163] The researcher translated Professor Mapara's Shona contribution into the Ndau dialect in keeping with the context in which I conducted the fieldwork of the study.
[164] P 1: Traditional Leadership.txt - 1:109 (304:306) (Super) Codes: [*Chimusamapfiya*::family care for by a relative]
[165] P 1: Traditional Leadership.txt - 1:115 (318:320) (Super) Codes: [*Chimusamapfiya*::it's done but not encouraged because of HIV/AIDS | those who want to take a blood test]

A handful of study participants speak plainly about how they perceive the practice and one such respondent rhetorically contends that the practice is:

> [It is] Not acceptable anymore, I may be infected with the HIV that may kill the wife again, would you continue to give me. [166] …whichever way it is death, and if I have AIDS, it also kills the new wife.[167]

Therefore, while the community does not have fixed rules on abolishing the practice, reality shows a positive skew towards its abandonment. Perhaps the threat and fear of HIV infection and the AIDS scourge, among other factors, are already making people reconsider the practice of *chimusamapfiya* among the Shona people in Chipinge. A young *chimusamapfiya* is vulnerable to HIV infection because of potential exposure. Quite often, the replacement wife would be too young to negotiate for safe sexual intercourse, let alone, demand that they go for HIV tests before any sexual contact. If the first wife died of AIDS or HIV-related opportunistic infections, then the new wife is likely to become infected with the HIV as well. Related to the *chimusamapfiya* practice is *chimusamusha* practice.

4.4.3.5 Chimusamusha (substitute-wife)

According to one interviewee, *Chimusamusha* (substitute-wife) refers to:

> *mukadzi unoroorwa kana wekutanga achembera kana kuti agume kubara* (Substitute-wife is a wife who gets married because the senior wife is too old, has reached menopause and can no longer bear any children or is barren) (J. Gwenzi, personal communication, 21 July 2012).

The idea of a substitute wife is meant to enable the family to have more children or, as Taringa (2014:402) explains, to "… revive the home." Taking a cue from the game of soccer, a substitute replaces a player who is not playing to expectations due to

[166] P 1: Traditional Leadership.txt - 1:107 (299:301) (Super) Codes: [*Chimusamapfiya*::not done anymore | fear of HIV/AIDS infection]
[167] P 1: Traditional Leadership.txt - 1:117 (326:328) (Super) Codes: [Chimutsamusha::not anymore | AIDS will kill all]

several reasons among which may be injury, fatigue, being out of form or as a tactic by the team manager/coach to win the game. Similarly, in the *chimutsamusha* practice, the senior wife would be alive, but because of age and menopause, she might be unable to perform all her traditionally prescribed marital and child-bearing duties. Thus, the husband, sometimes in consultation with the first/senior wife, would marry a younger wife, *chimutsamapfiya,* to assist her in running the family, and above all, continue to bear children for her husband.

Similar to the practice of *chimusamapfiya,* the study aimed to determine the prevalence of *chimusamusha* practice as a marriage type in the era of the HIV and AIDS pandemic. It is in this context that the researcher posed this question:

- In light of HIV and AIDS, what is your opinion on the practice of *chimusamusha* (substitute-wife)?

The study shows that the Shona people of the Chipinge District rarely practise *chimusamusha* nowadays. The slow demise of the practice is attributable to the people's empowerment through education as well as the human right to choose their life partners. It is also possible that the rising cost of living, having to pay for several wives and many children, discourage such practice. Most of the participants state:

> It used to be done, but it is now declining; education is getting rid of it.[168] Women are supposed to date whomever they like, not forced into a marriage.[169]

The study shows the influence of the HIV and AIDS pandemic in the community's marriage institution and moral fabric as well, although other factors probably play a bigger role regarding the abandonment of this practice. This is of relevance to this study. Some of the participants note that the *chimusamusha* practice is dying

[168] P 1: Traditional Leadership.txt - 1:123 (341:342) (Super) Codes: [Chimutsamusha::was stopped | education empowered people to leave it]
[169] P 1: Traditional Leadership.txt - 1:124 (342:343) (Super) Codes: [Chimutsamusha::women to date whomever they like not forced into marriage]

because "…if either of us has HIV, we continue to infect each other."[170] Therefore, while education will have empowered women to have power in the choice of their spouses, the threat of HIV infection seems to be taking its foothold as well.

4.4.3.6 Kupindira (substitute-husband)

Another practice within the marriage milieu among the Shona people of Chipinge District is *kupindira* (substitute husband). Children are valued in any marriage. Children cement the marriage and perhaps in a significant way, ensure the stability and longevity of the marriage. Society ridicules a couple that has no children. Regarding the ability to procreate, society might accuse the husband of 'firing blanks', or as *kabi* (an ox)[171], and the wife for being *ngomwa*[172]. The inability to procreate creates tension within the marriage institution, and the couple usually ends up blaming each other. Usually, failure to procreate could lead the man to divorce and marry another woman, especially when he believes that his wife is infertile.

However, if the family establishes that the problem of infertility lies with the husband, it tries to preserve the marriage by secretly instituting the *kupindira* or *kutumira* practice. *Kupindira* is a traditional practice, whereby an aunt or uncle negotiates with the younger brother of the husband to impregnate his brother's wife secretly. When he agrees, the wife is informed and gets pregnant by his spouse's young brother, and all this takes place in secret. According to Bullock (1927:11), the woman agrees to the practice of *kupindira* because of cultural socialisation, and because barrenness "… is more bitter than death…". Thus, the young brother becomes a 'substitute-husband'. The aunt or uncle and the parties involved keep this arrangement a top secret. The husband, the rest of the family and the community must not know about this secret because 'heads may roll' if it becomes known. It is against this background, and in the light of the HIV menace that the researcher sought information about the state of the practice. The researcher asked participants the following question:

[170] P 1: Traditional Leadership.txt - 1:116 (322:324) (Super) Codes: [Chimutsamusha::not anymore | AIDS will kill all]
[171] One distinctive attribute of an ox (plural, oxen) is that it is castrated, and therefore cannot sire calves. Thus referring to a man as an ox is indicative of his failure or inability to father any children.
[172] *Ngomwa* refers to someone who is barren.

- In light of HIV and AIDS, what is your opinion on the practice of *kupindira* (substitute-husband)?

As found in other Shona (Ndau) traditional practices, the study reveals divergent views, especially as the Shona people in the Chipinge District, and possibly others elsewhere as well, veil *kupindira* practice in confidentiality. Some of the participants point out that the practice of *kupindira* or *kutumira* is rare among the Shona people of the Chipinge District. The participants cite several reasons for the decrease in practising *kupindira*, but among them, three recur frequently. Some of them indicate that the practice is rare because it is outdated, while others identify the problem of disclosure as militating against *kupindira*.[173] Lastly, participants identify the reality and threat of HIV infection and the AIDS scourge as championing the demise of the practice.

Nevertheless, some culture-conscious participants are very optimistic. The citation hereunder summarises their opinions:

> As long as this is not divulged to outsiders, it [*kupindira*] is a welcome aspect of our culture. After marriage, we expect children. Families cannot vanish, so for families to grow, it is good to be continued.[174]

The citation opens the doors to the hearts of the Shona people of Chipinge and their socio-emotional and cultural aspirations and expectations concerning the practice of *kupindira* or *kutumira*. The practice is veiled in secrecy, and is highly restricted, and is, therefore, not for people who cannot keep highly confidential and sensitive secrets. It is a carefully guarded traditional practice because once it becomes public knowledge, it has the potential to leave socio-emotional scars and fuel family feuds. It has the potential to create hatred between family members, and brothers might kill each other over the rights to both the wife, and the children. The husband might

[173] P 1: Traditional Leadership.txt - 1:135 (360:362) (Super) Codes: [Kupindira::(kutumira) rarely done | problems of disclosure due to deaths]
[174] P 1: Traditional Leadership.txt - 1:136 (353:355) (Super) Codes: [Kupindira::done to bear children

divorce the woman, and demand his *lobola* from his in-laws on the grounds of infidelity. Above all, it could be an embarrassment to the affected families, as it damages the families' honour. Perhaps, these arguments might as well explain why, to an extent, the Shona people of the Chipinge District rarely practise *kupindira*. However, the people's culturally-driven passion for raising families and preserving the families' lineage seem to give the practice an impetus to endure the HIV threat, notwithstanding the fact that there is an additional requirement, as discussed below, for those involved. The fact that participants identify the problem of disclosure is in itself an indication that, though rare, *kupindira* is still present among the Shona people of the Chipinge District.

At the same time, other participants do not follow the prescriptions of the Shona people's traditional beliefs and practices blindly. In addition to abiding by the dictates of this long-held custom, they seem to have noticed a health risk and attribute to the practice. They affirm:

> It [*kupindira*][175] is practised, but it is very secretive. Our encouragement is that people first go for a blood test before getting involved in it because AIDS kills.[176]

The above citation highlights some important points concerning the practice under discussion. The affirmation indicates clearly that the Shona people in the Chipinge District practise *kupindira*, albeit surreptitiously. Additionally, the people involved should be brave enough to take an HIV blood test. In other words, *kupindira* is no longer a traditional practice for everyone anymore. It is now practice for men and women who are culturally as well as health conscious. Perhaps, the threat of HIV has made the Shona people of Chipinge adopt a new health-screening dimension in the practice of their centuries-old custom with the aim of safeguarding the integrity of the family unit through procreation as well as ensuring that the marriage institution and the family unit are free from HIV infection and the AIDS pandemic.

[175] Emphasis added and author's word in brackets.
[176] P 1: Traditional Leadership.txt - 1:130 (376:377) (Super) Codes: [Kupindira::privately done | people to take blood test first]

4.4.3.7 Kufohla (elopement)

The last marriage practice the study made an inquiry into is *kufohla* (elopement). Like the previously discussed marriage practices, *kufohla* is one of the several other marriage practices found in the Chipinge District. As with the inquiries made on other marriage practices, the assumption was that the HIV and AIDS scourge that has ravaged the district might have an influence on this marriage practice. Once more, the researcher questioned:

- In light of HIV and AIDS, what is your comment on the practice of *kufohla* (elopement)?

The study's results reveal that *kufohla* is one of the most popular marriage practices among the Shona people in Chipinge District. Most participants identify migrant workers, (*maJoni-joni*)[177] mostly working in South Africa, as the chief culprits when they state:

> *Kufohla* instances are too many these days practised in particular by those who work in South Africa. When they come home during the holidays, they arrange for the elopement of their girlfriends, even when they are young or at school.[178]

Another finding of the study is that this widespread marriage practice is rushed, and has perhaps lost its traditional attribute. Some of the respondents affirm that some of the elopers '… these days come without the escort of their sisters or aunt.'[179] The presence of an eloper's aunt and sister(s) is an important cultural practice, which by the Shona traditional standards legitimise the whole process. Their absence signals

[177] Joni is a term that refers to South Africa, and maJoni-joni refers to young men who go to search for work in South Africa.
[178] P 1: Traditional Leadership.txt - 1:158 (434:437) (Super) Codes: [Elopement::practised too much especially by those who work in South Africa]
[179] P 1: Traditional Leadership.txt - 1:154 (422:423) (Super) Codes: [Elopement::It is prevalent, but these days they come without the escort of their sisters or auntie.]

a hurriedly arranged elopement or family members' disapproval. This could have negative consequences in future because the elopers might not have any family to go back to in times of problems.

While elopement may have taken place because of financial reasons, avoiding having to pay lobola, a section of the participants brand the practice as immoral, and that it exposes people to HIV infection. They state that:

> It is a bad practice, and in most cases, they would not have gone for a blood test; you elope to a young man who may be infected with HIV, and it will kill the wife. It also shows a lack of self-discipline.[180]

Thus, the study shows that while *kufohla* might be popular, it is dangerous especially considering potential infection with HIV. The study also shows that the parties involved in elopement lack self-discipline (*kukorere kuzvibata*). They demonstrate impatience to wait for the right time, or in some cases, to mature. What marriage decision or consent may a primary school girl grant, immature as she might be? Participants also suggest that most elopements were taking place because the girls would be pregnant. Thus, teenage pregnancies force the girls to elope as a way of trying to fit in society and normalise their new statuses. The concerns raised in the mention of '… not have gone for blood test…' and '… infected by HIV …' in the question above, seems to suggest that some people in the Chipinge District are aware of the inherent dangers of the *kufohla* practice due to the HIV menace. However, if the young bride is already pregnant, it means it is too late for avoidance of HIV as they are already sexually active. If participants moral high ground were noble, then the Shona people of the Chipinge District and, indeed, others elsewhere, must educate the youths about the consequences and dangers of early sexual contact such as unwanted pregnancies and subsequently dropping out of school, losing honour and above all, contracting HIV or any other sexually transmitted diseases. The objective of the communities' engagement with the youths would be to ensure the safety of future families by saving their lives while they are still young.

[180] P 1: Traditional Leadership.txt - 1:151 (413:415) (Super) Codes: [Elopement::is bad | lack of self-discipline]

4.5 Modifications to the Shona traditional practices and beliefs in light of HIV

Having discussed some of the several Shona marriage practices[181] in the Chipinge District, the study made an inquiry on the changes that the communities might suggest and recommend to improve the safety of those who might want to continue with their traditional marriage practices. The researcher asked the study participants the following question:

- In light of HIV infection and the AIDS pandemic, what changes to the cultural practices and beliefs would you suggest?

The responses show a clear demarcation between those from the health professionals and the rest of the study participants in the sample. Using Atlas.ti software for qualitative data analysis, the researcher coded the question 'modifications to practices', but the responses from the health professionals are not modifications at all. Their suggestions are for complete discontinuation of some of the Shona traditional practices. Most of the health professionals' so-called modifications are an encouragement to the Shona community of the Chipinge District to practise monogamy and put an end to polygamy, whatever the circumstances. Most of them state that:

> People should not practise wife inheritance and should stop the traditional practice of forced or pledged marriages. Men, who are infected, should stop the practice of sexual intercourse with virgins 'to try to cure their' HIV[182]… and should stop polygamy …[183]

Thus, the perception of the health professionals is that the community should stop traditional practices such as wife inheritance, and pledged or forced marriages. On

[181] The marriage practices examined in the study report are not exhaustive because of time constraints.

[182] P 5: Health professionals.txt - 5:59 (125:128) (GUEST) Codes: [Modifications::stop wife inheritance] [stop pledged marriages] [stop virgin sex to cure AIDS]

[183] P 1: Participants' responses.txt - 1:670 [S 3 3(d) 3 Stopping polygamy; a…] (1409:1411) (Super Codes: [campaigns on belief in witchcraft] [Solution::stop polygamy]

discontinuing the forced marriage practice, health professionals agree with the rest of the participants who suggest that government and traditional leaders should work together to discourage the practices that are no longer culturally friendly, particularly those that encourage and promote child abuse[184]. They encourage the communities in the Chipinge District to stop the practice of having sex with virgins as a way of trying to cure STIs, and possibly, HIV infection or AIDS. Their suggestion to discontinue the practices is because of the realisation that the practice makes people, especially the girl-child, vulnerable to HIV infection. The issue of virgin sex is not a marriage practice, which is the concern of this section, but a fallacious belief among some sections of the community. Some people are encouraged by irresponsible and bogus traditional healers and herbalists to believe that having sexual intercourse with a virgin can cure a man of HIV infection. The fallacy came up through the responses to the question on the suggestions participants have on some of the traditional practices in general. It has found space in this write-up in order to underscore the absence of any cure for HIV infection to date - *not even sex with virgins is a cure for the deadly AIDS pandemic* (e.a.)[185].

The responses from the other participants (the elderly in general and traditional leaders) suggest reasonable modifications, while maintaining the practices. The participants suggest that the widow and the inheritor should go for an HIV test before inheritance. They state

> Wife inheritance - before we get into the house, [bedroom] we should go for an HIV and AIDS test so that we know our status. Sometimes we may be infected.[186] If either of us is infected with HIV and AIDS, we must use condoms.[187]

[184] P 1: Participants' responses.txt - 1:638 [B 12 3(d) 3 Marriage should be...] (1339:1343) (Super) Codes: [discourage customs that pamper child abuse] [Solution::HIV test before marriage]
[185] e.a. means emphasis added.
[186] P 2: Local Authorities.txt - 2:28 (61:63) (GUEST) Codes: [Modifications to practices::mandatory blood test before wife inheritance].
[187] P 1: Participants' responses.txt - 1:642 [C 19 3(d) 3 One should get blood...] (1351:1353) (Super) Codes: [Solution::HIV test before wife inheritance]

Thus, participants advocate for the addition of a health element to the long-held wife or widow-inheritance practice. 'Before getting into the house …' in the above quotation means that both the widow and the inheritor or heir should have an HIV test done before sexual intercourse.

However, others suggest a non-sexual practice. They state:

> People should stick to one faithful partner. Wife inheritance should be about taking care of the family of the deceased and not a sexual relationship with the surviving wife.[188] The wife must not be inherited on the bed, but assist in the provision of groceries, school fees for children…[189]

The research participants in the Chipinge District are, therefore, suggesting a novel and drastic change to the wife inheritance practice. The inheritor should not engage in any sexual relations with the widow. It is a suggestion, where the inheritor takes care of the family in any way possible. The community calls for the inheritor to provide for the welfare of his late brother's family in every respect other than sexual intercourse with the widow. It is perhaps a new call for the inheritor to become 'a father to the children, but not a husband to the mother'. Although it might be difficult or impractical for the inheritor to implement, the suggestion helps in the transformation of the practice to become culturally and health friendly. The difficulty arises, when one takes cognisance of the submission by Weinrich (1982:65) that when death terminates a marriage, the deceased's heirs inherit his estate and his widow(s). The submission resonates well with the traditional perception of the death-heir-widow relationships. Traditionally, after the husband's death, the widow(s) become a portion of the property of the deceased's estate.

The issue of a non-sexual wife inheritance practice is, in essence, not new at all. Tradition has always offered a safety net for widows by allowing them to choose an

[188] P 2: Local Authorities.txt - 2:25 (52:54) (GUEST) Codes: [inheritance not to involve sex] [Modifications to practices::sticking to one faithful partner]
[189] P 1: Participants' responses.txt - 1:639 [B 33 3(d) 3 The wife must not b...] (1344:1345) (Super) Codes: [care for the children only] [Solution::no wife inheritance]

aunt, a son or a daughter as the inheritor (Weinrich 1982:65). Therefore, what is new about the practice and as suggested by most participants in the study is the emphasis the community gives to the dimension of sons and aunts inheriting widows. Unlike in the past, when the Shona people of Chipinge used to expect a wife inheritance practice, where a sexual relationship was usually involved, the study shows a pronounced shift towards a non-sexual one. Primarily, this non-contact wife inheritance is possible, when the grief-stricken widow chooses an aunt or son as the inheritor. Furthermore, even when inherited by the deceased's younger brother, the widow may boldly declare to all relatives present during the inheritance ceremony that she accepts the inheritor to take care of the family, but not to be sexually intimate with him. Several factors offer plausible explanations for such a paradigm shift. These include the socio-economic and the health environments of the widow. Perhaps, the widow has grown up children who could take care of her, or she could be financially well-to-do such that she may not need any support from anyone, or she might be too old to bear any children. If the widow is still young, she may prefer, as stated by Weinrich (1982:65) and corroborated by the findings of this study, to marry a husband of her choice, or not remarry because she might be afraid of being infected with HIV.

Concerning witchcraft beliefs, participants suggest the conducting of awareness campaigns to educate the communities in Chipinge about the dangers posed by their beliefs in witchcraft, particularly as they relate to illness as a consequence of witchcraft.[190] The suggestion becomes plausible, considering the influence the belief in witchcraft has in explaining the causes of sicknesses in the Shona communities of Chipinge District. The people battle to find the cause of illness within the context of witchcraft and take long to acknowledge infection by HIV. The ripple effect of any delay in proper diagnosis is that anti-retroviral treatment (ART) is delayed as well, with fatal consequences. This suggestion is, in fact, one of the major premises of this study.

[190] P 1: Participants' responses.txt - 1:670 [S 3 3(d) 3 Stopping polygamy; a…] (1409:1411) (Super Codes: [campaigns on belief in witchcraft] [Solution::stop polygamy]

Related to the belief in illness as resulting from witchcraft, the Shona people of Chipinge District also believe that *ngozi* (avenging spirit) is capable of causing terminal sickness or a series of mysterious deaths. The community typically uses young and innocent girls as objects of reparation to placate the *ngozi's* harmful acts against the family. It is in this context that participants suggest "… avenging spirits should be compensated in monetary terms, and not using girls".[191]

The Shona people of the Chipinge District still believe in the efficacy of traditional healers, whom they consult on a regular basis for their routine health check-ups. Sometimes, even when people have visited a clinic or hospital with health problems, they still consult traditional healers for a second opinion. With such a high demand for their services in the society, the Chipinge District perhaps ranks among some of the districts with the most substantial numbers of traditional healers. However, because of the influence of HIV transmission and its encroachment into the moral fabric of the society, study participants suggest that traditional healers should use a new razor blade per patient, if the healing process includes scarification and incisions on their bodies. Taking cognisance of the health dangers posed by belief in witchcraft, *ngozi* and some healing methods of traditional healers as well, these suggestions are fundamental.

4.6 Conclusion

This research was an examination of the Shona traditional beliefs and practices in light of the HIV and AIDS pandemic in the Chipinge District. It aimed to establish the extent to which HIV and the AIDS pandemic have influenced the cultural practices and beliefs in communities under study. The chapter presented and discussed the research findings. The chapter presented the participants' demographics and showed that they were appropriate. Their ages and religious backgrounds, for instance, showed that they were capable of providing the appropriate data for the study, particularly on questions related to their cultural practices and beliefs.

The study shows that most participants are knowledgeable about HIV and AIDS and their causes, except a few, from the sample of traditional healers and older adults.

[191] P 1: Participants' responses.txt - 1:647 [C 5 3(d) 3 When incisions are d...] (1363:1366) (Super) Codes: [keeping a respectable social distance on wife's sisters] [reparation of avenging spirits in cash] [Solution::use sharps once]

Their perceptions and comprehension of HIV infection, the AIDS menace and their causes are fragmented and incoherent. The study shows that some participants still believe that traditional medicine could cure HIV and AIDS, despite the absence of any scientific proof on the efficacy of traditional herbs in the treatment of HIV and AIDS. The results also show that the Shona cultural philosophy that *chiripo chari uraya, zizi harifi ngedutu* (something has killed the owl, it cannot just be the wind) and their beliefs in the efficacy of traditional medicine leads many people who are infected or affected by HIV and AIDS to consult traditional healers. As the results show, this happens even where there is an array of ways (posters, workshops, print, electronic media and health workers) in which information about HIV and AIDS is disseminated to the communities of the Chipinge District.

The study also examined the belief in witchcraft and spirit mediums as well as some cultural marriage practices. The rationale for studying these was that they were linked to the health systems of the people and how they dealt with illness. Also, marriage practices were necessary as the marriage institution is related to sexuality through which the HIV and AIDS pandemic is transmitted.

The results show that most participants (Christians and believers in African Traditional Religion alike) believe in spirit mediumship – that as a people, anyone might be chosen to be a spirit medium. The results also show that the belief in spirit mediumship is potentially detrimental to the health of the affected people because sick people delay seeking medical help, believing that they have been chosen to become spirit mediums. By the time they realise that their immune system is weak because of HIV, it might be too late for any treatment.

The study established that some methods of healing practised by traditional healers are not only detrimental to their health, but to those of their patients as well. The practice of bloodletting, mainly when the healers use their mouths, is dangerous. It exposes them to HIV infection. Scarification for medication, mainly if one razor blade is used on several clients, exposes patients to infection by HIV as well.

Results also show that the people in the impoverished rural Chipinge District still practise *kugara nhaka* (wife inheritance), *barika* (polygamy), *kuputsa* (forced/pledged marriages), *chimusamusha* (substitute wife), *kupindira* (substitute husband) and

several other practices to varying degrees. For instance, the study established that people practise forced/pledged marriages surreptitiously since Chief Musikavanhu, enforcing the Government of Zimbabwe's law on the practice and upholding of children's rights, decreed that anyone caught being involved in the pledged/forced marriage formalities should be prosecuted.

The study also discovered that there are modifications to some of the practices, for example, that those willing to be involved in wife inheritance or to become a substitute husband should be tested for HIV first. Participants, especially from the health professionals' sample, advocate for the total abolition of most of the traditional marriage practices examined. They feel that it could be one of the ways to achieve the zero infection goals as envisaged by the Ministry of Health and Child Welfare to meet the Millennium Development Goals (MDGs). However, it is insurmountable advocacy, as many of these traditions form the basis of the local societies, their belief system and moral fibre. In the next chapter, the researcher summarises the study report, draws conclusions and suggests recommendations.

CHAPTER 5

SUMMARY, CONCLUSIONS AND IMPLICATIONS

"…what is significant in their wrong perception is the realisation and conclusion that the pandemic is incurable. This inference might, perhaps, make the community and particularly those who are more at risk to be more morally vigilant when it comes to issues related to HIV and AIDS"(The researcher's comments on study findings in Chapter 4).

5.1 Introduction

In Chapter 3, the researcher presented the methodology utilised in this study and the research questions that guided the study as identified in Chapter 2. In Chapter 4, the researcher discussed and analysed thematically the research findings that concerned the interface between, and the state of, the Shona traditional beliefs, cultural practices, the HIV and AIDS pandemic in Chipinge District, Zimbabwe. The current chapter winds up by presenting an outline of the entire study report, highlighting the significant themes discussed.

5.1.1 Chapter 1: Background to the study

Chapter 1 constituted the microcosm of the macrocosm. It mirrored, in a small way, the nature of the whole study before its commencement. The chapter, developed from the research proposal, introduced the entire study and its constituent sections and sub-sections. Grounded in the traditional religious milieu of the Shona people in the Chipinge District, the chapter presented the study's statement of the problem or research topic, which was, '*The African Religious Landscape: An examination of the Shona traditional beliefs and practises in light of HIV and AIDS and its ramifications for mitigation and care'.* It revealed the objectives of the study, some of which were to:

- Evaluate the current knowledge, fears, perceptions, attitudes and beliefs about HIV and AIDS among the Shona people of Chipinge;
- Investigate the cultural beliefs and practices likely to perpetuate or lower the risk of HIV infection, and the AIDS pandemic; and

- Discuss the traditional beliefs and practices that have continued, were discontinued or modified due to the threat of HIV and the AIDS epidemic.

The overall aims of the study were to interrogate and assess how HIV and the AIDS pandemic had influenced the traditional beliefs and practices of the Shona people of the Chipinge District in Zimbabwe. In short, it sought to establish if the traditional beliefs and practices of the Shona people of Chipinge were, in fact, not fuelling the spread of HIV and AIDS, thereby endangering the lives of the people they are supposed to safeguard. The chapter justified the study by indicating that there is a dearth of information and literature concerning how the Shona traditional beliefs and practices were responding to the influence of HIV and AIDS epidemic. This viewpoint was significant considering Patterson's (2005:2) reports that indicated that the AIDS threat remained rampant in Sub-Saharan Africa, of which Zimbabwe is a member.

As the chapter indicated, the phenomenological theory or approach influenced this research. Taking every care to be as objective and impartial as possible, the approach allowed the researcher to conduct the fieldwork and collect data *Sitz im Leben* and *in situ.* Thus, the researcher collected raw data straight from the sources, undiluted and uncompromised. This, perhaps, contributed much to the study's reliability and validity.

Chapter 1 also highlighted the parameters of the study area. The researcher conducted the study in selected Shona communities in the Chipinge District in the Manicaland province of Zimbabwe. Some of the communities and environs studied included but were not limited to the following: Zuzunye, Muzite, Gwenzi, Jersey Tea Estate, Mt. Selinda Mission, Mapungwana, Chikore Mission, Dzika, Kondo, Mwacheta, Chibuwe, Rimbi, Manzvire, Mambarangwa and Vheneka. These communities included primary and secondary schools, clinics, hospitals, mission stations and the impoverished rural communities.

Furthermore, it considered research ethics issues. All participants voluntarily participated in the study and signed a consent form. Additionally, it delineated a preliminary literature review that demonstrated that, while some scholars have written on the topic, a gap in knowledge still existed to warrant this research. The

literature review section also indicated the traditional practices and beliefs that the study discussed in detail in the relevant and subsequent chapters.

In the chapter, the researcher also delineated the research questions and the theoretical framework, which guided the study. The researcher rounded off the chapter by providing a conclusion. It indicated the significant highlights of the chapter such as the statement of the problem, the study objectives, ethical considerations, a summary of the literature review, and delimitation of study. The chapter ended by briefly considering the main contents of the chapters that make up this research report.

5.1.2 Chapter 2: Literature review

Whereas Chapter 1 acted as the launch pad of the study, Chapter 2 continued to pave the way for the study by reviewing literature related to the problem statement, that is, an examination of the Shona traditional beliefs and practices in light of HIV and the AIDS threats, and how they affect people's mitigatory efforts and care. The chapter reviewed some traditional practices, especially those from the traditional marriage institution. The rationale for examining these particular practices was the realisation that HIV infections and the AIDS epidemic are more than 90% sexually transmitted. The researcher thus decided it was prudent to examine the problem right at the causes' level, rather than to deal with it solely at the level of symptoms. Some of the marriage practices discussed included but were not limited to the following: Polygamy, wife inheritance, pledged/forced marriages, substitute-wife, replacement-wife, and substitute-husband. The rationale provided by the people practising them was to ensure the family line or clan continuity and stability. The review, however, also demonstrated that the same practices endangered the families or groups they wanted to preserve and perpetuate. The people became vulnerable to HIV infection, which has no cure to date. Traditional healers' methods of dealing with HIV infections did not take into account the real danger of the virus. Some healing methods like bloodletting and the use of one razor blade for scarification exposed both the traditional healer and the patient to HIV infections. The researcher also examined beliefs in witchcraft and spirit mediums, especially the process of becoming possessed.

Furthermore, the chapter reviewed the communities' perceptions of, and knowledge about HIV and the AIDS pandemic. It explored people's basic understanding of the causes of HIV and AIDS. It assessed the literature on traditional leaders and healers' comprehension of HIV infections and transmission, and the AIDS scourge. The rationale for this assessment was to establish the communities' knowledge of the disease and its causes. It also sought to determine the interface between HIV and AIDS epidemic and the participants' cultural practices and beliefs. Literature surveyed showed that there was a lot written on cultural practices and beliefs, and also on HIV and the AIDS pandemic. However, the literature review also indicated a dearth of information concerning how the Shona traditional practices and beliefs were responding to the threats posed by HIV and AIDS in the Chipinge District. The Chapter then indicated that this study was an attempt to address the identified knowledge or information gaps and add some information to the current body of knowledge. It concluded by highlighting the major points examined in the chapter. The next section summarises how the researcher carried out the study, and the methodology executed to accomplish the research.

5.1.3 Chapter 3: Research methodology

In Chapter 2, the researcher reviewed literature related to the research topic – *The African Religious Landscape: An examination of the Shona traditional practices and beliefs in light of the HIV and AIDS pandemic, and its ramifications for mitigation and care*. Since the study had a bias towards cultural practices and beliefs of the Shona people in the Chipinge District, the researcher reviewed literature that gave him an insight into what cultural icons in the communities under study stated in similar studies. He examined the literature concerning the perception of community elders, traditional healers, traditional leaders, experienced teachers, and seasoned health professionals on HIV, the AIDS pandemic and cultural practices. Current literature concerning the impact on, and the cultural practices and beliefs' response to the impact of HIV and AIDS epidemic showed wide gaps in knowledge. This knowledge deficiency enabled the researcher to generate the study questions that steered the conduct of the survey.

In Chapter 3, the researcher discussed the research design and procedures followed in carrying out the study. The researcher used the descriptive survey approach from

the qualitative paradigm stable because it was not only helpful in data description and classification, but also in placing the study in the broader socio-cultural milieu. Furthermore, the researcher chose to use this research design because of its "ability to produce a representative distribution, or a cross-section of the "target population" (Gray *et al.* 2007:122). Thus, with the study located in the proper cultural context, the researcher made an effort to maintain cultural validity (Cohen *et al.* 2007:139), research validity and reliability. Validity is the degree of accuracy of the research outcomes' reflection on the realities of the participants' social phenomena (Creswell & Miller 2000:124). The researcher also identified and discussed the data-gathering instruments, that is, the non-scheduled structured interview (Aberbach & Rockman 2002; Gall, Borg, & Gall 1996) and the open-ended questionnaire.

The researcher collected data in the field by administering the research instruments to participants for close to 10 months. The communities were situated far apart, and the dusty roads were practically unnavigable, especially after it had rained. The state of the roads was deplorable - they were in a state of disrepair due to the neglect by the District Development Fund (DDF). Official documents and fieldwork diary complemented the interview and the questionnaire in providing data; hence triangulation of data sources came into effect (Figure 3.1, Section 3.5).

Furthermore, the research instruments had open-ended tasks that allowed participants to express themselves freely in the Ndau language. The study allowed participants to use the indigenous Ndau language for its benefit; language is the carrier of culture, attitudes, feelings and beliefs, which are the mainstay of the research. Language experts assisted the researcher with translations that enabled coding and inferring meaning from the data. The significance of this process was that the processed data portrayed the intricate pattern of what the researcher researched "*in sufficient detail such that one who had not experienced it can understand it*"(emphasis added) (Marashe 2014:4 citing Nyoni *et al.* 2011:280; Ary, Jacobs, & Razaviel 1990:445).

A sample of 70 mature people participated in the study. They represented a cross-section of people in the Shona communities in the Chipinge District – teachers, elders, nurses, traditional healers and traditional leaders. Their ages ranged from 30

to 55 years of age, and the researcher used both purposive and snowballing methods in deriving at the research sample. The composition of the sample was significant because of the philosophy that the elderly are not only wise and knowledgeable in the people's traditions, but are also the custodians of cultural practices and beliefs. These beliefs and traditional practices formed the backbone of this study.

The study upheld the core principles of research ethics. To maintain participants' autonomy, confidentiality and the right to privacy, the researcher provided them with and asked them to read, the consent letter and then sign a consent form (Appendix C), using pseudonyms (Christian 2006; Cohen *et al.* 2000:61). The researcher explained the aims and objectives of the study, and after establishing rapport with the study participants, they signed the consent form voluntarily (Kyale & Brinkmann 2009). The researcher informed participants that they were at liberty to withdraw their participation from the study at any time during the data collection process without any harm or punishment. Thus, the researcher, in agreement with Mugweni (2012:183), maintained basic research ethics of “autonomy, beneficence, non-maleficence and justice”.

The chapter further included discussion of qualitative data analysis procedures used in the study. The researcher used the qualitative data analysis software, Atlas.ti 4.2 for Windows. The software was significant in data analysis. After the transcription of raw data from participants, the researcher uploaded the transcribed data into Atlas.ti software for processing. Using the open coding format, the researcher systematically broke down data into codes that took cognisance of the research question, sub-questions and the objectives of the study. The researcher merged similar codes to form code families, and from the related code families, created super codes. The researcher generated categories and themes from the code families and super codes, for instance, the perceptions of the participants regarding the traditional practices and beliefs, or the participants' perceptions of HIV infections or the AIDS pandemic. The chapter went on to discuss several sub-themes under each of the broader themes or data categories. Thus, the themes, sub-themes or categories generated from research data, processed by the qualitative data analysis software,

Atlas.ti 4.2, formed the backbone of data presentation, discussion, analysis and synthesis of research outcomes in Chapter 4.

5.1.4 Chapter 4: Research findings and analysis of data

Chapter 3 laid the foundation for the execution of the study among the Shona people in the impoverished rural Chipinge District. Operating under the umbrella of the qualitative paradigm, the study employed the descriptive survey design. The researcher used both the unstructured interview and questionnaire to gather data from a sample of participants that constituted a cross-section of people – educators, health professionals, traditional leaders, the elders in the different communities, and traditional healers. The researcher sought information from participants who were mature and had the requisite knowledge about the interface between traditional beliefs and practices of the Shona people in the Chipinge District, and the HIV and AIDS pandemic cardinal to the success of this study.

In Chapter 4, the researcher presented and discussed the research outcomes about the research questions and reviewed related literature, and themes identified consequent to the coding of data with the aid of Atlas.ti, qualitative data analysis software for Windows. While the first theme mirrored the nature of the participants in the study, the other two naturally followed two strands dictated by the nature of the research topic, and these were perceptions regarding HIV and the AIDS pandemic on the one hand and traditional beliefs and practices on the other hand. Several sub-themes and sections ran under these three broad themes. The first theme the researcher presented was the participants' demographic information, followed by one on the HIV and AIDS pandemic, and ended with the one on traditional beliefs and practices.

The researcher commenced the section by presenting the demographical information of traditional leaders first, which constituted part of the research participants of the study, and then that of the rest of the participants. The researcher presented traditional leaders first since a refereed journal *Verbum et Ecclesia* published the same information in 2014. Biographical data was significant in the study because it doubles as general information about the nature and integrity of the study participants, and the yardstick, through which the relevance of the data collected, was measured. The results indicated that the study participants were

appropriate. They were mature, literate and able to understand and respond to questions well, and had a relevant socio-religious background, considering the nature of the research topic studied. The Christo-traditional divine attribute provided the study with the right impetus and sound grounding as it sought to unravel the stamina of the traditional practices and beliefs of the Shona people of Chipinge, in a socio-cultural and religious terrain that the HIV menace has invaded. Most participants, even Christians, had an experience in the traditional practices of the people and shared some of the beliefs. The implication of this fact is that all respondents in the study, Christians and non-Christians alike, had the requisite background knowledge about Shona traditional practices and beliefs necessary for this study. Their socio-cultural and religious milieu meant that they had a firm grounding to provide rich and valuable data on the Shona traditional beliefs and practices, and the influence of the HIV and AIDS pandemic on the same. Consequently, the appropriateness of the research sample, in a way, might have increased the cultural validity and reliability of the study. Having established the suitability of the participants in the study by unlocking the details of their demographic data, the research report subsequently presented the results on their perception on the causes of HIV infections and the AIDS pandemic.

The section presented several sub-themes that included but was not limited to the following: Definitions and causes of HIV and AIDS, the role of witchcraft in HIV transmission, symptoms, diagnosis and cure of HIV and other ailments by traditional healers and advice to both the affected and the infected in communities. Results showed traces of misconceptions, mythical beliefs, nostalgic tendencies and the reality of what HIV and AIDS and their causes are, especially seen from the traditional leaders' and traditional healers' points of view. It was a misconception to suggest that one gets HIV infection by having sex with a partner who has just aborted, had a stillbirth, is menstruating, or through ancestral spirit malice.

In explaining the causes of HIV and AIDS, they were, in fact, highlighting the causes of both the virus and the disease, a situation suggesting the inseparability of both definitions and causes of HIV and AIDS from each other. However, results from other samples of the study participants demonstrated a clear distinction between HIV and AIDS, with the former being seen as a virus and the latter as a disease.

Participants also identified unprotected sexual intercourse with an infected partner and women's inability to compel condom use as some of the chief causes of HIV infection. Results also indicated that the primary drivers of HIV infection included sexually related behaviours such as promiscuity and unfaithfulness within and outside marriage. The study results also cited extended periods of spousal separation due to work commitments in the diaspora as some of the principal causes of HIV infections due to extra-marital sexual relationships, a practice that exposes and makes people highly vulnerable to infection.

Results of the study further showed that individuals who have HIV or AIDS and those sick consequent to having been chosen to become spirit mediums, exhibited similar symptoms – opportunistic infections taking long to heal, constant physical pains, loss of appetite and weight loss among several others. The belief in spirit mediumship thus complicates the idea of early HIV identification and subsequent mitigation. Some people, genuinely requiring medical attention for HIV infection, delay getting antiretroviral therapy (ART) as they, or their relatives, think that ancestral spirits might have chosen them to become spirit mediums. The delay in introducing ART is worse in the rural and impoverished communities in the Chipinge District, where the majority of people are still traditional in outlook. They still hold on to some of their cultural beliefs, despite the fact that these endanger their lives by making them more vulnerable to the ravages of HIV. The chapter, therefore, argued and concluded that the continued belief in spirit possession may fuel HIV infection because people may think they are so sick because a spirit has chosen to possess them, while they may be ill from opportunistic infections caused by a weakened immune system due to HIV infection.

Furthermore, the chapter revealed that the belief in witchcraft and the efficacy of traditional healers are some of the impediments to HIV and AIDS mitigation efforts. Premised on the cause-effect philosophy as expressed in the proverb, *chiripo chari uraya, zizi arifi ngedutu* (something must have killed it, the wind cannot kill an owl), participants expressed the belief that illness or any misfortune, for that matter, results from the work of witches and wizards, not always in a direct manner, but often exposing the person to unfortunate choices. Consequently, if people get sick from other causes or by HIV infection, they first look for a remedy from traditional

healers. The chapter showed that traditional healers could, at best, prescribe pain-killing therapy, and, at the time of writing this report, there was no cure yet for HIV and AIDS. Traditional healers who claim to have a cure for HIV or AIDS are only seeking attention. Their claim is a marketing ploy to attract unsuspecting clients. Thus, as results show and in harmony with similar medical studies globally at the moment, HIV infections and AIDS are not curable. Nonetheless, the prompt administration of anti-retroviral treatment (ART) could arrest the multiplication of pathogens.

Results also showed that some of the traditional healers' methods of healing could be detrimental to themselves and their clientele. The use of one razor blade on several clients during the scarification process and bloodletting in the extraction of magical projectile or any foreign body from patients' bodies could lead to HIV infection for patients and traditional healers alike. These results reinforce the perception that in sickness, the belief in witchcraft drives the Shona people in the impoverished rural Chipinge District to seek traditional medical care from traditional healers, who, through some of their methods of healing, not only endanger their lives but those of their patients as well.

Furthermore, the chapter discussed the role of traditional leaders in the fight against HIV transmission and the AIDS scourge. In most cases, they assist in practical ways the vulnerable in their communities; for instance, Chief Mapungwana states that using his government-donated vehicle, he transports sexually abused victims to the hospital for immediate medical attention and the prevention of unwanted pregnancies and HIV infection. Chief Mapungwana and headmen Chibuwe and Mutorwa concur in their handling of cases involving extramarital sexual relations or those who deflower the girls and are brought to their traditional courts. They charge the culprits brought to their traditional courts '*mwombe nemwana wayo*' (literally two herds of cattle) commonly referred to as 'damage'. The two herds of cattle act as compensation for the deflowered young woman.

Traditional leaders take advantage of community gatherings, in places where they register for or receive food rations, to encourage abstinence and safe sex as a way of minimising the spreading of HIV and AIDS scourge (Marashe 2014:6-7).

Traditional leaders take advantage of the gatherings because it is difficult to have good attendance at any other meetings. People are too busy trying to make ends meet because of poverty and El Nino-induced poor harvests. So gatherings to register or receive food rations from NGOs are generally over-subscribed.

Results of the study also showed that the community and particularly the caregivers advise people living with HIV or those sick with the AIDS to take their '*Mwari ndouyeyo'* (God, I am coming) medication religiously as prescribed by the doctors. *Mwari ndouyeyo* is a local *nom de guerre* for ARVs and is significant because, by using such term, people infected with HIV or who have AIDS take their medication without feelings of shame, guilt or remorse.

The chapter examined the various ways, in which stakeholders spread information about HIV and the AIDS pandemic among the Shona people in the impoverished Chipinge District. Figure 4.1 summarises the different ways, in which information about HIV and the AIDS pandemic reaches the people. The modes of information dissemination discussed include, but are not limited to the following: Electronic and print media, posters, influential community leaders and workshops. Traditional and community leaders were particularly significant as they are the contact persons in the different communities. Non-Governmental Organisations officials, health professionals and several others first communicate with the traditional leaders before any contact with the communities is made. Most health professionals indicated that they teach patients who visit either clinics or hospitals the necessary information about HIV infection and the AIDS scourge. They sometimes take advantage of outreach programmes; for instance, when they go to immunise children in the communities, to teach people about the HIV and AIDS epidemic, as well as urging them to be faithful in relationships, have protected sex. They also supply them with condoms. The primary objective of spreading information about the HIV and AIDS scourge is to cause, or at least, influence behaviour change. The information, by whatever mode of transmission, carries with it an explicit drive to instil behaviour change or reform in sexual relationships among the Shona people in the impoverished rural Chipinge District.

After discussing the people's perceptions regarding the HIV and AIDS pandemic, the chapter examined the people's perceptions concerning traditional beliefs and practices. Mindful of the fact that HIV is over 90% sexually transmitted, the chapter presented results of investigations into the traditional practices that have a bearing on human sexuality. Specifically, it presented results of the traditional practices within the marriage institution of the Shona people in the rural and impoverished Chipinge District. Thus, by examining some of their marriage practices, the study aimed to determine those practices that expose practitioners to HIV infection and those which are culturally appropriate as well as safe.

Results indicated conflicting information on the practice of *barika* (polygamy). While the majority of the participants stated that polygamy, as a marriage type, was less prevalent, the health professionals were adamant that the practice was still rife. They cited instances of men who had as many as 15 wives from their medical historiography records. A case in point is a traditional healer, who had 13 wives and 36 children, many of whose names he did not know. These fewer cases of polygamy are potential outposts of HIV infections, more so if some of the parties involved in polygamous marriages are unfaithful and engage in extramarital sexual relationships. Results indicate that as a marriage type, polygamy is now less widespread for a variety of reasons, some of which include high cost of living and perhaps men's fear of contracting the deadly HIV and of AIDS.

The chapter presented results on *kuputsa* (forced marriages) as well. Most participants indicated that the practise of *kuputsa* had tapered off over the years, while a handful, including headmen, maintained that some families still practised it, *clandestinely* (e.a.). The admission of its secret practise indicates that the practice lives on, albeit on a small scale. This is notwithstanding the threat of HIV infection the practice might pose to the innocent girl-child. That the frequency of its practice has decreased is not surprising. Perhaps, it is a natural response to the decree of Chief Musikavanhu who, in enforcing a government ban on forced marriages, vowed to arrest anyone who was caught practising it (Marashe 2014:6).

Discussed in the same chapter are results on *kugara nhaka* (wife inheritance). It examined the *kugara nhaka* discourse on the premise that the practice could be a

danger to the family lives that it intended to preserve. Most conservative participants argued that *kugara nhaka* was worth continuing because it ensured the continuity of family lineage. At the same time, neo-liberal participants stated that *kugara nhaka* is an HIV high-risk practice, especially if the husband had passed on due to AIDS or HIV-related sicknesses. They suggested that the grief-stricken widow and the would-be-inheritor should take an HIV and AIDS test before engaging in sexual intercourse. The suggestion to have a blood test for HIV constitutes a modification of the age-old practice. If taken on board, the modification ensures the continuation of the practice as well as guarantees the safety of the participants.

The chapter discussed wife inheritance by an aunt or son as well. This scenario is another welcome development or modification of the long-held practice that could help curb HIV prevalence. The inheritance of this nature is ceremonial. It serves to fulfil the cultural norms and prescriptions of people, without exposing the family to the dangers of human immunodeficiency virus and the acquired immunodeficiency syndrome. Traditionalists reject any modifications or adjustments to their cherished traditions and practices and argue that any modifications to this or any other practice for that matter are hallmarks of Western cultural influence or imperialism.

The more liberal participants were entirely against the practice of *kugara nhaka,* which they felt could decimate whole families if there was any an HIV infection or AIDS. Therefore, one of the more significant findings of the study presented in the chapter was that there is a visible move by the community, perhaps as a response to the AIDS scourge, to promote a culturally safe widow/wife inheritance practice. Taking a blood test before any sexual activity to establish the statuses of both the widow and inheritor and the encouragement to remain faithful to each other could help in achieving a zero HIV infections target in the Shona communities in the Chipinge District. The fear of HIV infection is possibly leading to some of the modifications and adaptations to the wife inheritance practices as revealed by this study.

The chapter also presented other marriage practices of the Shona people in the Chipinge District. They included *chimusamapfiya* (replacement-wife), *chimusamusha* (substitute-wife) and *kutizira* (elopement). The study aimed to determine the

prevalence of these marriage practices in the Shona communities in the Chipinge District, mainly when viewed from the HIV and AIDS lenses. Results showed a similar pattern – these traditional marriage practices were less often practised, save for *kutizira* (elopement). While *chimutsamapfiya*'s slow demise is attributable to the people's enlightenment and empowerment through education and consequently the realisation that they have the right to choose their life partners. *Chimusamusha* is 'dying' because people are afraid of contracting HIV. The chapter showed that *kutizira* is a popular marriage practice especially among the local youths working in South Africa (Chapter 4 Section 4.4.3.7). However, some of the participants branded the practice as immoral because none of the traditional values were adhered to. While the practice could expose young people to HIV, it is probably also a practice that is financially motivated as the male partner avoids having to pay lobola. Elopement often also follows teenage pregnancy, thus causing a higher HIV risk, if the partners were already sexually active before elopement and having multiple sexual partners.

The chapter discussed the results on the practice of *kupindira* (substitute-husband) as well. Practically, *kupindira* by its very nature has to be kept extremely secret because of its sensitive nature. Results show that the practice of *kupindira* has become rare. People may fail to keep the highly private practice a secret and thus endanger the harmony of the families the practice is supposed to protect.

Quite significantly, the reality and threat of the HIV and AIDS pandemic, real or imagined, is championing the demise of some of the marriage practices, and leading to the modification of others. The chapter indicated that the people's culturally driven passion for raising their families and maintaining the families' lineage gave the marriage practices the impetus to endure the threat of HIV, notwithstanding the health-screening dimension for those who might be involved. Therefore, while their practice is waning, the aspect of ensuring the safety of the practitioners through HIV screening might be rejuvenating their continued practice. On modifications to the practices, the chapter showed that health professionals lobbied for the total discontinuation of most traditional marriage practices, while the rest of the research participants suggested modifications to existing ones. The chapter showed that unlike in the past, when people expected that sexual intercourse was normal and

unavoidable in wife inheritance, there was pronounced shift towards a non-sexual stance. Allowing a son or an aunt to inherit the widow on the one hand, and widow consenting to inheritance without sex on another hand, could ensure the achievement of non-sexual wife inheritance.

From the study results discussed in the chapter, it can be argued that the Shona people in Chipinge District believe in the efficacy of traditional healers, whom they regularly consult. However, because of the effects of HIV infection and its encroachment onto the moral fabric of society, participants suggested that traditional healers should modify how they conduct their work. For instance, participants urged traditional healers to *use a new razor blade per client* (e.a.), if the healing processes included scarification and incisions onto their bodies.

5.2 Chapter 5: Synthesis and conclusions about each research question

The preceding section provided an overview of the chapters that constituted this research report. It highlighted the main points and arguments discussed in Chapter 1 through to Chapter 4. The discussion took cognisance of the study objectives and the research questions that guided this research (all outlined in Chapter 1), the reviewed literature (Chapter 2) and the themes that emerged during the coding process (Chapter 3). The current section focuses on the inferences and deductions from the results of specific research questions to improve the research report's clarity and comprehensiveness. It is an attempt to derive meaning from the research results (Chapter 4), thereby evaluating their significance in relation to the study objectives, in pursuance of the research topic regarding the Shona traditional beliefs and practices in a socio-moral environment, where HIV and the AIDS pandemic is wreaking havoc. In this synthesis, the researcher merged questions that led to similar research output or themes in order to avoid repetition. While the results of the study show that there might be peripheral causes too, or insignificant factors that aid HIV infection, this section shows that there are significant contributing factors to HIV and AIDS.

The first broad theme realised after the coding process was the people's perceptions regarding the causes of HIV infection and the AIDS pandemic. The leading questions in this regard were:

- What do you think are the major causes of HIV and AIDS in your community?
- Some people believe that HIV and AIDS are punishment by angry ancestors. What is your comment on this belief?
- Others believe that witches can infect people with HIV through witchcraft. What is your opinion on this claim?

The sections below provide the significance and conclusions of the results of the study in relation to the aforementioned guiding research questions.

5.2.1 'Pollution' as a cause of HIV and AIDS

As Mills (2005) observed in his work, the participants in this study also offered various explanations, perceptions and comprehension of HIV and AIDS. However, most participants did not have adequate or accurate knowledge of the leading causes of HIV infections and the AIDS pandemic. Some perceived *utachiwana* (HIV) or *mukondombera* or *edzi* (AIDS) as an illness resulting from having sexual intercourse with a woman who has had an abortion, who is menstruating or who has just given birth. This borders on the belief that women were 'unclean' during these episodes in their lives (Willms *et al.* 2001). This is obviously at odds with the real causes of AIDS. The Shona people in the Chipinge District are very cautious when it comes to sexual relations during the times when they consider women as 'unclean'. It is a widely recognised belief that sex with a woman in her menses, or who has aborted, or who has just given birth, causes an illness that some participants in the study believed to be AIDS (Section 4.3.1). The 'unclean' belief is based on the concept of 'pollution'. From the study results and the Shona people's belief landscape, the researcher concurred with Simmons' (2009) observations that 'pollution' is the belief that one becomes sick "…through contact with, or contamination by, a substance or essence considered dangerous because it is dirty or impure" (Simmons 2009:232).

Thus, sexual contact with the blood of a woman who has just given birth, menstruum, or who has had an abortion is discouraged, as people believe that such

blood is not only impure but lethal as well. It seems that in the struggle to gain some insight into what HIV and AIDS were, participants, mainly traditional healers, resorted to the schema of diseases of the past, and concluded that they might not be new diseases after all (Simmons 2009:233). This kind of belief and perception makes the Shona people of Chipinge blind to the reality for what HIV and AIDS really are.

5.2.2 HIV infection as punishment by angry ancestral spirits

As Chipinge is mainly a rural and impoverished district, Western or European culture, which made significant inroads into most cities and towns of Zimbabwe, hardly influenced the people's cultural mores. Consequently, most of the people living there still hold traditional beliefs and practices in high esteem. They still firmly believe in the malevolence of ancestral spirits. Only few participants, especially from the traditional healers' sample, roped in the supernatural and spiritual paradigm to explain the causes of HIV transmission or the AIDS pandemic. However, the belief in the involvement and influence of spiritual forces anchor on the philosophy that ancestral spirits may be malevolent if they are angry, and to whip their benefactors into line, they allow *munyama* (bad omen), witchcraft, or illness to befall the living. Some of the traditional healers and indeed many people in Chipinge believe that angry ancestors, who feel neglected by the living, withhold their protection, thereby making the people more vulnerable to infection. Without the ancestor's protection, the individual could wantonly engage in casual sexual intercourse, and be infected by HIV (Chapter 4 Section 4.3.2). This stance is perhaps an instance of indigenous interpretation of the causes of HIV infection or AIDS, their effect on the infected individual and the affected families, the community, and the healers' belief in a "traditional moral order" (Dickinson 2008:285). Although the involvement of ancestral spirits as agents capable of causing HIV was an opinion of a few participants from the traditional healers' sample, it is significant because of their status and influence in the Shona communities of the Chipinge District. They have the power to influence communities' public opinion because they meet people from all lifestyles daily who come to seek medical services. Thus, lack of knowledge about the real causes of HIV by the majority of traditional healers' who participated in the study is a real source of concern. Researchers and policymakers ignore them to the detriment of society.

5.2.3 Witchcraft and HIV infections

Although the belief in the nefarious and nocturnal activities of witches and wizards is unyielding in the Chipinge District, most participants refuted any relationship between witchcraft and HIV and AIDS. The majority of the study participants rejected the witchcraft-HIV infection relationship, arguing that HIV is a viral infection, and witches and wizards cannot invent human immune viruses. Above all, they also dismissed the notion of witchcraft causing HIV because since 'HIV is acquired, witches cannot cause AIDS' (sic).[192] Research participants who felt that witchcraft might have a hand in HIV infection argued that witches could cast an evil spirit over their victims that then steered them into situations, where they could acquire HIV.[193] At this point, it is important to recognise the paradigm shift in participants' responses and the study findings. Even if some believe that witchcraft can influence people's behaviours, it is the decisions people make and the actions they take that cause HIV infections. The study highlighted that HIV is a sexually transmitted infection, and, therefore, it is through sexual intercourse, not witchcraft, that people get HIV infection. Therefore, people will have to take responsibility for their behaviours, particularly where innocent parties are involved such as young girls or virgins being abused.

From the preceding synthesis, the researcher can conclude that the belief in HIV infection or AIDS as a consequence of sexual intercourse with 'dirty' women either because they are menstruating, have aborted or have just given birth is a hindrance to swift medical intervention. The sick or their guardians might delay the commencement of antiretroviral therapy (ART) on the basis that they are sick from *richirana* or *runyoka.* Since that *richirana* or *runyoka* are 'traditional STIs, not curable by modern medical methods, those who are ill from HIV/AIDS causes and their guardians in these rural areas then consult traditional healers, who, by their admission, are not able to cure AIDS. Meanwhile, the patients become increasingly ill by the day, and CD4 count drops to levels beneath which the *'Mwari ndouyeyo'* (ARV) tablets cannot save them, and, consequently, despair becomes an unavoidable daily experience while the reality of death beckons.

[192] P 1: Participants' responses.txt - 1:818 [S 30 3 This is not true for HIV...] (1668:1670) (Super) Codes: [AIDS and witches::witches do not cause AIDS]
[193] Ibid.

The sections mentioned above provided conclusions on what the Shona people in the Chipinge District believe are some of the causes of HIV and the AIDS pandemic. The sections have shown that people still hold on to traditional beliefs on 'pollution', angry ancestral spirits and witchcraft as agents of or contributors to HIV transmission. More significantly, they indicated that these beliefs have a delaying effect on HIV and AIDS mitigation and care efforts. The next section focuses on symptoms of AIDS and spirit mediums and spirit possession.

5.2.4 The dilemma of the symptoms of AIDS and spirit medium possession

In Chapter 4 Sections 4.3.3, 4.4.1 and 4.4.2, the following research questions guided the study:

- What symptoms do someone suffering from AIDS show?
- Briefly explain how a person becomes a spirit medium?
- What is the difference between a person who is ill because the spirit chose him to be a medium and one who has AIDS?

The researcher merged the results of the above three questions because they are all health-related and address the health conditions of individuals concerned. As the results of the study show, there were similarities in the responses given by the participants. The symptoms they identified – loss of body weight, reduced healing of body, body wasting, loss of appetite, general body weakness, pain, and so forth, present themselves both AIDS-related cases and people chosen to be spirit mediums. This similarity is an obstacle to early HIV and AIDS diagnosis, mitigation and care. As such, victims of HIV infection take time to be introduced to ART because of their belief that their recurring sickness could be caused by having been chosen by ancestral or alien spirits to be their mediums. Because of the belief in spirit mediums, the sick or their guardians in the Chipinge District consult traditional healers to remedy illnesses whose symptoms are akin to those of AIDS. As results of the study showed, discussed in Chapter 4 Sections 4.4.1, 4.4.2 and illustrated in

Figure 4.2, respectively, people chosen to become spirit mediums get sick[194] from a wide range of illnesses whose symptoms are similar to those of medically confirmed AIDS cases. As the rural communities still believe in the efficiency of traditional healers whom they hold in high regard, they delay effective HIV and AIDS treatment. Instead of rushing the sick to the nearest modern health centre, they take them to traditional healers (Chapter 4 Section 4.3.7) who, after trying several herbs and failing to provide a cure, would then eventually refer them to the clinic or hospital. By the time they refer the sick to a clinic or hospital, their condition might have worsened to levels beyond remedy. Given the preceding analysis and the role of traditional healers, the study argued that the continued belief in spirit possession or spirit mediumship may be a vehicle that hinders HIV and AIDS mitigation and treatment. People suppose that the sick have hard-to-heal illnesses because a spirit has chosen to possess them, when they may be ill from opportunistic infections caused by a weakened immune system due to HIV infection.

This section provided a conclusion on the confusion in the Shona communities of the Chipinge District created by the similarities of the symptoms of confirmed AIDS cases and those exhibited by people chosen by either alien or ancestral spirits to be their medium. This challenging dilemma negatively affects the mitigation and care efforts. The people who are sick pay regular visits to traditional healers in the company of their guardians, hoping for a remedy. The traditional healers eventually would refer them to the clinic or hospital when their condition would be far worse than before. The next section highlights conclusions about the diagnosis and potential cure of HIV and other diseases.

5.2.5 Traditional diagnosis and cure of HIV, AIDS and other diseases

In Chapter 4 Sections 4.3.4, 4.3.5 and 4.3.6, the following questions guided the study from a traditional medical perspective:

[194] P 1: Participants' responses.txt - 1:482 [M 20 3(a) When grandfather was...] (988:991) (Super) Codes: [Spirit mediumship::host becomes sick] [traditional healer is consulted]

- How do you diagnose that a patient has HIV or AIDS, and other diseases?
- Headaches and stomach pains are curable. Do you think HIV or AIDS is curable?
- How far can your healing methods cure AIDS?
- In what ways may traditional healers help a person who has AIDS?

The nature of the questions was such that only practising traditional healers or known herbalists responded. Traditional healers' diagnosis and treatment of HIV infections or AIDS are problematic, while fascinating. Casting or throwing bones (divination), or invocation of ancestral or alien spirits to 'reveal' the cause and nature of the disease demonstrates the traditional healers' dependence on the traditional occult powers to determine the disease affecting an individual. Traditional healers may also use their 'inner eye' to observe the patients' appearance, and, sometimes, their excreta, to determine their sickness. They strongly believe that they have the ability to diagnose by observation if a patient has HIV infection, or is already suffering from AIDS. They believe that theirs is a skill gained through years of experience in dealing with different kinds and degrees of illnesses. Traditional healers veil their diagnosis of HIV or AIDS in secrecy, beyond the comprehension of the ordinary members of the Chipinge District's impoverished rural communities.

The question of HIV/AIDS treatment was two-pronged. It aimed to solicit information on whether traditional healers had medicines that they believed could cure AIDS, and whether they actually provided treatment for HIV and AIDS. The study showed that traditional healers, indeed, provided medication to individuals infected with HIV, and those sick with AIDS. However, results also revealed that their medication did not cure the virus or the disease, but only temporarily relieved pain, and treated opportunistic infections such as diarrhoea, nausea, headache and any other symptom that the patients may show, after which traditional healers referred them to the hospital for further tests. One of the participants summarised it up by saying, "all

they did was to prop up the patient with their medicine so that the patient may get to the hospital". Thus, the study's results are clear that traditional healers cannot cure HIV or AIDS, but they can provide traditional concoctions to ease pain, and enable one to go to the clinic or hospital. As shown in Section 4.3.5, the study results are in harmony with similar medical studies conducted globally that indicate that HIV and AIDS so far remain incurable, while administration of ART may slow down the multiplication of pathogens.

Some traditional healers and elderly participants still believe that AIDS used to be, and can still be cured. That it used to be a curable disease in the past indicates that some traditional healers and others still believe that the epidemic is an old disease that became more sophisticated and difficult to cure because of moral decay in society. As Walwayn (2010:12) reported, the traditional healers associate the HIV and AIDS symptoms with "cultural notions of sickness …" For instance they may misconstrue unresponsiveness to medication as indicative of becoming a spirit medium and delay seeking proper medical care. The persistent illness that remains even if one is treated precedes spirit possession (Zvarevashe, 1970:45; Gelfand, 1962:84-85 & 1973:127; Bourdillon, 1976:277; Bucher 1980:48). The issue of immorality, as some of the study participants stated, echoes Simmons' (2012:3) perception that HIV and AIDS in Zimbabwe, "…serves as a punishment …" for the breakdown of society's moral fabric, and is indicative of the blatant transgression of cultural beliefs and practices' borders. It seems, therefore, that the perceptions of the traditional healers and elders in the communities in the Chipinge District are nostalgic, believing there were fewer serious or incurable diseases in the past when morals were higher and traditions strictly adhered to. Perhaps, some traditional healers genuinely believe they can cure HIV and AIDS and any other illness or they are merely claiming it to attract more patients. They are abusing the trust the people have in their abilities to cure other diseases to hoodwink them on HIV and the AIDS pandemic.

The study results regarding traditional healers' modus operandi regarding treatment of other sicknesses are worth commenting on. The question that led this subsection sought to determine if traditional healers, by some of their healing methods, were not themselves susceptible to HIV infection. Some of the methods of healing, especially

of foreign objects within the body such as *chitsinga* (magical projectile), are a health hazard to the traditional healers. The methods of bloodletting or biting out (*kurumika*), incisions (*kutema/kucheka nyora*), and subsequent removal of any 'foreign objects' (*chitsinga*) with bare hands could be vehicles for HIV infection and transmission. Therefore, it is safe to state that there are some traditional healers who still conduct their work without taking enough precautionary measures to protect themselves against HIV infection and subsequent transmission to other patients. Exposure to blood and other body fluids, whatever the HIV status, is dangerous nowadays. The section has shown that there is no cure yet for HIV/AIDS and that some of the ways traditional healers use to heal or remove 'foreign objects' (*zvitsinga*) from patients' bodies expose them to HIV infection because they get into contact with blood and body fluids. The next subsection provides a conclusion on people's persistence in consulting traditional healers.

5.2.6 Persistent consultation of traditional healers despite failures

In an effort to understand the significance of traditional healers fully in the traditional health delivery system in the Chipinge District the researcher posed the question:

- Why do people living with HIV and AIDS continue to go to traditional healers, even after consulting medical doctors or hospitals?

The reviewed literature showed that a population's state of health mirrors the welfare of any country and the efficacy of the health providers. When a nation's health service provision collapses, as was experienced in Zimbabwe, the person in the impoverished and underdeveloped rural districts, one of which is Chipinge, is the first to feel the ripple effects. In such cases, as the results of this study show, the community reverts to the traditional medical care. Thus, when clinics and state-run hospitals fail to deliver, the people consult the traditional healers who, like Pearson and Makadzange (2008:370) argued, are always accessible, and have long-proven techniques of treating a broad range of diseases. Related to this, Dickinson (2008:282) argued that African traditional healers are more holistic in their approach toward the patient as opposed to the allopathic medical practices. Thus, when people get sick in the community, their first port of call, even before going to the

clinic, is a visit to the traditional healer. Results discussed in Section 4.3.2 and concluded in Section 5.2. 3 corroborate Dickinson (2008:282)'s findings by showing that the reason for persistent visits to traditional healers is that there is engrained belief in traditions, magic and witchcraft. So, sick people or their guardians request traditional healers to cast out *'bvuri'* (i.e. shadow or shade; pl. *mabvuri*) that people think could be responsible for causing the sickness and dilute the efficacy of bio-medical medicines. Grounded in the traditional philosophy of cause-and-effect as expressed in the Shona proverb, *chiripo chari uraya, zizi arifi ngedutu* (something has killed the owl, it cannot just be the wind), the sick or their guardians consistently consult traditional healers to establish a sound explanation for the cause of any sickness or misfortune. Normally, they would try to establish if the disease will be taking longer to cure (Simmons, 2012:10; Bourdillon, 1998:167; Gelfand, 1985). Only when, for instance, exorcism has been conducted to remove any angry spirit, but the person does not recover, would they go to the clinic or hospital.

However, as hospitals and clinics do not have sufficient and qualified medical personnel or adequate stocks of medicine because of the political and economic meltdown[195] in Zimbabwe, they just give patients a prescription of medicines to buy from the pharmacy and possibly, dispense a few stop-pain medications for any sickness.[196] This supports the UNAIDS 2002's results as indicated in literature review chapter 2 Section 2.3. The report of the shortage of drugs in government health institutions is a reflection of inadequate government's health funding and results from a poorly performing economy. Because of poverty and unemployment caused by the decade-long economic meltdown, most people cannot afford to buy the medication, so they would go back to the traditional healers, where they can either negotiate the price of treatment given, or the terms of payment. They can even negotiate to pay in cash or kind – in the form of livestock, maize, and so forth. Patients suffering from AIDS or those discharged from the hospital and placed under

[195] On 18 January 2016 and 25 January 2016, both the Zimbabwe Broadcasting Corporation and the editorial of *The Chronicle* indicated that major referral hospitals in the country ran short of essential drugs. The nationwide drug shortage that affected major referral hospitals did not spare district hospitals of which Chipinge is one.

[196] From a Daily News report entitled 'ZANU PF favours defence over health' by Bridget Mananavire, the health sector situation is heading for the worse. Drug shortage was the order of the day with a budget allocation of $330.7 million in 2016; the situation is most likely to get worse with a reduced budget allocation of $282 million in 2017.

the home-based care programme face the same predicament – they receive prescription of pain-killers, instead of anti-retroviral drugs. They also find themselves queuing at a traditional healer's 'surgery' for medication. Then, when the sickness becomes severe, they go back to the hospital, where they eventually die. Thus, as Pearson and Makadzange (2008:370) wrote, sick people use several health service providers consecutively or simultaneously as efficacious treatment is more valued than the source. Treatment of diseases, inclusive of HIV/AIDS, assumes a multidirectional cyclic routine as shown in Figure 5.1 below.

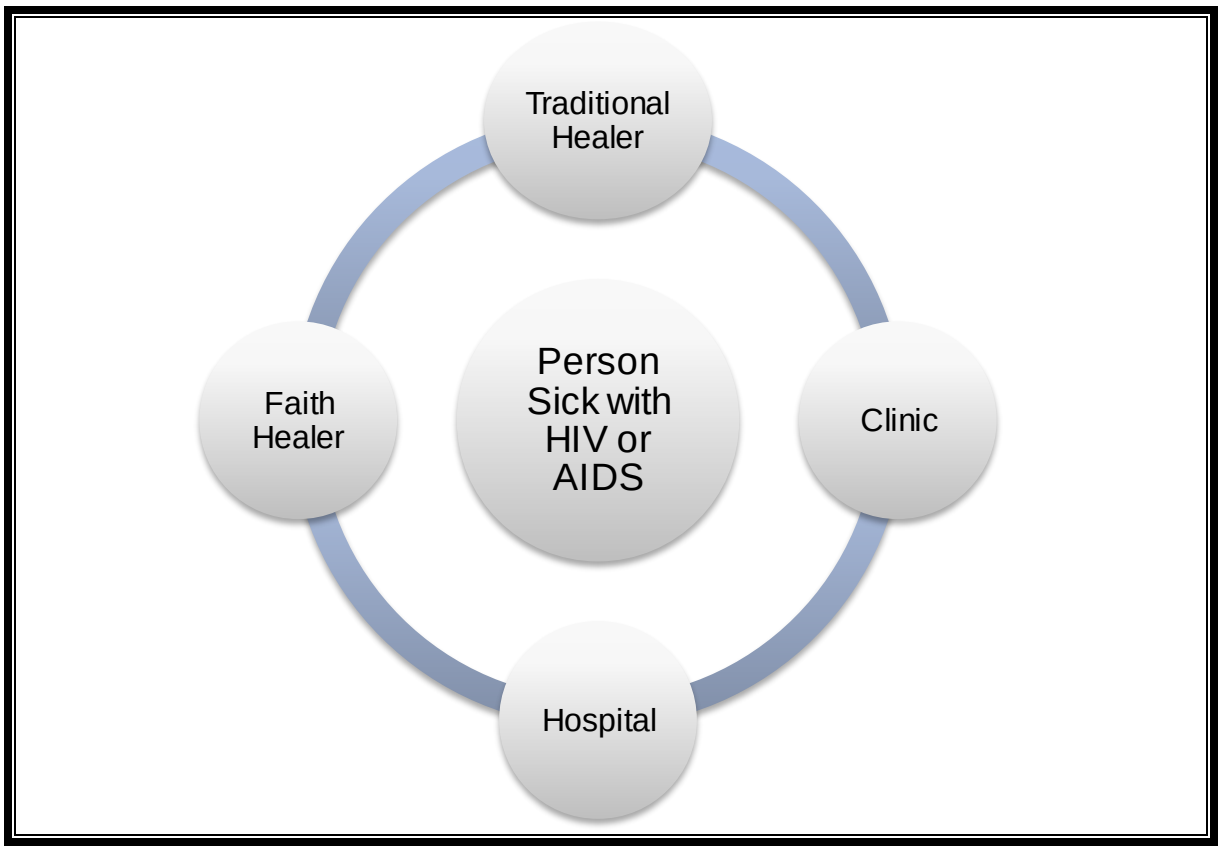

Figure 5.1 Health Service Providers in the Chipinge District

As shown in Figure 5.1, people who are sick with HIV or AIDS, for instance, have several treatment options at their disposal. These treatment options rotate, in any direction, between traditional healers, clinics, hospitals and faith healers.[197] The study results on the above sub-questions have shown that despite failing to have offered a cure for HIV and AIDS, people in the Chipinge District regularly consult

[197] Hospitals in this case include both government and church-run institutions, while faith healers include prophets from Zionist and Pentecostal churches.

traditional healers on matters of health, possibly because of a deep-seated belief in their 'magical' ability. The section below endeavours to derive meaning from the findings on the advice the Shona people in the Chipinge District give to people infected with or affected by HIV or those sick with AIDS.

5.2.7 Advice to people infected and affected by HIV and the AIDS pandemic

The sub-heading in this sub-section stems from two questions that sought information on the kind of counsel the study participants gave to patients (Sections 4.3.9 and 4.3.10). The results of the study indicate that the research participants across the socio-economic divide urge people who are sick with HIV or AIDS to take their '*Mwari ndouyeyo*'[198] (ARVs) regularly as prescribed by the medical doctors – obviously subject to such medication being available and prescribed/given in the first place. Furthermore, they advise them to desist from casual sex, especially with multiple partners, use protection each time they have sexual intercourse and also be on a healthy diet. The advice they give is indicative of a caring society. This is so because words of comfort are a significant step in the recovery of the sick. The thoughts and words of comfort have power and potential to assist the sick people psychologically and in their recovery.

The advice to the affected was brief – they should take care of their sick relatives well, do their laundries if the patients cannot do it on their own, prepare their food, and ensure that they take their medication consistently and on time every day. The findings suggest that caregivers should not end at feeling sorry for the sick, but should assist them practically in several ways as well. Participants, therefore, implore caregivers to be approachable and supportive towards those ill with AIDS, showing them care, respect and provide a supportive family network. This and the conclusions mentioned above are significant strides in mitigating and managing HIV transmission and the AIDS epidemic in the rural and impoverished Chipinge District. Having explored the advice the communities gave to those who are infected and affected by HIV and AIDS (Sections 4.3.9. - 4.3.10), the study explored if there was enough information available about HIV and the AIDS scourge in the communities.

[198] '*Mwari ndouyeyo*' literally means 'God I am coming there.'

5.2.8 HIV and AIDS information dissemination

Two questions, indicated below, were radars for Section 4.3.11:

- How do you reach out to the community with information about HIV and AIDS?
- How do you get information about HIV and AIDS?

The basis for these twin questions was the realisation that knowledge or information is power. Therefore, the study, through the questions, strove to establish the extent to which information about HIV and AIDS reached and empowered the communities in the Chipinge District. Figure 4.1 summarises the several ways in which the people in the district under study receive information about HIV and the AIDS pandemic. The results of the study show that Chipinge District receives adequate information through the electronic and print media, in addition to workshops and community leaders. Traditional leaders provide and facilitate the acceptability of those who provide information to their communities, thereby enriching and empowering their members to make the right choices in their lives and those of their children.

As shown in Figure 4.1, precise and comprehensible information on HIV mitigation and care is essential for people living with the human immunodeficiency virus. It makes the people who are sick observe the doctor's instructions to manage their conditions. When this happens, fewer people are ‘lost to follow-up.' This means fewer people would skip taking their medication. Thus fewer would require a follow-up to remind them of their medication uptake obligations. Moreover, accurate and precise HIV information helps to avert unnecessary mitigating procedures, thereby saving on financial and other resources.

The importance of accurate information about HIV or the AIDS epidemic comes to the fore if considered through the lenses of the transmission mode. Figure 4.1 indicates the modes of information dissemination within the Chipinge District communities. The variety of ways of disseminating information give the Chipinge District communities the best opportunity to retain and remember essential information about HIV and AIDS, and is in line with the idiom, ‘a picture is worth a

thousand words'. Posters, television advertisements and programmes, books and pamphlets provide comprehensive information that reinforces messages about HIV mitigation and care. They appeal to both the affective and visual senses and helps in high retention of information.

Moreover, the Pamphlets have the added advantage of flexibility in usage. The Ministry of Health and Child Welfare (MHCW) and other health stakeholders designed pamphlets or leaflets in such a way that people can take them home from the clinics, read and digest them at an appropriate time at their own pace. Accessing information about HIV and AIDS equips the people and make them aware of the dangers associated with irregular intake of antiretroviral (ARV) drugs. It can be concluded that people with accurate information are more likely to take their ARVs religiously as prescribed by the doctors. The information empowers and motivates them to overcome stigmatisation. However, it is significant to indicate that the availability of accurate information about HIV is one thing and its uptake by the communities under study is quite another. Armed with that information in a cultural landscape, where traditional beliefs and practices die hard, the chances are high that the people, especially the elderly, might always fall back on their traditions in times of social and health hardships. At the same time, the trusted traditions and beliefs have proven to contribute in part to the potential risks of becoming infected by HIV. The beliefs have developed fault lines that expose people to HIV infections. Thus, any information provided to these people is only as good as their trust in that information beyond that given by their traditional healers or their families. Having looked at the Shona people in the Chipinge District's perceptions regarding the causes of HIV transmission and the AIDS pandemic, the synthesis shifts focus to the second and last major theme of the study, perceptions regarding the traditional beliefs and practices as reflected in Section 4.4.

5.2.9 Traditional marriage practices

The section presents conclusions on some of the marriage practices that the Shona people of the impoverished rural Chipinge District practise. It draws up the conclusions in consideration of the fact that HIV and the AIDS scourge intruded into the traditional marriage landscape and people's relationships. It concentrates on the marriage practices because Sections 5.2.1 to 5.2.6 presented some of the pertinent

Shona traditional beliefs for this study in their treatment of the first major theme. The sections presented conclusions on the following beliefs: 'pollution', angry ancestral spirits, witchcraft and the efficacy of traditional healers. This section proceeds by presenting inferences about traditional marriage practices that the Shona people in the Chipinge District practise.

5.2.9.1 Barika (polygamy) and kuputsa (pledged or forced marriage)

The researcher had already published conclusions on *barika* (polygamy) and *kuputsa* (forced or pledged marriage) (Chapter 4 Sections 4.4.3.1 and 4.4.3.2, respectively) in a refereed journal, *Verbum et Ecclesia*.[199] However, it is significant to reiterate that instances of polygamy are declining in the Chipinge District because of the economic meltdown that left many people without meaningful employment,[200]and thus unable to fend for large families, as well as their fear of contracting HIV.

Concerning *kuputsa,* a few people are still forcing or pledging their children for a marriage to save the families from either starvation or an avenging spirit. Thus, some households in the Chipinge District surreptitiously pledge their girl-children to the well-to-do in the communities to appease the avenging spirits who would be fighting, seeking recompense from the family of the killers[201]. They do it secretly because traditional leaders, under instruction from the government, do not condone the practice anymore (Mohammed 2016). The problem with forced or pledged marriages is that child brides are taken advantage of by their more experienced and older grooms. The older grooms not only force the younger child brides into unprotected sexual intercourse, but may expose them to STI infections as well. Because of their powerless position and immaturity, child brides may not negotiate for safe sex and are, therefore, vulnerable to also contracting HIV. Therefore, as traditional marriage

[199] Marashe, J. 2014:6, 7. The African traditional religious landscape: An examination of the role of traditional leaders in the fight against HIV and AIDS in Chipinge, Zimbabwe.

[200] Zimbabwe's economic downturn took a nosedive after the violent and bloody expropriation without compensation, of white-owned commercial farms after the no vote on the new constitution referendum of 2000. Since the economy was agro-based, most industries, factories and agro-businesses shut down, leaving many people in farming areas, cities and towns unemployed and living in abject poverty.

[201] Writing about the Hwesa people in Katerere village in North Eastern Zimbabwe, David Maxwell stated that people feared *ngozi* (avenging spirit) the most. It is a spirit of someone whose killing has no justification and is buried in a shallow grave. Maxwell (1995: 311) argued: "Through a host in the offending family, it demanded that fines be paid to its kin in the form of money or cattle or, and often a young girl."

forms, *barika* and *kuputsa* are social problems or fault lines contributing potentially to HIV infections of young women/children living in the Chipinge District. Obviously, other factors such as migrant labour, men taking girlfriends and visiting prostitutes in other countries/areas, are serious contributing factors in the spread of HIV infections, beyond traditional marriage practices, and require a study of their own as these factors are beyond the scope of this study.

5.2.9.2 Kugara nhaka (Wife inheritance)

Two questions guided the research on this marriage practice, and these are:

- In light of HIV and AIDS, what is your comment on the practice of *kugara nhaka* (wife inheritance)?
- What risks of HIV (if any) may be associated with the *kugara nhaka* practice?

Results on the first question were inconclusive as demonstrated in Figure 4.3, where some of the study participants argued for the continuation of the practice and others pushed for its abolition. However, others remained non-committal to any particular position. They were comfortable with either of the positions. The overall perception of the study results is that while wife inheritance as a marriage practice can continue, both partners should undergo a blood test to establish their HIV status before they stay together as husband and wife. The HIV test safeguards the parties involved in the wife inheritance practice from blindly engaging in a practice that may decimate families if any one of them has HIV infection. This means that HIV and the AIDS epidemic have had an effect on the Shona people's socio-cultural landscape as exemplified by the age-long wife inheritance practice that is now conditional. The presiding family members on the day of the ceremony might urge and encourage the people to be involved in the practice to go for an HIV test. The demand for a blood test is a relatively new requirement, especially to those who care for their health and particularly in cases, where the cause of the death of the husband remains a closely guarded secret.

5.2.9.3 Chimusamapfiya (replacement-wife) and chimusamusha (substitute-wife)

In sections 4.4.3.4 and 4.4.3.5, the researcher asked participants their perceptions concerning *chimusamapfiya* (replacement wife) and *chimusamusha* (substitute wife) marriage practices in light of HIV and the AIDS pandemic. The former practice is when a widower has his deceased wife replaced by her younger sister or her brother's daughter, while the latter is a woman who is married because the first one is too old or no longer bears children. The results of the study indicate that these traditional marriage practices are no longer that popular. The practices are losing ground because education has shown women that they have a right to choose their own partners, are not a commodity to be used for replacement or substitution. Another significant reason the study participants cited was the fear of HIV infection and the AIDS menace. They argue:

> It is practised, but we do not encourage it because of AIDS disease. We encourage those who want it to take a blood test (sic).[202]

The admission of fear of HIV infection and AIDS is a clear indication of the impact these health threats have had on these traditional marriage practices. Therefore, it may be concluded that to some extent, HIV and the AIDS pandemic have led to the scaling down or modification of some of the traditional marriage practices. The adjustment, in this case, comes in the wake of the suggestion by the study participants that a couple taking part in either *chimusamapfiya* or *chimusamusha* marriage practice should go for HIV test. The next question the researcher asked concerned a customary practice that ensured that a couple has children.

5.2.9.4 Kupindira (substitute husband)

Kupindira is a top-secret practice done by the Shona people in the Chipinge District to make sure that a wife bears children in a marriage, where the husband is infertile. An aunt or uncle secretly negotiates with the wife to have a child by the younger brother to her husband. When she agrees, the surrogate father is informed, and the aunt/uncle tells them that it must remain top-secret, whatever the circumstances.

[202] P 1: Traditional Leadership.txt - 1:115 (318:320) (Super) Codes: [*Chimusamapfiya*::it's done but not encouraged because of HIV/AIDS | those who want to take a blood test]

Therefore, the strength and functionality of the practice are in it remaining a secret. The question that directed the section was:

- In light of HIV and AIDS, what is your opinion on the practice of *kupindira* (substitute husband)?

As the results of the study showed, the development of love feelings for each other or love for the children by the younger brother is, and remains a taboo because it leads to disclosure and normally, death. The prevalence of the practice is difficult to quantify. *Kupindira* or *kutumira* is a practice done by communities so secretly that even other family members may not know about it and so to express its prevalence in communities is mere conjecture. Participants who expressed the gradual demise of the practice cited the problem of disclosure as one of the challenges. Furthermore, the research participants cited the fear of HIV infection and the AIDS menace as a challenge against the practice as well. The nature of the practice is such that it is top-secret, and so going for HIV screening or testing is not secret-proof. Any relative or family member who spots the wife and a younger brother going in and out of the VCT centre might reveal their plan to have the wife of the infertile man be impregnated by his younger brother. The practice has the potential to destroy families if the secret becomes known. Brothers may kill each other, and there could be feuds about the ownership of children.

Although the practice continues to endure in secret, fears of disclosure and HIV infection have reduced the incidence of the practice of *kupindira* or *kutumira.* The greatest challenge is that besides the fact that those involved in *kupindira* should keep it a secret, there are also other challenges. The younger brother could have already contracted HIV and could spread it to the brother's wife and subsequently his brother. Therefore, in such arrangements, vulnerability to HIV infection and sexually transmitted infections remains very high.

5.2.9.5 Kufohla (elopement)

As with the other marriage practices discussed above, one question directed the search for an answer concerning *kufohla*:

- In light of HIV and AIDS, what is your comment on the practice of kufohla (elopement)?

The results of the study show that *kufohla* is a popular marriage practice[203] in more recent times. The pattern that emerges from the study results is that *kufohla* is mostly popular with young men, *maJoni-joni*, who work mainly in South Africa. It is possible that conscious of the short period before they trek back to their workplaces, they hurry to marry. If they leave the wives in the custody of their parents or guardians at home, the men could easily get back to their places of work, take a girlfriend and on their return home, infect their wife. In light of the danger of HIV infections and the limited time available to the couple before elopement, the parties might not have enough time to go for a blood test and everyone involved is exposed and vulnerable. When the holiday is over, the labourers go back to their various South African bases, leaving pregnant wives behind. The challenge that soon comes is the long spell of spousal separation as one of the causes of HIV infection in the Chipinge District.[204] The study identified spousal separation as one of the causes of HIV infection in Sections 4.3.1 and 4.3.2, respectively. As the results of the study indicate, the husbands would cheat on their spouses and this creates tremendous opportunities for HIV infection and transmission. Thus, though the marriage practice is popular with *maJoni-joni*, it has its fair share of health hazards. The faraway husbands are as exposed and vulnerable to the HIV infection and AIDS pandemic as their wives back home in the District of Chipinge and elsewhere.

The preceding sections provided conclusions to the different questions that directed the course of this study. They highlighted the kind of challenges most traditional marriage practices face or introduce, considering that the HIV and AIDS pandemic wreaked and continued to wreak havoc in the Shona traditional marriage landscape.

[203] P 1: Traditional Leadership.txt - 1:158 (434:437) (Super) Codes: [Elopement::practised too much, especially by those who work in South Africa]
[204] P 1: Participants' responses.txt - 1:756 [C 9 2 The major causes of HIV ...] (1549:1551) (Super) Codes: [AIDS causes::unprotected sex with infected partner] [spousal separation]

The next section seeks to derive meaning from the suggestions participants gave to ensure that the traditional practices and beliefs are culturally appropriate.

5.3 Suggested modifications to the Shona traditional practices and beliefs in the HIV milieu

The preceding sections tried to derive inferences from traditional marriage practices in the rural and impoverished Chipinge District concerning the HIV and AIDS epidemic. This section proceeds by interrogating the modifications to the beliefs and practices as exhibited by the Shona people in Chipinge District. The question below provided the radar for this section:

- In light of HIV infection and the AIDS pandemic, what changes to the cultural practices and beliefs would you suggest?

While the health sector participants in the sample suggested far-reaching modifications, other participants' suggestions were moderate. The health sector participants' recommendations to discontinue the practice of pledged marriages, polygamy, wife inheritance and beliefs that witchcraft or wizardry cause sickness may not be feasible in the Shona communities of Chipinge, who are, by-and-large, conservative and value their customs, beliefs and traditions. The cause-and-effect Shona philosophy, expressed in the proverb, *chiripo chari uraya, zizi arifi ngedutu,* had deep-seated roots in people's minds, and it may take ages to reform. It is their way of life. To change it in order to embrace new ways of life that are culturally safe may be a herculean task. The researcher believes that the suggested recommendations are confrontational, pitting the people against their traditional practices and beliefs. Therefore, adoption by the communities in Chipinge remains doubtful and uncertain.

However, recommending the discontinuation of pledged marriages, the health professionals concur with the rest of the study participants. In light of this unanimity in condemning forced or child marriages, the government of Zimbabwe instructed traditional leaders to arrest anyone who married or gave his underage daughter

away in marriage. Besides, the Constitutional Court of Zimbabwe outlawed the marriage of children under the age of 18 years in a landmark ruling in January 2016.

Therefore, allowing pledged or forced child marriages in the pretext of either saving a family from starvation[205] or from the clutches of avenging spirits seeking compensation (M. Mbonyeya [Headman] personal communication 5 February 2012)[206] has become unjustifiable. It is important to note that it is now a punishable offence under the law to preside over lobola procedures that involve girls below the age of eighteen years.

Some of the suggested modifications revealed the different socio-cultural and educational backgrounds of the participants. Participants in the study sample aligned to the Ministry of Health and Child Welfare were chief proponents for the abandonment of traditional practices and beliefs, which include beliefs that witchcraft and ancestral spirits cause sickness, whose symptoms resemble those of HIV and AIDS illnesses. They strongly recommended the discontinuation of some of the Shona traditional marriage practices such as *barika* (polygamy)*, kuputsa* (forced marriage) and *kugara nhaka* (wife inheritance).

In addition, the participants noted that husbands might not be able to adequately support their large families thereby affecting the children through malnutrition, kwashiorkor and other diseases. They therefore discouraged these marriage practices and also noted the problems of poor postnatal care in polygamous marriages. The study participants, especially those from the health professionals' sample, stated that the nature of sicknesses they attended to in clinics and hospitals confirm their argument. Their recommendations are consistent with participants referred to as liberal-minded and expressed in Chapter 4 Section 4.4.3.3, Figure 4.3. The suggestion for a non-sexual wife inheritance practice seemed to be popular with some of the participants, the liberal and neo-liberal included. The conservative

[205] Young girls are married off to wealthy men to avert starvation, especially in times of poor harvests. The practice mushroomed in other districts too, for instance, in Nyamajura to the east of Harare; a girl of 14 years was married to a 65-year old man to save the family from starvation. More details on http://mg.co.za/article/2006-05-17-hunger-forces-zim-girls-into-forced-marriages.

[206] Marashe, J. 2014:6,7, 'The African traditional religious landscape: An examination of the role of traditional leaders in the fight against HIV and AIDS in Chipinge, Zimbabwe'.

section of the participants argued it would be difficult to get help from heirs who did not have conjugal rights.

Nevertheless, the proposed modifications by most of the participants in the study sample, referred to as conservative in Figure 4.3, were not as drastic as the liberals' suggestions. Their recommendations tended to try to overcome traditional, harmful elements within the practices to make them safe for the Shona people in the Chipinge District. Accordingly, while the health professionals were lobbying for the discontinuation of some of the traditional practices, the conservative participants of the study sample recommended the introduction of a health check. For instance, they suggested that people should first go for an HIV test before engaging in *nhaka* (wife inheritance), *chimutsamusha* (substitute wife) and *chimusamapfiya* (replacement wife) practices, to ensure the safety of all people involved. The slight modification to some of the traditional practices as reflected by the examples mentioned above is significant in that it shows people's unwillingness to abandon their customs in their totality. The traditional practices and beliefs define who they are as a people. Therefore, their suggestions are a kind of compromise between the people on the one hand, and their traditional practices, on the other. This compromise represents an adaptation to the traditional practices. This adaptation ensures that people's customs survive the HIV onslaught albeit in modified versions. Viewed from the HIV and AIDS pandemic landscape, the modifications to the practices, real or imagined, mean that the communities under study would be able to mitigate and better manage HIV cases in both their families and the communities at large as far as behaviour around marriage practices is concerned. Though it is not within the scope of this study, it will not address problems caused by unfaithful behaviour, sexual relationships outside of marriage and even infections through crime.

The section presented conclusions derived from the results of the study. It is encouraging that the study participants appreciated the threat of HIV and an AIDS pandemic, despite them being wrong about the causes and partially naïve about the treatment (by traditional healers), while suggesting modifications to traditional practices that accept HIV testing within its ranks for the safety of the people. These suggestions for modification are a welcome development. They equip the

communities with avenues to manage HIV cases better and, hopefully, communities may end up with fewer cases of HIV infections. Above all, it also indicates the degree to which HIV slowly starts to influence communities' beliefs and practices. It is no longer business as usual. There have to be a health checks in addition to traditional values, without which families could be decimated. Rural families in the district are still strongly patriarchal and thus, health checks will need to be acceptable to and accepted by men. Women, even if they are better educated, still do not have equal rights to demand health checks of their (potential) partners.

5.4 Conclusions about the research problem

The study set out to investigate the research problem: *'The African Religious Landscape*: *An examination of the Shona traditional beliefs and practices in light of HIV and AIDS, and its ramifications for mitigation and care'.* It aimed to find out if HIV and the AIDS pandemic had an influence on the cultural beliefs and practices of the Shona people in the Chipinge District. Key objectives directed the fieldwork for the study, and these were to:

- Evaluate the current knowledge, fears, perceptions, attitudes and beliefs of the Shona people in the District of Chipinge about HIV and AIDS;
- Investigate cultural beliefs and practices likely to perpetuate or lower the risk of HIV infection and the AIDS pandemic; and
- Discuss traditional beliefs and practices that have continued, were discontinued or modified due to the threat of HIV and the AIDS pandemic

The fieldwork enabled the researcher to have access to the source of raw data collected, transcribed and coded. Chapter 4 of this thesis presented the results of the findings. This section, therefore, aims to draw conclusions about the research topic. Naturally, the conclusions shape up by evaluating the extent to which the study achieved the set objectives.

The researcher raised several questions to examine the level of general knowledge about HIV and the AIDS pandemic. They ranged from the question that sought definitions of terms such as HIV and AIDS, their causes and symptoms (the first objective) to the one that sought to examine traditional beliefs and practices that have been discontinued or modified due the influence of HIV and the AIDS pandemic. From the results presented in Chapter 4, the study found that the communities under study have knowledge of HIV and AIDS pandemic. Their knowledge of the existence of this scourge comes as no surprise since the communities receive information about HIV and AIDS from several sources, chief among which are posters and pamphlets from health institutions, workshops and community leaders. However, the response to the question on the causes of HIV shows that participants' knowledge was still superficial and often severely misguided, notwithstanding the fact that communities received adequate information about the pandemic. While they acknowledge that unprotected sexual intercourse with infected partners can cause HIV infection, they still believe that 'other causes' based on their traditional beliefs in illnesses and their causes, are to blame. Citing 'pollution' (Sections 4.3.1 and 5.2.1) as one of the major causes of HIV infection indicates people's entrenched beliefs in the indigenous stories and legends that are difficult to let go[207]. It is also surprising to note that culturally, people believe women who recently gave birth or aborted or is menstruating is 'unclean' or 'dirty', but prostitutes are, by comparison 'clean' – although they could be a major contributing factor to the spread of HIV and other sexually transmitted diseases considering the number of men they have sex with and sometimes without any protection.

Traditional belief systems continue to influence people's perceptions regarding the causes of illnesses, AIDS included. The challenge comes when the communities still hold that AIDS is not a new disease and could have been healed in the past, as some of the traditional healers in the study sample believed. Traditional healers are an essential group of people in these communities. They are therefore likely to influence people into believing that AIDS could be cured by them, despite their admission that it has no treatment yet.

[207] Traditional healers.txt - 3:7 (14:16) (GUEST) Codes: [Causes of HIV/AIDS::sex with a 'unclean' woman]

The other two objectives focused on examining traditional practices and beliefs that have withstood the HIV menace, adapted or modified due to the influence of HIV, and those that the Shona people in the Chipinge District have discontinued. The study results show that witchcraft beliefs are still deeply entrenched in the people's minds and therefore, when people fall sick, they first visit traditional healers before going to clinics or hospitals. The visit to traditional healers indicates the trust people have in them, irrespective of the sicknesses people have. The visits are not surprising because the country's health delivery system has collapsed because of the general economic meltdown in Zimbabwe.

Private and public electronic and print media reports of drug shortages and suspension of the primary theatre procedures and other essential services in significant referral hospitals of Zimbabwe bear witness to this argument.[208] When the primary referral hospitals run short of medical supplies and other provisions, the provincial and district hospitals feel the ripple effects most, which leaves the rural population without proper healthcare, no free supply of medication such as ARTs and no option but to consult traditional healers.

The results also show that the Shona people of Chipinge believe in the benevolence of ancestral spirits who express their wishes through spirit mediums. The process of becoming a medium is strongly linked to illness. When ancestral spirits choose their hosts, the would-be mediums become sick. The nature of the sicknesses is such that they take a long time to cure and do not respond positively to conventional Western medication. Such patients only respond to traditional medication and rituals. The study also reveals that the sicknesses exhibit similar symptoms to those of confirmed HIV or AIDS cases. Thus, if people get infected by HIV, they may delay seeking proper medical attention, thinking that ancestral spirits have chosen them to be spirit mediums. Meanwhile, they consult traditional healers, faith healers or prophets, while their condition deteriorates. It is, therefore, the argument of this study that some of the Shona traditional beliefs negatively impact on the swift and proper

[208]In a *ZBC* news bulletin of 18 January 2016 and an editorial in *The Chronicle* of 25 January 2016, it was reported that major referral hospitals in Zimbabwe had run short of essential drugs. The nationwide drug shortage that affected major referral hospitals did not spare district hospitals of which Chipinge is one.

management of HIV infections, their mitigation and care. The sick and their guardians, because of the belief that a victim may be a potential spirit medium, delay the introduction of antiretroviral therapy (ART). The people's beliefs in spirit possession and spirit mediumship are still high, leading to an immediate assumption of 'being chosen' rather than assuming that they have been infected by the deadly human immune virus. The study thus concludes that some of the Shona traditional beliefs pose a danger to the very lives that they are supposed to protect.

The Shona people of Chipinge subscribe to a variety of traditional practices, which define them as a people. However, the study's cardinal aim was to examine the traditional beliefs and practices in light of the HIV and AIDS scourge. The study focused mainly on those practices through which people could get HIV infection. Since HIV is mostly a sexually transmitted virus, the study focused on traditional marriage and related practices with the aim of establishing how safe they were.

Potential starvation and the desire to compensate avenging spirits, among other causes, led some families in the Chipinge District to force their girls into marriages. The results of the study show that some families, though few, still pledge or force their young girls into early marriages. Looking at the practice through the HIV spectacles, Marashe (2014), concluded thus:

> This [forced marriages] shows the presence of a practice notwithstanding the danger and threat of HIV infection it has on innocent young girls in the impoverished rural District of Chipinge. The young, innocent and immature girl is at the mercy of the husband, who would force her into sexual intercourse before she is ready for it, and exposes her to STIs or the dreaded HIV. The young girl would be too young to consent to or negotiate for safe sex (Marashe 2014:6).

Results of the study show that the practice of *barika* (polygamy) is waning. Some of the reasons for the decline are economical, the fear of having to support the larger-than-normal families and possible HIV infection. From the results of the study, the researcher infers that the chances of getting infected with HIV in polygamous

marriages are high. People infected with HIV could unknowingly and unintentionally infect their spouses who could then pass it to the rest of the polygamy partners. Hypothetical as this scenario might seem, it has the potential to wipe out families who still practise and are comfortable with polygamy. Thus, HIV mitigation and care efforts in large polygamous marriages are a challenge, especially if the partners do not cooperate. The other foreseeable challenge is that people in these marriages would, after finding out that they have HIV or STIs, trade accusations of infidelity at each other, thereby creating disharmony and disunity in the family. With accusations and counter-accusations within families, management, mitigation and care of HIV cases suffer the most.

The overall aim of the other traditional marriage practices is to ensure the blessings of the marriages through procreation. Without the blessing of children, marriages are likely to end in divorce, or in polygamous unions. Children are particularly valued in African societies, and communities describe those without them in derogatory ways. Therefore, the Shona traditional marriage systems of c*himusamapfiya, chimusamusha* and *kupindira* or *kutumira* are traditional mechanisms to ensure that couples have children. All these mechanisms have one challenge. If for some reason, one of the couples refuses to take an HIV test, both can possibly get infected with HIV that can wipe out the entire family. *Kupindira* is even worse than the rest of the marriage practices, considering the threat of HIV. It is a secret arrangement, which could threaten the cordial patrilineal relations if any one reveals the secret. If the secret is not handled correctly, it has the potential of igniting an uncontrollable family feud between brothers.

The practice of *kugara nhaka* could sustain the family of the deceased brother, if conducted appropriately. It ensures that the children and widow continue living in a family environment, except that the breadwinner is the patrilineal younger brother of the deceased, where there is such younger brother and if he is able and willing to take on extra burdens. Several participants identified HIV as one of the cardinal reasons for people's loss of zeal for wife inheritance, especially the young generation. The argument they advance is that it is possible that the deceased could have died of AIDS, and thus rushing into the practice is like committing suicide.

Results of the study, therefore, show that these four practices are diminishing in their societal roles, although the real reasons may be economical in nature and only blamed on HIV. Thus, even if the true reason is maybe economical, one of the reasons advanced for the low uptake is the fear people have of HIV infections. AIDS has the potential to wipe out whole families, and people are afraid, except for the conservative group (Figure 4.3) of people in the communities, where traditional practices such as these dictate their lives. In such cases, mitigation and care for HIV cases become elusive. They may also then ascribe any infections and potential deaths to traditional and fatalistic beliefs in magic, malevolent spirits, witchcraft and the impact by departed ancestral spirits.

Kufohla seems to be the most popular marriage practice in the impoverished rural areas of Chipinge. The young men, particularly the *MaJoni-joni,* working in South Africa, are the common practitioners. Extended periods of spousal separation are the main challenges to this practice. As the results show, many of them are tempted to engage in extra-marital sexual affairs, thereby exposing themselves and on their return to their wives to HIV infections. In such situations, mitigation and care of HIV are indefinable.

The study participants proposed several modifications to the traditional practices of the Shona people of the Chipinge District. While a few participants, especially the health professionals, suggested the total discontinuation of some of the practices such as polygamy and wife inheritance, the rest of the participants suggested modest adaptations to be made to the practices. Considering the threat of HIV infections and AIDS, the overall perception is that those willing to participate in these practices should be prepared to go for HIV tests as well. The dimension of HIV screening or testing is a new addition to the traditional practices of the Shona people of the Chipinge District. The HIV test requirement is a direct response to the threat of HIV infection and AIDS, and if communities fully embrace it, traditional practices can remain user-friendly. Therefore, some practices become less popular with people because of liberation through education from the clutches of traditional practices, or people's fear of possible infection.

The researcher might conclude from the study results, discussion and analysis that the intrusion of HIV and the AIDS pandemic onto the socio-moral fabric of the Shona people of Chipinge is influencing how people participate in the practices. Some marriage practices such as wife inheritance still exist, though in slightly modified forms that happened perhaps because of education. Adopting HIV testing within the procedures and conduct of some of the practices that involve sexual relationships is a welcome suggestion. It enhances the safety of all people, also those who might be involved in the healthcare of people infected with HIV. Thus, in a way, HIV and the AIDS pandemic influences the conduct of some of the Shona traditional practices in the Chipinge District by making people more cautious, more eager (in theory) to be tested. However, there are some beliefs (for instance, belief in witchcraft, angry spirits and magical healing) and practices that might be harmful to the same people they are supposed to safeguard. Therefore, the suggestion to embrace HIV testing is healthy, and assists in the mitigation and care of HIV cases. The next section attempts to evaluate the significance of the findings considering the theory that informed this study.

5.5 Implications for the phenomenological theory

The phenomenological approach informed this study, and as such, the researcher did not venture into the truthfulness of what the study participants said in interviews or wrote on questionnaires (expunction of value judgements and own beliefs commonly referred to as *epoché*). The researcher used the responses as participants gave them to him, and sometimes verbatim. Most elderly participants responded in the Ndau dialect, and the researcher cited them as given. With the assistance of language experts, the researcher translated their responses given in the Ndau dialect into English, for everyone to understand. Some of the Shona traditional religious beliefs and practices provided the context of the study, and the mantra or perception, 'the believer is always right' guided this study. The researcher conducted fieldwork to give participants a voice, to let them express their beliefs and practices in ways that they understood and practised them. This aspect was significant as the researcher interacted with data at the source and environment – *Sitz im Leben* and according to Scott (2001:1) *Zen den Sachen* ('to the things themselves' or 'to the data'). Understanding raw data from the participants in their

settings is critical as it placed the researcher at a point, from which to make informed recommendations. Cox (1992:32) highlighted the importance of this method in his concept of ‘describing the phenomena'. He stated:

> In his observation of the activities of any religious group and by his getting inside them, the phenomenologist will encounter a wide variety of religious data. His first task in this process is to describe the data as accurately as possible, paying careful attention to the various aspects … to avoid premature interpretations… Moreover, the descriptions obtained must correspond as faithfully as possible to the believers’ own testimony.

The researcher tried to describe the data as accurately as possible. With the practice of *epoché*, the researcher transcribed and coded the raw data repeatedly to get the gist of the data. That process was indeed a revelation. While exercising *epoché*, eidetic intuition (Sharpe, 1986:224; Van der Leeuw, 1963:646) came into play. The descriptions of the people's traditional beliefs and practices became apparent and comprehensible. Empathy, as Sharma (2001:232) stated, enabled the researcher to feel the experience of participants concerning their traditional beliefs and practices, and their perceptions of HIV and the AIDS pandemic "… unencumbered by pre-existing or superimposed ideas, beliefs, presuppositions or suspicions".

The researcher admits that despite taking every care to be as objective as possible in the fieldwork, the methodology is not immune to limitations. The researcher acknowledges that no clear description is possible without a robust attitudinal element. The researcher described accurately what the study participants said during the interviews and in their responses on the questionnaire. Although the researcher tried to present the perceptions of people about their traditional beliefs and practices, and their comprehension of the HIV and AIDS menace, he inevitably and unintentionally influenced these descriptions. The researcher followed the idea of being faithful to the believers' or study participants' perceptions, but not under the illusion that the research produced pure objectivity.

5.6 Implications for policy and practice

The last section evaluated the study findings and their significance to the phenomenological approach that informed this research. This section examines the influence of the findings to public health and traditional leadership policy and practice. It assesses the study results to establish how useful these results might be to policy formulators and the Shona people in the Chipinge District.

5.6.1 District Medical Director (DMD) and District Nursing Officer (DNO) - Ministry of Health and Child Care

The study results have indicated the people's general awareness of HIV and the AIDS pandemic in the Chipinge District. However, despite the information about HIV reaching the communities (Figure 4.1), there are large gaps in knowledge when it comes to specific issues relating to HIV transmission and symptoms because of the people's traditional beliefs and practices. Some of the study participants still believe that 'pollution' is one of the leading causes of HIV infection. The issue of 'pollution' (Section 4.3.1) is a long-held traditional belief, which the communities might have used as a birth-control mechanism, as well as maintaining strict sexual hygiene standards at times when wives might be menstruating, have an abortion or have just given birth (Simmons 2009:232). Therefore, to continue to attribute HIV infection to menstrual blood, for instance, might be a recipe for disaster for the communities under study. The effect of this belief is that people may not take the HIV infection seriously, and may even delay seeking proper medical attention until it would be too late. It is only when the communities begin to take HIV for what it is that the HIV prevalence rate in the district might drop.

Furthermore, the study established that some traditional healers argue that HIV is not a new disease; hence they can cure it as they used to do with several diseases of yesteryear. This belief constitutes a misrepresentation of the truth about HIV. Traditional healers who inform people that AIDS is curable are dangerous elements in the communities in which they live, as many people might consult them instead of going to the hospital for antiretroviral treatment. In light of the preceding discussion, the current study makes the following recommendations to both the DMD and the DNO.

5.6.1.1 Induction of nurses

The District Nursing Officers (DNOs) must ensure that they conduct an induction for all the nurses whom the Provincial Nursing Officer deploys into the district. The induction session(s) should focus on educating the nurses on the people's traditional beliefs and practices. The study envisages that this kind of induction might help nurses to appreciate the people's beliefs and traditions, such that they would not, by omission or commission, unnecessarily antagonise the communities in which they would be working by passing derogatory or belittling comments about the people's cultural beliefs and practices. As Beuster and Schwar (2005:45) observed, the traditional practices and beliefs play a critical role in shaping people's attitudes towards and compliance with the recommended treatment plans by the medical personnel. If nurses pass derogatory comments about people's customs, they might disrespect the very people whom they have come to serve. Consequently, the people lose faith in their work, and for fear of having insults hurled at them, people might avoid going to the clinics/hospitals and, instead, visit traditional healers.

5.6.1.2 Correction of the misconception about the causes of HIV infections

To correct the misconception about the causes of HIV, the study recommends that health professionals revamp some of the ways they disseminate information about HIV. One of the ways, for instance, is to revise the language on the posters and pamphlets. Instead of either English or Zezuru,[209] they should display posters, distribute pamphlets and other materials written in the Ndau dialect that most people in the Chipinge District speak and understand better than any other language. The importance of a local language cannot be over-emphasised in communication, particularly of new ideas. Like Lawrence (2002:58) stated, the use of local languages [the Ndau dialect in this instance], "… can also be very persuasive". Such posters and pamphlets, written in the Ndau dialect, might make people understand more than if written in any other Shona dialects. Information conveyed in the people's indigenous language appeals and 'speaks' more to the people than one conveyed in a 'foreign' language.

[209] Zezuru like Ndau (ChiNdau) is a dialect of the ChiShona/Shona language. The inhabitants of Mashonaland East, Mashonaland West and Harare provinces of Zimbabwe speak Zezuru most.

Furthermore, the researcher recommends for a change in the information dissemination strategies, in particular on the intended targets. The researcher is of the opinion that there might be an improvement in HIV knowledge uptake if the health professionals target the school-going children, to catch them young. While the current and older generations might have had problems in comprehending HIV, AIDS and their causes, it is the researcher's hope that communities should not lose the next generation due to lack of proper and accurate information. So, targeting learners in the primary and secondary/high schools and those in tertiary institutions might help in reaching out to many people with information concerning HIV. The suggestion might be achievable if the Ministries of Primary and Secondary Education and Higher and Tertiary Education are involved as the next section shows.

5.6.2 Permanent Secretary and Provincial Education Directors − Ministries of Primary and Secondary Education and the Ministry of Higher and Tertiary Education, Science and Technology Development

The previous paragraph suggests that learners in schools and tertiary institutions should be the targets for information concerning HIV. This might not be possible without the involvement of the education ministries and departments. As educational and related institutions, they assist in the training of educators and providing relevant literature.

5.6.2.1 Training of HIV and AIDS educators

As Mugweni (2012:201) described, while the Government of Zimbabwe, through the Ministry of Primary and Secondary Education, might have introduced an HIV and AIDS policy, there are no proper supporting mechanisms in place to ensure its smooth implementation. For instance, while there are several teachers' colleges and universities that train educators and provide in-service programmes for some in the entire curriculum, none of them train educators specifically to teach HIV and AIDS education in the schools, colleges and universities.

Thus, the study recommends that teachers' education colleges and universities' should educate and produce educators who are qualified and explicitly equipped to teach HIV and AIDS education to learners at all levels in the schools. Therefore, after their two- or three-year training course, educators should be able to teach HIV and AIDS education from junior grades, and from Form 1 level up to Upper 6th. The

basic, but correct, knowledge learners would get in HIV and AIDS education lessons should equip them to be able to make good choices for their future lives.

5.6.2.2 Curriculum Review

HIV and the AIDS pandemic are threats within the traditional health landscape of the Shona people in the Chipinge District and indeed elsewhere. These new health challenges cause health disequilibrium. Many people, irrespective of age, social standing, ethnicity, religion and income fall victim to HIV if they are reckless regarding their sexual habits. HIV does not spare the youths and learners in schools, colleges and universities either. Lawrence (2002:66) lamented how sex came into learning institutions "with the stink and stain of disaster, almost subverting the goal of schooling". Young children are often subjected to abuse, traded for economic reasons blamed on tradition. Learners, mainly from higher grades to universities are particularly vulnerable as they are experimental. These new health challenges call for the revision of the current curriculum to address them. Therefore, the study strongly recommends for the introduction of HIV and AIDS education through the Curriculum Development Unit (CDU), as an examinable subject.

The aspect of HIV and AIDS education being examinable is significant. The educators and educatees might not take the subjects seriously, if they are not examinable. In the current curriculum, Guidance and Counselling allow for the teaching of AIDS education. However, the subject has some challenges, some of which include inadequate teaching and learning materials, lack of qualified educators, and above all, being non-examinable. For these reasons and more, teachers and learners alike do not take the subject seriously. Quite often, some educators use the time for Guidance and Counselling to either conduct extra lessons in other disciplines such as English or Mathematics or use the time to catch up on lost time in other subjects.

5.6.2.3 Production and provision of relevant reading materials

Provision of reading materials such as textbooks, learning models and other related teaching and learning media so as to aid learning should complement the training of relevant educators. There should be reading materials and textbooks for use at both primary and secondary schools. The Ministries of Primary and Secondary Education and that of Higher and Tertiary Education, in liaison with stakeholders, should

produce teaching and learning materials, taking cognisance of the ages of the learners. Above all, these materials should be adequate for all learners in the Chipinge District and beyond.

Thus, with posters, reading materials and pamphlets written in the Ndau dialect reaching out to the schools staffed with qualified educators to teach Sex Education or HIV and AIDS, communities might win in the war against new HIV infection cases in the Chipinge District and beyond. Learning materials produced in other countries might not be appropriate to the learners in the Chipinge District and Zimbabwe at large due to the differences in socio-educational contexts obtained in the respective countries.

5.6.3 Permanent Secretary, Provincial and District Administrators – Ministry of Local Government, Public Works and National Housing

The management and supervision of all the activities of the traditional leaders fall under the Department of Traditional Leaders in the Ministry of Local Government, Rural and Urban Planning. Traditional leaders are the custodians of the people's traditional beliefs, customs and the land. The invasion of the socio-cultural landscape by HIV and the AIDS pandemic poses a significant challenge to traditional leaders' roles as the gatekeepers of the people's traditions and beliefs. The study results show that some beliefs and traditional practices expose people to potential HIV infection, rather than protect them. At the same time, people's cultural beliefs and traditions provide the individuals with an identity. They define them as a people different from the rest, and the threat of HIV is a cause for concern. However, people cannot lose their lives because of beliefs and traditions. The study, therefore, makes a few recommendations to the people regarding their beliefs and traditional practices.

5.6.3.1 Witchcraft and spirit medium beliefs

The results of the study indicate that the Shona people in the Chipinge District believe in witchcraft and that ancestral spirits have the power to choose people to become their hosts. In most cases, when people fall sick, they believe that they are bewitched, or ancestral spirits have chosen them to be their hosts. They express the belief that sickness might be a consequence of witchcraft in a proverb, *chiripo chari uraya, zizi arifi ngedutu* (something has killed the owl, it cannot just be the wind),

which underlines the cause-and-effect philosophy. The challenge comes when people attribute sickness from HIV infection to witchcraft or spirit mediumship. These beliefs cause unnecessary delays in the infected seeking antiretroviral treatment. The delays inversely allow the people's health condition to get worse. The researcher, therefore, suggests that ideally, sick people should visit the nearest clinic or hospital at the onset of their illness rather than visiting a traditional healer at that point. Early diagnosis of HIV is significant as it quickens the commencement of ART. Consulting traditional healers for treatment of HIV is a waste of time and scarce financial resources since, as the study results have shown, traditional healers can neither treat HIV nor cure AIDS. There is no cure yet for AIDS, and the earlier people go to the clinic/hospital to be correctly diagnosed and treated, the better.

5.6.3.2 Adaptation and adoption of user-friendly traditional practices

It is in the light of the findings of the study on some of the Shona traditional marriage practices and traditional healing methods that the study recommends the adaptation, adoption and practice of traditional practices that are not harmful to the people's health. Like some participants in the study suggest, chiefs, headmen and village heads should make it obligatory that individuals who want to take part in *kugara nhaka* (widow-inheritance), *kupindira* (substitute-husband) or *chimusamusha* (substitute-wife) undergo a legitimate HIV test. The HIV test requirement should precede the *kugara nhaka* (wife inheritance) practice. If traditional leaders adopt the recommendation, it might naturally screen out those who want to ignore the impact that their past sexual activities might have on their new roles, sexual partners (old and new) and families.

Alternatively, and like in the past, people might also revert to the non-sexual wife inheritance practice, where the widows elect their eldest sons/daughters or aunts from the family of their deceased husbands. In scenarios such as these, the families might be spared from new HIV infections.

5.6.4 The President − Zimbabwe National Traditional Healers' Association (ZINATHA) and Director − Department of Traditional Medicine

The section above provided recommendations concerning traditional beliefs and practices of the Shona people living in the Chipinge District. The study makes the recommendations with a view to adapting the traditional practices to become less

harmful to the people. This section focuses on traditional healers' in their capacity as the guardians of the communities' healthcare system.

5.6.4.1 No Cure yet for either HIV or AIDS

The study results indicate that some traditional healers provide medication that can stop pain for people showing signs of HIV infection. While there are some who confirmed that they were not able to cure AIDS, others mislead people by telling them that they can cure AIDS. It is because of the above arguments that the study recommends that the ZINATHA management, in liaison with the Department of Traditional Medicine, enforce the Traditional Medical Practitioners Act (2002, Chapter 27:14). The Act regulates the activities of all registered traditional and faith healers in Zimbabwe. These people's utterances about their ability to cure AIDS are untrue, unprofessional and a breach of Zimbabwe's medical ethics. Currently, results of this study show that there is no cure available as yet for HIV and AIDS and, therefore, ZINATHA should rein in some of its members to stop their false claims of the ability to cure AIDS.

5.6.4.2 AIDS is a new and complicated disease

Furthermore, results of the study show that there are traditional healers whose perception is that the AIDS pandemic is an old disease they have always been able to contain. By such statements, traditional healers mislead unsuspecting clients. The effect of traditional healers' perceptions and utterances make unsuspecting people consult and rely on them for medical attention. The visit to traditional healers would constitute a delay in proper ART treatment, if the people have HIV, and their conditions become worse than before. Once again, the researcher recommends that the Department of Traditional Medicine and ZINATHA management closely monitor all activities (in deed and word) of traditional healers, and ensure compliance with their mandate and expectations as laid out in the Traditional Medical Practitioners Act (2002, Chapter 27:14). AIDS is a new disease that poses new health challenges, and it has no cure as yet. Traditional healers in the impoverished rural Chipinge District and elsewhere should recognise this fact, if the war against HIV and the AIDS pandemic were to be conducted successfully.

5.6.4.3 Safety in traditional healing methods

Results of the study show that in some instances, traditional healers expose themselves to HIV infection in the performance of their healing duties. In the process of *kurumika* (bloodletting) or *kutema nyora* (scarification), for instance, traditional healers come into direct contact with blood and body fluids. If the patient is infected, they become vulnerable and exposed to infection. Furthermore, the use of one razor blade on many clients for scarification endangers the lives of many people.

Given the above arguments, the researcher recommends that the ZINATHA management reiterate the importance of safety for both the clients and the traditional healers themselves at all times. The use of gloves by traditional healers should be mandatory for hygiene and safety purposes, and the use of a single razor blade per client should be obligatory and not optional. A stiff penalty, either a hefty fine, de-registration (withdrawal of a practicing licence) or both might be imposed on all offenders as a deterrent measure and means of ensuring compliance.

5.6.5 Public sector policy analysts and managers

In sections 5.6.1-5.6.4, the study makes several recommendations aimed at improving the identified challenges concerning traditional beliefs and practices in light of HIV and the AIDS pandemic. The suggestions made are an attempt to minimise new HIV infections among the Shona people in the Chipinge District. This section examines the significance the study might have to public sector policy analysts and managers. In this study, the focus might be on the education sector as it relates to educators' training, the area of health because of the involvement of health professionals and traditional healers and their interaction with communities and patients. It also highlights policy issues concerning the local government department because it is responsible for the supervision of traditional leaders, the custodians of the cultural practices of the people.

5.6.5.1 Training of HIV and AIDS educators, and the provision of adequate teaching and learning material

Policy analysts in the ministries that deal with education matters might have to enact policies that seek to address the absence of suitably trained educators in the schools and tertiary institutions. The current situation in the schools in the Chipinge District, and perhaps elsewhere in the country, is that educators who teach Guidance and

Counselling, which houses AIDS education, did not train to teach it. This lacuna inadequately trained educators is unusual in the health landscape more than three decades after the first confirmed AIDS case in Zimbabwe. Therefore, policy analysts, managers and quality assurance directors in the Ministries of Primary and Secondary Education and Higher and Tertiary Education, Science and Technology Development should conduct a needs analysis to establish the training needs of educators regarding HIV and AIDS education. The needs analysis should then inform the relevant offices on the budget required for the massive educator training exercise. The responsible ministries should draft a policy circular and instruct educator-training institutions to recruit trainee educators for the exercise and conduct in-service classes for those already in the system, who might require such training.

Provision of relevant and adequate teaching and learning materials should complement the training of educators, if the government is serious about managing and minimising the impact of HIV and AIDS in the country in general and among the Shona people in the Chipinge District in particular. Thus, policy analysts should establish the population of educators and learners in the country through a study, and provide such information to the relevant ministries, which would engage stakeholders to do the work. For instance, the Curriculum Development Unit (CDU) designs the syllabi for different levels of learners, while experts in the subject – HIV and AIDS education, write relevant literature and publishers publish the books. The statistics from the policy analysts and managers inform the publishers on the number of books they should publish.

5.6.5.2 Literature in the Ndau dialect

Policy analysts and administrators in the Ministry of Health and Child Care should conduct research to establish the HIV and AIDS information needs of communities in the Chipinge District. Informed by the findings of the policy analysts and managers, the Department of Community Health could determine the number of posters and pamphlets to produce, and inform the Publications Department for production. Ndau language experts should be involved throughout the production process to ensure that the materials produced efficiently communicate with the intended targets – the Shona people in the Chipinge District. The posters and pamphlets should contain information about the causes and effects of HIV and AIDS as well as warning

patients about the dangers of delaying going to the clinic or hospital because of the belief that their ancestral spirits have chosen them to become their mediums or that witches caused their sickness. This has to be delicately phrased so as not to sound derogatory, patronising or not accepting traditional value systems.

Furthermore, policy analysts and managers in the health sector should constantly liaise with ZINATHA management and conduct research with traditional healers to establish the efficacy of their herbs and medicines. This is helpful as it informs the parent ministry of the availability of discoveries in medicinal herbs, and helps to work towards their patenting, packaging and marketing. They should also counter and dispel information about the AIDS cure, and reiterate the message that there is no cure yet for HIV or the AIDS pandemic.

5.6.5.5 Review of the Traditional Leaders Act (2000, Chapter 29:17)

Policy analysts and managers in the Ministry of Local Government, Public Works and National Housing should inform the Ministry, particularly the Department of Traditional Chiefs to review the Traditional Leaders Act (2000). The review should aim at assisting traditional leaders to appreciate that the advent of HIV and the AIDS pandemic demands a new evaluation of traditional beliefs and practices with the aim of adapting new features to the traditional practices to ensure the safety of people who might be adhering to the traditional practices. It does not make sense that the traditional practices that are supposed to safeguard the lives of the practitioners become vehicles, through which people can get infected with HIV.

5.7 Limitations

The section is a continuation of Chapter 1 Section 1.7, which highlighted a few constraints to the study. It sheds light on eight major limitations the researcher encountered during the study.

5.7.1 Participants reserved on HIV and AIDS issues

The study, like any other empirical study, had many constraints. One of the challenges concerned the research topic itself, which, if justice was to be done to it, the researcher had to ask questions to the study participants concerning their knowledge about HIV and the AIDS pandemic, beliefs in witchcraft, spirit mediums and marriage practices. At face value, these topics may not be problematic.

However, the communities, in which the researcher conducted the study, are conservative, traditional and reserved. To many of them, academic research is a foreign concept. Thus, asking the study participants about their beliefs in witchcraft, and ancestral spirit mediums and sexual matters was tantamount to an invasion of their cultural and social privacy and might have made them uncomfortable. Furthermore, the communities under study associate issues about HIV and the AIDS pandemic with breaking sexual taboos, promiscuity and immorality. They may have felt that the topics were unpleasant to talk about publicly. Generally, issues about sex are sensitive, especially when a male researcher (as was this case) interviewed female study participants from the sample of the study.

5.7.2 Participants losing interest

Furthermore, the researcher might have lost potentially valuable and knowledgeable participants. During fieldwork, most people, among them potential participants thought the researcher was an agent of NGOs such as Christian Care or Plan International, responsible for registering people in the rural areas for food aid. During the initial consultations to establish rapport, they listened carefully and attentively, but lost interest the moment the researcher informed them that he was a University of Pretoria postgraduate student in search of information to complete his studies and satisfy the conditions requisite for the award of a doctoral degree. The main reason for this reluctance was that they had not benefitted anything (such as food or money) from previous researchers. Therefore, they consider such studies as irrelevant to them and their families. Poor rainfalls during the 2011-2012 farming season had exacerbated their situation, and people were starving because they had not harvested anything from their fields. So, seeing a stranger with a clipboard, moving from one homestead to the next raised their expectations of registration for food aid. When they lost interest, the researcher also lost potentially valuable information. The researcher sometimes managed to convince such potential study participants to take part and got rich data, and then left others who indicated their unwillingness to participate. The researcher could not force them to participate because it would be a breach of the research ethics.

5.7.3 Politically charged fieldwork environment

Conducting fieldwork was difficult because of the politically charged environment in 2012, when preparations for the 2013 harmonised parliamentary and presidential elections were in full swing. At one point, a war veteran interrogated the researcher on the main objectives of the study, the study financiers and if the researcher was not carrying out reconnaissance for the MDC-T political party. The war veteran candidly informed the researcher that it was not the right time to conduct academic fieldwork, and that he could not guarantee the researcher's safety. In response, and considering that to be forewarned is to be forearmed, the researcher hastily left the Checheche area in Chipinge South and went to Mapungwana area, to the southeast of Chipinge Town, where it was relatively calm.

5.7.4 Researcher biases

The researcher might have his own biases concerning HIV, AIDS, traditional beliefs and practices as informed by his Christian and social background, and as the sole interpreter of data. However, as Creswell (2003:182) advised, the researcher tried as much as possible to avoid his socio-religious and professional backgrounds to influence his perceptions of issues under discussion, though some influences might have escaped the researcher's attention. The amount of direct quotations and subsequent explanations is indicative of the study's aims and objectives. The researcher admits that a different researcher using the same data set might come up with different codes and conclusions altogether. One of the main reasons for this stance is that human behaviour is dynamic, and might change anytime.

5.7.5 Non-completion of questionnaires

At times, the researcher went to collect questionnaires left with study participants for completion. Either they had not been at home, or the questionnaire had been either partially completed or not completed at all. This was the researcher's experience even with appointments for interview. Participants gave several reasons for non-completion – attending funerals, some of which were AIDS-related, visiting the local township to receive food aid rations, or having gone *Kwa* 2[210] to sell different items

[210] *Kwa* 2 (On the 2nd) refers to a day, which Jersey Tea Estate and others have set aside to allow informal traders to converge at the estate's ground to sell their wares to the company workers whose paydays usually fall on the second day of every month. The merchandise includes second-hand

for the survival of their families. This meant that the researcher might have missed potential valuable and insightful information from those who opted out of being interviewed or lost interest in participating even after initially agreeing to do so.

5.7.6 Interference of workload

The researcher completed the last three chapters of the thesis, while being faced with a heavy work programme of lectures at Great Zimbabwe University (GZU). In this case, it meant conducting lectures in four courses, supervising more than 15 undergraduate and postgraduate students' research projects and supervising several student teachers on Teaching Practice at different primary and secondary schools all over Zimbabwe. This meant that there was little time left to devote to compiling the research report. The demands of the thesis and work took a toll on the researcher, and slowed down the process to the extent of having to complete and submit the thesis report well after the expected due date.

5.7.7 The disadvantage of using the institution's qualitative data analysis software

The use of Atlas.ti proved to be a major challenge, since the researcher did not have his own software because of the prohibitive costs. The researcher, therefore, depended on the University of Pretoria's institutionally licenced Atlas.ti software for qualitative data analysis. In 2014, the University of Pretoria, in a clean-up of all the institution's computers, wiped out all of the researcher's transcriptions and codes, and efforts to recover them were fruitless. The researcher restarted the transcription of data and coding, and this was a major setback. It slowed down the progress of compiling the research report.

5.7.8 Study findings not universal

Finally, yet importantly, the study results may not be transferable to areas other than the Chipinge District because of the small size of the sample that included teachers, traditional leaders, traditional healers, mature adults (of 35 years of age and older) in the communities and health professionals. However, in as much as the sampling made efforts to reflect a cross-section of the communities under study, they were not representative of all teachers or traditional leaders, other districts or the country.

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clothes smuggled into the country through the porous Zimbabwe–Mozambique border, electric gadgets, grocery items, chickens and goats.

Perhaps, the sampling misrepresented the population and thus, inadvertently limited the validity of the study results (Ruane 2005:117; Neuman 2006:220; Mouton 2001:118). Furthermore, time and financial constraints restricted the places, where the researcher conducted the study. The researcher confined the study to the Shona people in the Chipinge District. It was not possible for the researcher to cover the whole of the country for collecting data as he had limited financial resources and time available for the study.

5.8 Further Research

Considering the results of the study, the researcher suggests that there is a need for further studies in the following areas:

i. **The interface between traditional healers and medical doctors in the provision of HIV healthcare**

A study to establish the possible coordination of research in providing HIV healthcare is important as it may help minimise harmful pronouncements concerning the cure of HIV infection or AIDS. The same study might also help medical doctors and traditional healers to perceive each other as complementary colleagues and not as adversaries. It might also contribute to creating areas of synergies for the betterment of their profession and practice in traditional medicine and the people.

ii. **Evaluation of traditional beliefs and practices of the Shona people in the Chipinge District in light of HIV and AIDS**

The current study examined mainly traditional marriage practices and beliefs, mainly focusing on how HIV and the AIDS pandemic influenced some of the identified practices. It would be interesting for others to take a different dimension and evaluate other traditional practices and beliefs, given the devastating effects of HIV infections and the AIDS menace, and how to make them user-friendly as well.

iii. **An investigation into learners' perceptions of HIV infections and the AIDS pandemic in light of the traditional practices and beliefs of the Ndau people of Chipinge District**

The current study's focus was on mature Shona people in the impoverished rural Chipinge District. The rationale for such a focus was guided by the belief that the mature people in the communities are the custodians of the people's cultural beliefs and practices. The envisaged study could focus on the classroom, from primary school to university. The rationale for the study would be to understand the learners' perceptions on the subject in order to recommend corrective measures and to catch them young, while they are still receptive to instruction.

iv. The Feasibility of Introducing HIV and AIDS Education in schools

It is one of the recommendations of this study that the CDU should conduct a curriculum review with the aim of introducing the subject as separate from Guidance and Counselling. The envisaged study could take this suggestion up to determine budget requirements for staff development, production and the provision of the necessary teaching and learning materials. This planning stage is essential so that when Government finally rolls out the subject, it is not done haphazardly.

v. A Comparative Study of African traditional practices and beliefs in Zimbabwe, South Africa and Botswana

While the current study focused on the Chipinge District in Zimbabwe, a comparative study with neighbouring countries could be valuable in establishing the differences and similarities in understanding the problems of HIV and the AIDS pandemic vis a vis traditional practices and beliefs in neighbouring countries, particularly in rural areas.

5.9 Conclusion

In this study, the researcher set out to examine the Shona people of Chipinge District's traditional beliefs and practices, in light of the HIV and AIDS menace, and assess the influence of these beliefs and practices on mitigation and care efforts. The study aimed to determine if, in practising some of their cultural practices and beliefs, the people were not, in fact, exposing themselves to HIV infection. It also examined traditional practices that the people have changed, modified or discontinued due to the advent of the AIDS pandemic, and assessed the people's awareness and knowledge of HIV and AIDS.

In closing this final chapter, the researcher presented a series of summaries of all the chapters that make up this thesis. The chapter presented the main research topic and the study objectives. It summarised, from a review of related literature, what scholars have written to date concerning the Shona people's traditional beliefs and practices. The literature review established lack of significant information regarding the influence of HIV and the AIDS pandemic on the people's cultural beliefs and practices, especially how these affect HIV mitigation and care. This dearth of information provided justification for the conduct of this study.

The chapter also indicated the methodology the study utilised, and the theoretical framework that guided it. It used the descriptive survey research design because it allowed the researcher to conduct fieldwork in the Chipinge District, right at the source of relevant information for this study. The chapter highlighted the research instruments the study utilised as well, and these are the questionnaire, field diary and the non-scheduled structured interview. The chapter also identified Atlas.ti software, the qualitative data analysis software the study utilised for organising transcribed data. The software helped to generate the codes and themes that the researcher made use of in analysing the research data and the study findings. The phenomenological theory or approach influenced this study because of its emphasis on 'going back to the things themselves' or the conviction that 'the believer is always right'.

The chapter summarised the main conclusions of the study. It indicated that there are people in the Chipinge District whose attitude to matters relating to health, and their perceptions of HIV infections and the AIDS pandemic revolve around the people's belief in magic, witchcraft and the role of ancestral spirits. This cause-and-effect Shona philosophy finds expression in their proverb, *chiripo chari uraya, zizi arifi ngedutu* (something must have killed it; an owl cannot be killed by the wind). Belief in spirit mediums is also strong in the study area covered during the fieldwork. The process of becoming a spirit medium is closely linked to illness. The would-be mediums get sick at first, and their diseases appear to be immune to current Western medication. Traditional healers, the study participants added, know how to deal with that kind of illness. Regarding HIV mitigation and care, these findings are significant. The symptoms shown by people, who fall sick because the ancestral

spirits might have chosen them to be their mediums, or have HIV infection, are similar. Consequently, individuals who are genuinely infected with HIV could delay going for clinic consultation and getting antiretroviral treatment because people might be thinking that they are suffering from the effects of witchcraft or are ill because the spirits have chosen them to be spirit mediums. By the time they get antiretroviral treatment (ART), it might be too late to avert the course of the illness.

As the chapter indicates, the results of the study regarding the people's perceptions about HIV, AIDS and their causes are indicative of the lack of accurate knowledge, confusion and misinterpretations. A number of traditional healers believed that HIV infection and the AIDS pandemic were not new epidemics. They believed that there had been similar epidemics before, which traditional healers had managed to deal with. A number of participants relied on old tales and believed that HIV or AIDS were caused by ‘pollution', that is, having sex with women in their menses or those who have had an abortion or have just given birth, thus coming into contact with unclean blood. Healthcare workers confirmed the reality of HIV and the AIDS pandemic in the Chipinge District. A significant find of the study was the affirmation, in the word (through interviews) and deed (through questionnaires) that unprotected sexual intercourse with an infected sexual partner was the principal cause of HIV infection in the district. This finding corroborates the results of similar studies, not only in the main towns and cities of Zimbabwe, but the region and abroad as well. Regarding traditional practices, the study showed that there are some of these might fuel the spread of HIV. To avert such a disaster, the communities suggest modifying some of the practices such as wife inheritance, and substitute-wife, with the aim of ensuring that the practices are not harmful to the people's lives that they are supposed to safeguard. Indeed, in the conduct of most marriage practices, people seem to be more cautious nowadays than they were before because of the impact of HIV infections and the AIDS pandemic. Some of the modifications cited are the requirement to undertake an HIV blood test before widow-inheritance, for instance, and a widow opting to choose one of her sons or aunts to be the inheritor. Either way, this adaptation makes significant strides in minimising the chances of widows becoming infected or spreading the human immunodeficiency virus.

The chapter ended by making some recommendations for different government ministries and departments. It recommended that the Ministry of Higher and Tertiary Education, Science and Technology Development speed-up and facilitate the training of educators to teach and examine HIV and AIDS education in the schools and provide adequate teaching and learning materials. It also suggested that the Ministry of Health and Child Care provide posters and pamphlets written in the Ndau language for better understanding and uptake of HIV and AIDS information in the Chipinge District. The research topic raised many issues that this study could not exhaust. It, therefore, ended by providing several areas and topics for further research.

APPENDICES

Appendix A
Copy of the Ethics Clearance Letter

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Humanities
Office of the Deputy Dean

12 October 2010

Dear Prof Groenewald,

Project:	**The African religious landscape: an examination of the Shona traditional beliefs and practices in light of HIV and AIDS, and its ramifications for mitigation and care**
Researcher:	**J Marashe**
Department:	**Old Testament**
Reference:	**10574281**

Thank you for the application that was submitted for review.

The application was **approved (with comments)** by the Postgraduate Committee on 14 September 2010. The **Research Ethics Committee** reviewed the application on 7 October 2010, and a decision is pending due to the following:

- The letter of informed consent must be translated into vernacular;
- The researcher and supervisor must make an appointment with the Department of Anthropology to discuss the research.

To facilitate the administrative process, please respond to Ms Tracey Andrew, Room HB 7-25, at your earliest possible convenience.

Sincerely

Prof. John Sharp
Chair: Postgraduate Committee &
Research Ethics Committee
Faculty of Humanities
UNIVERSITY OF PRETORIA
e-mail: john.sharp@up.ac.za

Appendix B
A Sample of a Consent Letter

Faculty of Theology

Old Testament Studies Department

Lynnwood Road, Hatfield Campus

0002 Pretoria

Republic of South Africa

28 April 2011

Dear Participant

My name is Joel Marashe, and I am studying for a PhD [Biblical & Religious Studies] at the University of Pretoria. As part of my programme, I am currently conducting a research study entitled *The African Religious Landscape: An examination of the Shona traditional beliefs and practices in light of HIV & AIDS, and its ramifications for mitigation and care*.

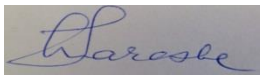
The study aims to examine the Shona traditional beliefs and practices that people continue to practise, discontinued or modified due to HIV and the AIDS scourge. The study further intends to evaluate those practices that are likely to fuel or lower the risk of HIV transmission.

I cordially invite you to participate in this study by completing a questionnaire, which will not take more than 40 minutes of your valuable time. Your contribution will help expand our cultural knowledge base and make people engage in cultural activities or practices that would not put their lives at risk of contracting or transmitting HIV.

Participation in this study is voluntary, and there will be no negative consequences for not participating. You may also withdraw your participation at any stage of the research. I promise to ensure confidentiality at all times, will not disclose your name, whatever the circumstances. If you are willing to participate in this research, may you please fill in, sign the attached consent form, and then complete the questionnaire.

If you have any queries or would like more details of the study, you can contact me on +263 718558543 or e-mail me at joelgift@gmail.com

Thank you



Joel Marashe

(Student ID: 10574281)

Appendix C
A sample of a Consent Form

Faculty of Theology
Old Testament Studies Department
Lynnwood Road, Hatfield Campus
0002 Pretoria
Republic of South Africa

28 April 2011

Consent Form

Instruction:

Write your name and sign in the spaces provided before you participate in this study.

I, _____, voluntarily give my consent to participate in this research. I have been informed about the study, and I understood what it entails.

I understand that I may withdraw from participation at any time, that my data will be used solely for academic purposes, and shall be destroyed after use, and that my anonymity will be protected at all times. I give Joel Marashe the express permission to use my responses in the write-up of the research, and any future publications or presentations. I also give consent to have interviews, if any, to be tape-recorded by the researcher. I am aware that all the tapes will be destroyed after use.

_____ _____

Signature Date

With due acknowledgement to Rosnow & Rosenthal (1996:63)

Appendix D1

A Sample of an Application Letter to the Ministry of Education, Sport, Arts and Culture

Faculty of Theology

Old Testament Studies Department

Lynnwood Road, Hatfield Campus

0002 Pretoria

Republic of South Africa

28 April 2011

The Secretary
Ministry of Education, Sport and Culture
P O Box CY 121
Causeway
HARARE

Dear Sir/Madam

RE: APPLICATION FOR PERMISSION TO CARRY OUT RESEARCH IN SCHOOLS IN CHIPINGE DISTRICT

I am a PhD student at the University of Pretoria, applying for permission to carry out research in schools in Chipinge District. My research topic is:

The African Religious Landscape: An examination of the Shona traditional beliefs and practices in light of HIV & AIDS, and its ramifications for mitigation and care

Its primary objectives are to:

1) Examine the Shona traditional beliefs and practices that have continued to be practised; discontinued or have been modified due to the HIV and AIDS pandemic,

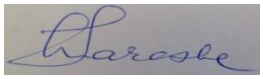
2) Evaluate traditional practices that are likely to fuel or lower the risk of HIV and Aids transmission, and

3) Discuss ways in which traditional healers could practice their trade in ways that do not put their lives at risk of contracting or spreading HIV and Aids.

With your express permission, I will gather data from elderly school headmasters, elderly school support staff and senior teachers from a sample of schools, as they are mature and custodians of culture. I intend to undertake the research later this year up to July 2012. The study may benefit the educators in their conduct of cultural activities in their schools. I greatly appreciate your assistance.

For further queries and clarification on the envisaged research, you are free to contact me either by e-mail on joelgift@gmail.com or by phone on+263 718558543.

Thank you



Joel Marashe

(Student ID: 10574281)

Appendix D2
A Sample of the Application for Clearance to Ministry of Health and Child Welfare

Faculty of Theology

Old Testament Studies Department

Lynnwood Road, Hatfield Campus

Pretoria 0002

Republic of South Africa

28 April 2011

The Permanent Secretary
Ministry of Health & Child Welfare
P O Box CY 1122
Causeway
HARARE

Dear Sir/Madam

RE: APPLICATION FOR PERMISSION TO CONDUCT RESEARCH AMONG HEALTH PROFESSIONALS IN CHIPINGE DISTRICT

I am a PhD student at the University of Pretoria, applying for permission to carry out research among health professionals in Chipinge District. My research topic is: *The African Religious Landscape: An examination of the Shona traditional beliefs and practices in light of HIV & AIDS, and its ramifications for mitigation and care*

The primary objectives of the study are to:

1) Examine the Shona traditional beliefs and practices that have continued to be practised; discontinued or have been modified due to the HIV and AIDS pandemic,

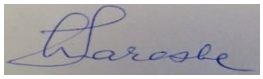
2) Evaluate traditional practices that are likely to fuel or lower the risk of HIV and Aids transmission and,

3) Examine the challenges that medical practitioners encounter in their duties because of cultural beliefs and practices.

With your express permission, I will gather data from elderly school headmasters, elderly school support staff and senior teachers from a sample of schools, as they are mature custodians of culture. I intend to undertake the research later this year up to July 2012. The study may benefit the educators in their conduct of cultural activities in their schools. I greatly appreciate your assistance.

For further queries and clarification on the envisaged research, you are free to contact me either by e-mail on joelgift@gmail.com or by phone on+263 718558543.

Thank you



_____

Joel Marashe

(Student ID: 10574281)

Appendix D3

A Sample of the Application for Clearance to the Ministry of Local Government, Rural and Urban Planning

Faculty of Theology

Old Testament Studies Department

Lynnwood Road, Hatfield Campus

Pretoria 0002

Republic of South Africa

28 April 2011

The Permanent Secretary
Ministry of Local Government, Urban & Rural Development

P O Box CY7706

Causeway

Harare

Zimbabwe

Dear Sir/Madam

RE: APPLICATION FOR PERMISSION TO CONDUCT RESEARCH AMONG TRADITIONAL LEADERS IN CHIPINGE DISTRICT

I am a PhD student at the University of Pretoria. I sincerely apply for permission to carry out research among traditional leaders in Chipinge District. My research topic is:

The African Religious Landscape: An examination of the Shona traditional beliefs and practices in light of HIV & AIDS and its ramifications for mitigation and care.
The main objectives of my study are to:

1) Examine the Shona traditional beliefs and practices that have continued to be practiced; discontinued or have been modified due to the HIV and AIDS pandemic,

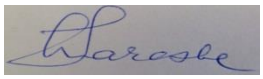
2) Evaluate traditional practices that are likely to fuel or lower the risk of HIV and Aids transmission and,

3) Discuss ways in which traditional healers could practice their trade in ways that do not put their lives at risk of contracting or spreading HIV and Aids.

With your express permission, I will gather data among chiefs, village heads, and the elderly in Chipinge District, as they are mature custodians of culture. The research I intend to conduct later this year up to July 2012 may benefit the participants in the conduct of cultural activities in their areas. I will greatly appreciate your assistance.

For further queries and clarification on the envisaged research, you are free to contact me either by e-mail on joelgift@gmail.com or by phone on+263 718558543.

Thank you



_____

Joel Marashe

(Student ID: 10574281)

Appendix D4
A Sample of the Application for Clearance to the president of ZINATHA

Faculty of Theology

Lynnwood Road, Hatfield Campus

Pretoria 0002

Republic of South Africa

28 April 2011

The President
Zimbabwe National Traditional Healers Association [ZINATHA]
Box 1116
98 Cameron Street
Harare
Zimbabwe

Dear Sir

RE: APPLICATION FOR PERMISSION TO CARRY OUT RESEARCH AMONG TRADITIONAL HEALERS IN CHIPINGE DISTRICT

I am a PhD student at the University of Pretoria. I sincerely apply for permission to carry out research among traditional healers in Chipinge District. The research topic is:

The African Religious Landscape: An examination of the Shona traditional beliefs and practices in light of HIV & AIDS and its ramifications for mitigation and care

The research objectives are to:

1) Examine the Shona traditional beliefs and practices that have continued to be practised; discontinued or have been modified due to the HIV and AIDS pandemic,

2) Evaluate traditional practices that are likely to fuel or lower the risk of HIV and Aids transmission and,

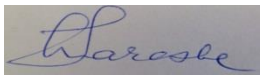
3) Discuss ways in which traditional healers could practice their trade in ways that do not put their lives at risk of contracting or spreading HIV and Aids.

With your express permission, I will gather data from traditional healers in line with the above objectives, and I think they are appropriate because they are traditional medical champions in their communities, and deal with people's health daily.

I am also requesting if you will be able to spare a few minutes to answer a few questions on the study during the course of this year. I intend to conduct the research later this year up to July 2012. It may benefit the participants in the safe conduct of their work, and avoid HIV infection or transmission.

For further queries and clarification on the envisaged research, you are free to contact me either by e-mail on joelgift@gmail.com or by phone on+263 718558543.

Thank you



_____

Joel Marashe

(Student ID: 10574281)

Appendix E
Confirmation of Candidature by Study Promoter (Supervisor)

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Theology
Department of Old Testament Studies

23 April 2012

The Secretary
Ministry of Local Government, Urban & Rural Development
P O Box CY 7706
Causeway
HARARE
Zimbabwe

Dear Sir

Confirmation of PhD-student: Mr J. Marashe

I hereby confirm that I am the supervisor of Mr J. Marashe, who is a registered PhD student at the University of Pretoria. In order to conduct his research successfully, he needs to carry out research in the Chipinge District.

I hereby request you to grant him permission to conduct research among the chiefs in Chipinge district. He needs to carry out research among the chiefs as they are custodians of culture.

I hope his request will be dealt with favourably.

Yours sincerely

Prof. A. Groenewald

Building and Room: Theology 2-3
University of Pretoria
Private Bag X20, Hatfield 0028
Republic of South Africa

Tel: +27-12-420 3487
Fax: +27-12-420 4016

Email: alphonso.groenewald@up.ac.za
www.up.ac.za

Appendix F

Copy of the Permission from the Secretary, Ministry of Local Government

(Next page)

MEMORANDUM

REF:

TO: **THE SECRETARY**

FROM: **TRADITIONAL LEADERSHIP SUPPORT SERVICES DEPARTMENT**

DATE: **03 JANUARY 2012**

SUBJECT: **APPLICATION TO CONDUCT RESEARCH AMONG CHIPINGE TRADITIONAL LEADERS: CHIPINGE DISTRICT: MANICALAND PROVINCE**

Reference is made to the above subject matter.

Background

1 Mr. Joel Marashe is a PhD student at the University of Pretoria and he wishes to carry out research among the Traditional Leaders in Chipinge District on the topic entitled; *'An examination of the Shona traditional beliefs and practices in light of HIV and AIDS and its ramifications for mitigation and care'.*

2. The study will gather informatioin from Chiefs, Village Heads, the District Administrator and the elderly in the communities of the District. Mr. Marashe has planned to conduct his research until end of July 2012.

3. The main objectives of the study are to:
   - Examine the Shona traditional beliefs and practices that have continued to be practiced, discontinued or have been modified due to theHIV/AIDS pandemic;
   - Evaluate traditional practices that are likely to fuel or lower the risk of HIV/AIDS transmission and;
   - Discuss ways in which traditional healers could practice their trade in ways that do not put their lives at risk of contracting or spreading HIV/AIDS.

Recommendation

In light of the foregoing, we have found Mr. J. Marashe's proposed study as noble and, therefore, recommend that his application be approved.

Signed _____ Date 03/01/2012
R.B Muchenje
A.O-Traditional Leadership Support Services

Recommended/ ~~Not Recommended~~

Signed _____ Date 03-01-2012
G. Madzimure
Deputy Director-Traditional Leadership Support Services

~~Recommended~~/ ~~Not Recommended~~

Signed _____ Date 3/1/12
F. Mukwaira
Director-Traditional Leadership Support Services

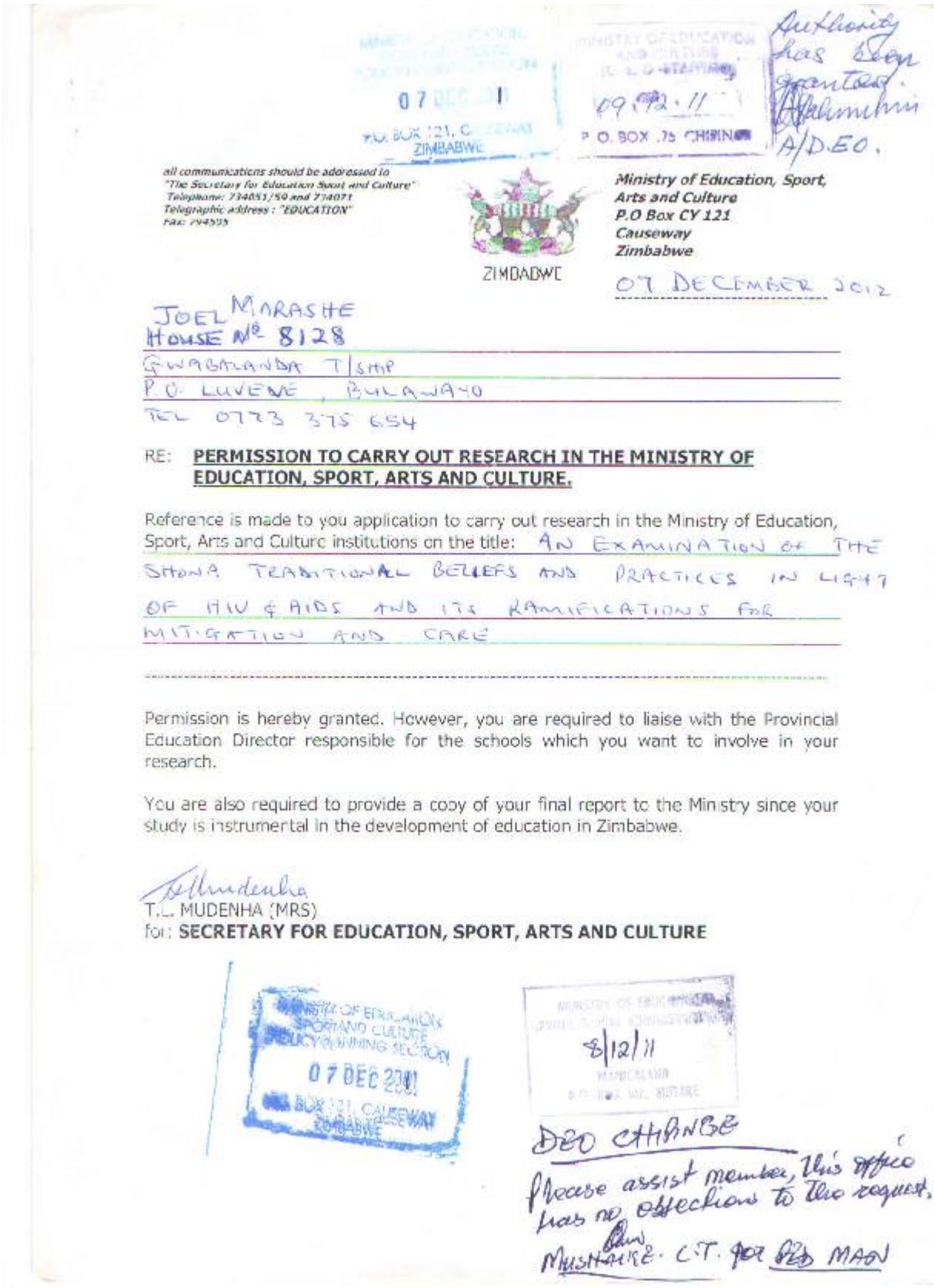
Approved/ ~~Not Approved~~

Signed _____ Date _____
K. Mupingo
Secretary for Local Government, Rural and Urban Development

Mr Marashe who confirmed that he is a University of Zimbabwe student

03/1/12.

Appendix G –Permission from Secretary, Ministry of Education



Authority has been granted.
A/D.E.O.

07 DEC 2011
P.O. BOX 121, C
ZIMBABWE

09.12.11
P. O. BOX 75 CHIRIN

all communications should be addressed to
"The Secretary for Education Sport and Culture"
Telephone: 734051/59 and 734071
Telegraphic address: "EDUCATION"
Fax: 794505

ZIMBABWE

Ministry of Education, Sport,
Arts and Culture
P.O Box CY 121
Causeway
Zimbabwe

07 DECEMBER 2012

JOEL MARASHE
HOUSE Nº 8128
GWABALANDA T/SHIP
P.O. LUVENE, BULAWAYO
TEL 0773 375 654

RE: **PERMISSION TO CARRY OUT RESEARCH IN THE MINISTRY OF EDUCATION, SPORT, ARTS AND CULTURE.**

Reference is made to you application to carry out research in the Ministry of Education, Sport, Arts and Culture institutions on the title: AN EXAMINATION OF THE SHONA TRADITIONAL BELIEFS AND PRACTICES IN LIGHT OF HIV & AIDS AND ITS RAMIFICATIONS FOR MITIGATION AND CARE

Permission is hereby granted. However, you are required to liaise with the Provincial Education Director responsible for the schools which you want to involve in your research.

You are also required to provide a copy of your final report to the Ministry since your study is instrumental in the development of education in Zimbabwe.

T.L. MUDENHA (MRS)
for: **SECRETARY FOR EDUCATION, SPORT, ARTS AND CULTURE**

MINISTRY OF EDUCATION SPORT AND CULTURE POLICY PLANNING SECTION
07 DEC 2011
BOX 121, CAUSEWAY
ZIMBABWE

8/12/11

DEO CHIRUNDU
Please assist member, this office has no objection to the request.
MUSHAURE. C.T. for DEO MAO

Appendix H
A Sample of an Interview Guide for traditional healers

Introduction

My name is Joel Marashe. I am carrying out research on the topic: *The African Religious Landscape: An examination of the Shona traditional beliefs and practices in light of HIV & AIDS, and its ramification for mitigation and care*. The objectives of the study are to:

a) Examine the Shona traditional beliefs and practices that have continued to be practiced, discontinued or have been modified due to the HIV & AIDS pandemic,
b) Evaluate traditional beliefs and practices that are likely to fuel or lower the risk of HIV & AIDS transmission, and
c) Discuss the ways in which traditional healers could practice their work in ways that do not put their lives at risk of contracting or spreading HIV. The interview will take between 15 - 20 minutes of your time, and I will greatly appreciate your assistance. May I ask you some questions?

Nhungamidzo

Zita rangu ndinonzi Joel Marashe. Ndirikuita tsvagurudzo nekuunganidza umboo pamusoro unoti: *Mhenenguro yezvitendero zvavaShona nekuitwa uye kutevedzwa kwazvo munguva yeutachiwana hweHIV nemukondombera, pamwe nezvazvinoreva mukudzivirira uye kuchengetedzwa kwevanorwara.*

Chinangwa chetvagurudzo iyi ndechekuferefeta zvitendero netsika dzavaShona dzichiri kutevedzwa nanhasi, dzakaregerwa kana dzakanhadzurudzwa nekuda kwedenda remukondombera, kupenengura idzo tsika dzingangogona kukuchidzira kana kuderedza kutapuriranwa kwemukondombera, pamwe nekuongorora nzira dzingashandiswe nen'anga pabasa ravo dzisingaisi upenyu hwavo munjodzi yekutapurirwa/kuparadzira utachiona hweshuramatongo. Hurukuro iyi inotora mamitsi anokwana mashanu kana gumi enguva yenyu, uye ndingakutendai cahizvo nerubatsiro rwenyu. Ndingakubvunzai mibvunzo?

SECTION A: Knowledge and perceptions about HIV & AIDS

This section aims to get information and insights about traditional beliefs and practices which may minimise or fuel the spread of HIV & AIDS. This information will be useful in lobbying for culturally-appropriate behaviour especially that which will help to minimize the spread of the AIDS virus. May you please answer the following questions?

1 What is HIV & AIDS?

Chinombonzi mukondombera chii?

2 In your opinion, what are the causes of HIV & AIDS? [Probe if it might be caused by witches, angry ancestors, alien spirits, etc.]

(a) Semaonero enyu, mukondombera unokonzerwa nei chaizvo?

3. Headaches and stomach pains are curable. Is there a cure for HIV & AIDS yet?

Kutemwa nemusoro uye kurwadziwa nemudumbu kunorapika. Kwati kwave nemushonga here unorapa chirwere chemukondombera?

4 (a) Did you receive training for the treatment of HIV & AIDS patients?

Makadzidziswa kurapa vanorwara nemukondombera here?

(b) How do you diagnose that a patient has HIV and, or AIDS?

Munoona sei kuti murwere ane hutachiona kana chirwere cheshuramatongo?

5 (a) Do you provide treatment for people with HIV & AIDS?

Munorapa vanorwara nechirwere cheshuramatongo here?

(b) If yes, briefly describe how you help patients suffering from HIV & AIDS?

Kana muchivarapa, tsanangurai muchidimbu kuti munovabatsira sei?

(c) How do you remove a foreign object in a patient's blood or flesh?

Munobvisa sei zvitsinga kana chirwere chinenge chiri muropa kana munyama yemurwere?

(d) How far can AIDS be cured by your methods of healing?

Munofunga kuti marapire enyu evarwere anorapa mukondombera here?

6. What precautions do you take to prevent infection by HIV & AIDS when attending to your patients?

Matanho api amunotora kuti musatapurirwe utachiona hweshuramatongo kana muchirapa varapwa venyu?

7. Why do people with HIV & AIDS come to traditional healers [even when they had visited medical doctors or hospital]?

Chii chinokonzera kuti vanorwara nemukondombera vauye kun'anga [dzimwe nguva vanenge vatombonorapwa navanachiremba kuchipatara]?

8. What is your advice to people living with HIV & AIDS in your society?

Irairo ipi yamungapa kune avo vane utachiona hweshuramatongo?

9. Is there anything that you may want to add concerning the HIV & AIDS pandemic?

Pane chamungada kuwedzera here maererano nechirwere cheshuramatongo?

SECTION B: Biographical profile

In conclusion, I wish to know a little more about you to enable me to see how different traditional healers feel about the same matters we have been discussing. Pakupedzisa, ndinokumbira kuziva zvishomanana pamusoro penyu kuti ndikwanise kuona musiyano uripo pamaonero enyu nevamwe varapi.

1. Gender

Male	Female
1	2

2. Age (Years)
Makore enyu

25-30	31-35	36-40	41-45	46 +
1	2	3	4	5

3. Marital Status [Probe for polygamy] [Makaroora?]

Married	Widowed	Divorced	Polygamy	Single
1	2	3	4	5

4. Years of Experience

Makore mangani ebasa?

4-10	11-15	16-20	21 +
1	2	3	4

5. HIV patients helped

in last 6 months [Varapwa vanehutachiwana vamabatsira mumwedzi mitanhatu

yapfuura]

1-5	6-10	11-15	16 +
1	2	3	4

6. Healer category [Mhandoyehurapi hwenyu]	Diviner	Herbalist	Both	Other
	1	2	3	4

Thank you very much for your time

Ndinokutendai chaizvo nenguva yenyu

Appendix I

A picture of a poster encouraging people to use condoms during sexual intercourse

Appendix J

A picture of a poster discouraging husbands from extra-marital sexual relationships

Appendix K

A picture of a poster advocating for prioritising children in the fight against HIV infection

Appendix L

A picture of a poster showing other ways of HIV infection prevention

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