PERSPECTIVES

The role of ethnography in STI and HIV/AIDS education and promotion with traditional healers in Zimbabwe

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SUMMARY

This article explores the utility of ethnography in accounting for healers’ understandings of HIV/AIDS—and more generally sexually transmitted infections—and the planning of HIV/AIDS education interventions targeting healers in urban Zimbabwe. I argue that much of the information utilized for planning and implementing such programs is actually based on rapid research procedures (usually single-method survey-based approaches) that do not fully capture healers’ explanatory frameworks. This incomplete information then becomes authoritative knowledge about local ‘traditions’ and forms the basis for the design and implementation of training programs. Such decontextualization may, in turn, affect program effectiveness.

Key words: Africa; STI/AIDS education; ethnography

INTRODUCTION

Recent evidence as to declining HIV/AIDS prevalence among pregnant women (and among women and men in the general population) in some sub-Saharan African countries is cause for measured celebration (UNAIDS, 2008). Preliminary evidence also seems to suggest that the declining prevalence is linked to the success of prevention efforts and that the rate of new infections could be slowing as well (ibid.). In the case of Zimbabwe, HIV prevalence estimates have followed a similar downward trend with a national estimate of 14.3% in 2010, among adults 15 years and above (UNAIDS, 2010).

Despite this fact, however, the overall number of people living with the disease continues to be high, and while biomedicine—particularly in the form of antiretroviral therapy—is touted as the best method for increased longevity for those living with HIV/AIDS, such treatments continue to be too expensive for the vast majority of people suffering from the disease in Zimbabwe. The lacuna of treatment options means that people living with HIV/AIDS (PLWAs) have to look for other therapeutic options in ameliorating the affects—physiological, psychological and spiritual—of the disease. Currently, there are some 1.2 million Zimbabweans age 15–49 living with HIV/AIDS and an estimated population of 389,895 adults and children were in urgent need of antiretroviral therapy by the end of 2009 (Zimbabwe Ministry of Health and Child Welfare, 2009).

Alongside the biomedical system in Zimbabwe, there is also a robust African vernacular medical system (also referred to as ‘traditional medicine’). In fact, it is estimated that the great majority of Zimbabwe’s population...
consults traditional healers for physical and mental health concerns (Chavunduka, 1978, 1998; Wafawanaka and Celine, 1990). Despite the biomedical services provided by the Zimbabwe Ministry of Health and Child Welfare, local governments, mission hospitals, employer-sponsored medical services and private practice, the ratio of biomedically trained doctors to patients is 1:7286 (and most of these doctors are concentrated in such urban centers as Harare and Bulawayo). On the other hand, the ratio of registered traditional healers to patients is 1:226 (Jijide, N.D.). If unregistered healers were included, this ratio would obviously be much smaller. These numbers underscore the centrality of traditional healers in matters of public health. If this is true—and particularly given the lack of access to other forms of health care in Zimbabwe’s deteriorating health care system—traditional healers are crucial nodes in any planned interventions for controlling the spread of HIV/AIDS.

There is a small but growing body of literature that explores African healers’ involvement in combating HIV/AIDS through education and counseling (Homsy and King, 1996; King and Homsy, 1997), general prevention programs (Green, 1997) and the scaling up of comprehensive care (Homsy et al., 2004). Despite these efforts, however, healers continue to be largely ignored by HIV/AIDS education programs sponsored by government and non-government organizations (Pucktree et al., 2002; Karim, 1993) and healers’ responses to the epidemic have been equally ignored—or maligned—in much of the scholarly literature (Neequaye et al., 1991; THETA, 1996; Chipfakacha, 1997; Ssali et al., 2005; Abraham, 2007). The concern over how and if to involve healers in efforts to combat HIV/AIDS centers on the presumption that healers subscribe to a disease/illness etiology that is not based on a biomedical model (Asuni, 1979; Foulkes, 1992). Given the dominance of biomedical approaches in many health development interventions, healers’ knowledge and practices have often been conceptualized as impediments to health promotion efforts—particularly since the advent of HIV/AIDS (Simmons, 2009).

In this article, I explore the utility of ethnography in accounting for healers’ understandings of sexually transmitted infection (STIs)—and more generally HIV/AIDS—and the planning of education interventions targeting these diseases for healers. I argue that much of the information utilized for planning and implementing such programs is actually based on rapid research procedures (usually single-method survey-based approaches) that do not fully capture healers’ explanatory frameworks. This incomplete information then becomes authoritative knowledge about local ‘traditions’ and forms the basis for the design and implementation of training programs (Pigg, 1997). Such decontextualization may, in turn, affect program effectiveness.

Qualitative data for this article are drawn from more than 10 years of ongoing ethnographic research exploring explanatory models for STIs and HIV/AIDS among Harare-based healers. I also draw on policy statements, training materials and secondary and grey literature to explore and triangulate findings.

Background/literature review

The use of ethnography in health research and health promotion

Ethnography as a research design is part of the major methodological cache of Anthropology. Its goals include describing a particular cultural context and offering interpretation of places, people and other meaningful things within that context (Spradley and McCurdy, 1972; Spradley 1979, 1980). The hallmark of ethnography is of course participant observation—simultaneously immersing oneself in a culture and also removing oneself from that immersion to intellectualize what one has seen and heard [(Bernard, 2002), p. 324]. The goal of participant observation is to move from an etic (objective, outsider’s) perspective to an emic (subjective, insider’s) perspective—that is, seeing and understanding the culture from the perspective of the people themselves (e.g. local explanatory models for a given phenomenon).

True participant observation takes time—to build proficiency in a foreign language (in some cases), to build rapport, and to move from an outsider’s perspective to more of an insider’s perspective. On average, most anthropologists spend a year in the field while conducting ethnographies. Some health professionals may find such an investment of time unreasonable. However, it is also possible to do useful participant observation in a matter of weeks or months, especially if the researcher has a history at that particular field site or is already well versed in a particular culture or
community. For those of us interested in participatory approaches to health promotion and education, more time spent in the field is important to building the kind of rapport necessary for developing collaborative interventions.

It has only been recently that ethnography has been recognized as a valuable tool for health care disciplines (Kleinman, 1992; Brink and Edgecomb, 2003). Some applied medical anthropologists, for example, use ethnography in conjunction with rapid assessment methods—an approach known as focused ethnographic study (FES). Originally developed by a physician and an anthropologist, FES was created for the World Health Organization to study acute respiratory illness (ARI) in children (Bernard, 2002), p. 332]. While many ARI episodes are what doctors refer to as pneumonia, this is not what many mothers call the illness. Thus, researchers elicit recent ARI episodes as well as symptoms, causes and cures in order to reveal the folk taxonomy of the illness and where ARI fits into the taxonomy. This evidence is used to understand ARI from an emic perspective, the local explanatory model for the illness (ibid.). Awareness of local explanatory models is an important first step in developing culturally sensitive health promotion and education training programs.

The context of STI and HIV/AIDS training programs for Zimbabwean healer

The majority of STI and HIV/AIDS training programs targeting healers are coordinated through the Zimbabwe National Traditional Healers Association (ZINATHA). The organization’s interest in combating AIDS began just 3 years after the first official case in Zimbabwe was announced in 1985. In collaboration with the Ministry of Health and Child Welfare (MOHCW), the Association organized two workshops in 1988. These workshops mainly targeted members of the ZINATHA national executive committee and members of the council. A few district officials also attended. In 1989, again in collaboration with the MOHCW, the association held four workshops. These were mainly for ZINATHA district officials. In January 1990, ZINATHA embarked on a comprehensive community-based health education program for STI and HIV/AIDS awareness, prevention and care, with some financial assistance from donors. Importantly, there had been no field research undertaken at this time regarding healers’ explanatory models for the disease.

The same year, a knowledge, attitudes and practices (KAP) survey was conducted at the time of the program’s initiation. The survey had three goals: (i) to understand healers’ KAP with regard to STIs and HIV/AIDS, in order to monitor the impact of the provision of new information through workshops; (ii) to identify the most important information gaps, misconceptions and requirements among participants and to advise on relevant workshop content; (iii) to provide some indication of appropriate and effective means of providing this information.

Results from the survey indicated low levels of education and literacy, which meant workshops would have to emphasize oral and pictorial methods of presenting information. A short pamphlet was designed in local languages, containing basic information on STIs and HIV/AIDS and illustrating how the disease related to healers. Importantly, because no prior ethnographic research had been conducted, planners were unaware of healers’ own explanatory frameworks for infectious disease (including STIs and HIV/AIDS)—frameworks that are convergent with more naturalistic explanatory frameworks (see below). Thus, health education efforts—usually in the form of workshops and educational pamphlets—relayed information using narrowly biomedical terminology, often in English or directly translated from English. So, while there is great convergence between biomedical and African vernacular explanatory frameworks for infectious disease, these areas of convergence were concealed because of the form the information took within the context of the interventions themselves. There was, for example, no effort to point out areas of convergence between the two explanatory models because there had been no research into African-derived explanatory models, but rather STIs and HIV/AIDS from the perspective of biomedicine (via the initial KAP survey).

ZINATHA AIDS coordinator, Peter Sibanda, has said, ‘We are teaching our people, particularly healers, AIDS awareness, prevention, some counseling skills and home-based care knowledge’. The impetus being that when HIV/AIDS was first discovered in the country, traditional healers were accused of undermining prevention efforts. Practices such as using understerilized razor blades for incisions on successive patients were attacked as potential HIV
transmission routes. Not wishing to antagonize either their clients or the government, ZINATHA initiated workshops throughout the country as part of an education campaign. ‘We are trying to remove the cultural taboos and stigmas, and to deal with what we may call controversial cultural issues. We try and ease the taboos by encouraging discussion on AIDS within families’, said Sibanda.

Indigenous theories of contagious disease
The KAP survey mentioned above privileges biomedical knowledge and practice and forms the foundation of many interventions targeting healers. The assumption of many health planners is that healers’ etiological understandings of disease are necessarily based on a personalistic model that ascribes disease to supernatural causes. Closer analysis of healers’ explanatory frameworks—especially based on ethnographic data—reveals a much more nuanced picture. Green (Green’s, 1999) work on indigenous theories of contagious disease, for example, helps illuminate the complex understandings healers have of such diseases as HIV/AIDS. In particular, pollution beliefs in sub-Saharan African therapeutic systems deserve special attention given: (i) their use as a major explanatory metaphor; (ii) their complex and symbol-laden nature; (iii) the confusion over the degree to which personalistic or supernatural causation dominates African health beliefs; and (iv) the fact that these beliefs tend to be overlooked by health researchers and anthropologists alike [(ibid.), p. 15]. In Green’s formulation, pollution refers to the belief that people will become ill through contact with, or contamination by, a substance or essence considered dangerous because it is unclean or impure [(ibid.), p. 13].

What is considered pollution and polluting (and therefore, contagious) covers a range of material and immaterial items and can be tied to local understandings of morality and immorality. A mother who commits adultery, for example, may get exposed to a polluting essence that ‘spoils’ or ‘heats up’ her breast milk, thus making her child sick (ibid.). Likewise, a man who commits adultery with another man’s wife may find he has developed a wasting disease that does not respond to conventional biomedicine (Simmons, 2000). So, while the above illnesses are the result of coming into contact with a polluting substance, they also represent the consequences of breaching social custom and therefore serve as local forms of social control and morality.

STIs constitute a very particular class of pollution, and given their moral overtones, they are thought to be particularly well-treated by traditional healers (Green, 1994). According to Willms et al. ((Willms et al., 1995), p. TSB-11), Zimbabwean healers’ base explanatory model for STIs is that of ‘dirt’ that collects in the stomach, bladder or the reproductive organs in the form of an ‘egg’. The egg hatches worms that spread to various parts of the body through the bloodstream, eventually weakening the body and making it vulnerable to different diseases. While ‘dirt’ is not well defined, it is sometimes described as dead sperm, menstrual blood or ‘leftovers’ of STIs. However defined, the dirt is transmitted during the act of sexual intercourse and accumulates to produce an illness state (ibid.). Thus, following the moral overtones of the illness state, it is the act of immoral sex that creates the disease.

Strategies
Ethnographic data gathering occurred in 10 designated districts in Harare, including Chitungwiza, Dzvarasekwa, Glen Norah, Glen View, Highfield, Kuwadzana, Mabvuku, Mbare, Mufakose and St. Mary’s. All of these districts are black residential areas, also referred to as ‘high-density’ areas. Participant observation occurred at ZINATHA meetings and headquarters as well as healers’ clinics. A snowball-sampling method was utilized with researchers first interviewing district chairs of the ZINATHA—the national organization for Zimbabwean healers. Later, an attempt was made to interview a representative sampling of healers according to gender and area of specialization. Types of healers interviewed, included herbalists, spirit mediums, faith healers, bone casters (diviners), traditional birth attendants or some combination of categories/types.

A team of four researchers, comprising two American researchers and two Shona researchers undertook the research. Both Shona researchers were affiliated with the ZINATHA and underwent training in ethnographic research techniques prior to the start of data gathering. An interview schedule was pre-tested at ZINATHA headquarters in Harare by
traditional healers before being administered in the field.

The data here draw from interviews with 150 healers over the course of 10 years (1996–2006). Most of the interviews were conducted in chiShona, though healers who were fluent in English were interviewed in English. Questionnaires were written in English, translated into Shona, and then translated back into English by a third party to insure their accuracy. A questionnaire designed to provide a demographic profile as well as healers’ explanatory frameworks HIV/AIDS, was utilized. Most often, interviews were conducted in healers’ homes (e.g. in their Matare—the place where they practice their curing/treatment), occasionally at ZINATHA headquarters and occasionally at district meetings. Thematic content emerging from interviews was triangulated with secondary literature and combined, compared and analyzed according to qualitative research practice (Ritchie and Lewis, 2003).

RESULTS

Healers and STIs

Ninety percent of the healers said that they treat STIs. Most commonly treated STIs, included drop (42%), syphilis (22%), gonorrhea (18%) and chancroid (18%). Interestingly, only 6% of the healers included HIV/AIDS on their list of frequently treated STIs.

Locally recognized STIs: their symptoms and treatment

It was common for n’anga to give English names for some STIs (for example, ‘drop’) and, in some cases the same indigenous and/or English names are used for different diseases. As Green (Green, 1999) notes, this does not mean that these STIs exactly correspond symptomatically to the STIs of biomedicine. Rather, this may signal disagreement and/or confusion over STI symptoms as well as overlap between the biomedically recognized symptoms of these illnesses.

For each STI elicited, a composite profile of causes, symptoms and other characteristics has been constructed from reviewing answers to interview questions and generalizing from the majority of answers.

Gonorrhea (yemaronda, isick, drop, njovera)
Abdominal pains, painful urination, loss of appetite, constipation and sores, as well as hair loss in the genital area usually characterize this STI. Men and women are affected in roughly equal numbers. Its cause was said to be sexual activities with prostitutes or with multiple partners—especially those with loose morals. Treatment strategies differed amongst n’anga. For example, an herbalist utilized ‘African injection’—an incision made through a razor blade—on the area near the respective vein that, he said, assured that the medicine went directly to the site of infection. He pointed out that eating or drinking the medicine would result in its ‘loss’ through digestion. He also prescribed a topical ointment for sores.

Syphilis (songeya, drop, yematariyana)
Symptoms included frequent urination followed by a whitish discharge, swelling of the penis, sores in the genital area, abdominal pain and difficulty walking. Men and women are affected equally. Causes were said to be having multiple sexual partners—particularly from places like bars and beer halls, older women engaging in sex with younger men, having sex with a menstruating woman or a woman who just miscarried, erratic menstruation cycle (causing dirt to collect in the vagina). In the case of the indigenously named yematariyana, folk explanations suggest that the Italians who worked on roads and bridges in the 1950s first brought the disease to the country. One bone caster/herbalist commented that ‘God created a black man for a black woman, and therefore it is not good for a white man to sleep with a black woman or vice versa. Our blood is different and that difference created the problem’. The most common forms of treatment were African injections—incisions made on the affected areas and medicine administered to the wounds. In the event that a man ‘had lost his manhood’—meaning he had become impotent—an additional treatment was carried out where a cock (rooster) would be cooked with special herbs, then consumed, for manhood restoration.

Chancroid (mvarapo, yemabhora, yemajuru, mazvimbiawa)
Symptoms included swelling of genital area—the development of hard boils—below the ribcage, foul-smelling whitish discharge from
the genitals, and the sensation of ‘ants marching from the stomach to the genital area’. Causes were said to be ‘having sex with a dirty woman’, multiple sexual partners, having sex with a woman who is menstruating or recently miscarried. Like syphilis and gonorrhea, treatment is in the form of a burnt medicine applied into incisions near the boils themselves. Boils are said to subside within a couple of days.

Drop
Symptoms included abdominal pains with genital discharge, foul odor, as well as sores. Sexual intercourse with multiple partners, sex with woman who is menstruating or recently miscarried, or having sex with a woman of ‘loose morals’ were the most commonly mentioned causes for drop.

Treatment strategies are consistent with others observed in the surrounding region. Green [(Green, 1999), p. 166], for example, notes that in Zambia: ‘The main objective of treatment is to kill an infective micro-organism (insect, dirt, bacteria, virus), or expel it from the body or blood. As is characteristic of healers in the broader region, they use herbal decoctions (teas or, less often, herbs mixed in porridge) made from boiled roots. These might have the effect of purgatives or emetics, especially if they are supposed to expel dirt. Some medicine is said to make the illness insect leave the body through frequent urination. Other treatment objectives include cleaning the blood, healing wounds or making specific symptoms disappear such as warts, ulcers, sores or other visible skin symptoms. STIs featuring sores or ulcers may be treated topically with poultices made with powdered roots. For STIs with warts or growths, these might be cut out and/or the patient may be asked to sit in a container of water with crushed medicinal roots’.

AIDS genesis and operation in the body
N’anga offer a variety of explanations for how AIDS is generated in the body. The common theme in these explanations is that blood of different constitutions (usually hot and cold) comes into contact and causes an illness state. Following the general model for the generation of STIs outlined above, a majority of herbalists and herbalists/diviners I interviewed explained that AIDS begins when young (hot) blood mixes with old (cold) blood through sexual intercourse. Likewise, AIDS starts when white (European or American) blood mixes with black (Zimbabwean) blood through sexual intercourse. Even sexual intercourse between different African ethnic groups can cause the disease.

This focus seems clearly to be on ‘mixture’. While it might be assumed that the mixing would be two-way—where the disease starts simultaneously in both partners—it is the ‘guilty’ partner whose blood is weakened or diluted during the mixing instead. Thus weakened, that person’s body becomes vulnerable to the multitude of illnesses that together constitute AIDS—weight loss, diarrhea, deep cough, etc. ‘Guilt’ is usually attributed to the individual who has willingly breached accepted social customs. Given the physiological, social and economic vulnerability of women to contracting HIV/AIDS from males, this way of thinking about the disease, unfortunately, can mean that many women are considered the ‘guilty’ ones—particularly when, because of standard blood tests during pregnancy, they are the first to know their sero-status. This can have devastating consequences for women—particularly poor women—and their children.

Indigenous names for HIV/AIDS
While the term HIV/AIDS is used almost universally in Zimbabwe by health professionals and lay people, there are also a great diversity of indigenous names for the disease which either reflect the vector of its transmission or its effect. Like Willms et al. (Willms et al., 1995), I also found that some of these names include mkondombera, or ‘a stubborn disease that once it gets hold will never let go’; gukurahundi, or ‘a heavy rain that washes away everything’; bumbiro rezvirwere, or ‘a basket full of seeds of different variety all germinating at one time’; and shuramatongo, or ‘a ghost homestead’ (meaning that an infected man will infect his wife and the wife will infect any children she’s pregnant with, thus destroying the home). Implicit in these local names for AIDS is the idea that it is a variety of illnesses—weight loss, chronic diarrhea, genital sores—that occur concurrently and, as such, are difficult to treat with one medicine; that AIDS is spread by prostitution or promiscuous behavior; and that AIDS is
devastating homes, families and communities (Simmons, 2009).

Another name elicited was *chiwere chepfambili*, which means ‘disease of prostitutes’. The belief that prostitutes are responsible for the spread of the disease was, in part, echoed in n’anga’ responses to the statement, ‘Prostitutes have a higher chance of getting AIDS’, to which 100% of both genders answered ‘True’. Some n’anga commented, ‘They are the ones spreading it’, ‘They spread AIDS—no decent woman would approach a man’, or ‘They’re the carriers’.

The stigmatization of prostitutes as carriers of the virus, as opposed to their clients or ‘johns’, may signal a general belief about women whose sexuality is not under the control of male partners, fathers or elders. The fact that these women’s sexuality is not controlled by males marks them as ‘guilty’ women, in that they are not submitting to male authority and, also, are enticing ‘decent’ men away from their families. This guilt then puts them at increased risk of contracting HIV/AIDS according to healers’ explanatory models. Prostitutes, or commercial sex workers (CSWs), in theory exercise control over their own sexuality by selling their bodies to clients. In practice, of course, it can be argued that CSWs are indeed not in control of their own sexuality—that it is still controlled by the clients themselves. For example, some studies indicate that female CSWs have little control over whether their clients use condoms during coitus, even when they request that clients utilize them (Wilson et al., 1990).

N’anga were less sure if HIV/AIDS could be transmitted through man-to-man sexual intercourse: 86% of the women and 79% of the men answered ‘True’. When asked this question, many n’anga asked to have the question repeated, some openly laughed, and others stated that they had never heard of such a thing. For the most part, Zimbabwe is a heteronormative nation where homosexuality is seen as quite uncommon and as a European or American transplant.

**DISCUSSION**

We interviewed Harare-based traditional healers in an effort to gather baseline knowledge of their explanatory models of STIs and HIV/AIDS. Ethnographic data revealed that healers’ base explanatory models for these infectious diseases fit within a broader explanatory model of diseases caused by exposure to polluting substances—both material and symbolic. Contrary to the assumption that healers subscribe to an etiological model of illness/disease that is incommensurate with biomedical models, ethnographic evidence suggests that there are areas of great convergence between the two models. However, because of language and translation issues—both literal and figurative—these areas of convergence are concealed in the contexts of workshops and educational materials.

Health promotion interventions could benefit from highlighting areas of convergence of both indigenous and biomedical understandings of the disease, particularly for developing content that can be more readily assimilated and understood. Evidence suggests that both models share the following areas of convergence: STIs and HIV/AIDS spread through sexual intercourse; sexual behavior puts people at risk; and one method of effective prevention is rooted in behavior change [(Willms et al., 1995), p. TSB-12]. As Willms et al. (ibid.) suggest the indigenous concept of ‘dirt’ might effectively be used in health planning and education as an idiom for HIV. Finding the most culturally appropriate form to communicate this is particularly important given the fact that the evidence above suggests that healers rely heavily on ‘African injections’ to treat STIs. Given the high number of people currently living with the disease as well as limited access to such biomedical treatment options as ARVs, collaborating with healers offers another option for shoring up general health promotion efforts in the country.

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