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Herstory: Maidei Chivi, an HIV positive
Zimbabwean Woman

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A minor dissertation submitted in part fulfillment of the
requirements for the award of a Master of Philosophy in HIV/AIDS
and Society.

Faculty of Humanities
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Compulsory Declaration

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in this dissertation from the work, or works of other people has been attributed, and has been cited and referenced.

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ABSTRACT

Sixty percent of the estimated 1.08 million people living with HIV/AIDS in Zimbabwe are girls and women. Analysts have attributed this state of affairs to gender power imbalances which are worsened by the fact that women are disproportionately represented among the poor and marginalised population groups.

The thesis is based on the story of a 36 year old HIV positive middle class black Zimbabwean woman, Maidei Chivi (pseudonym). Maidei is well educated, financially secure and wields enormous power both within her family and at her workplace. She therefore, unlike many women, does not fall into the typical HIV victim category, characterised by poverty, coerced sex and desperation. Maidei's story demonstrates that economic security does not necessarily result in women taking decision making roles during sex.

While the issue of stigma played a role in rendering her vulnerable to infection - and she herself believes she made irrational spur of the moment decisions which resulted in her engaging in unprotected sex even though she had a choice in the matter - her desire to become a wife and mother as deemed by the society which nurtured her also played a significant role. Her story therefore, apart from confirming the traditional gender theories on HIV transmission among women, is also about the complexity of sexual relations.

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To Maidei Chivi (pseudonym), the narrator of the story on which this dissertation is based, I simply do not have the right words to describe my gratitude to you for sharing your innermost thoughts with me. Your story touched on extremely intimate details of your life, and yet you did not hesitate to discuss what many would have considered cutting too close to the bone. I will forever be indebted to you. Spending time with you and listening to your story was an enriching and life-changing experience.

Last but not least, I am grateful to my family for their love and support. I am particularly grateful to my husband Simon and my daughter Yananiso for making sure that I stayed the course and for enduring my 18 month stay away from home without complaint. The daily phone calls were a source of comfort and inspiration. To my son Thabiso, thank you for the occasional e-mail.

TABLE OF CONTENTS

ABSTRACT	i
ACKNOWLEDGEMENTS	ii
TABLE OF CONTENTS.....	iii
LIST OF FIGURES & TABLES.....	vii
LIST OF ABBREVIATIONS	viii
PREFACE	x
1. CHAPTER 1: INTRODUCTION	1
1.1. The Story of HIV/AIDS in Zimbabwe	3
1.2. Modes of Transmission	5
1.3. Condom Use.....	7
1.4. The Female Condom	9
1.5. The Affected Groups	9
1.6. Background	11
1.7. Contemporary Zimbabwe: HIV/AIDS and the Economy.....	13
1.8. The Socioeconomic Consequences of Zimbabwe’s Economic Mal-performance ..	18
1.8.1. <i>Poverty</i>	18
1.8.2. <i>Mortality Rates</i>	20
1.8.3. <i>Malnutrition</i>	20
1.8.4. <i>Access to Health Care</i>	21
1.8.5. <i>Maternal Mortality</i>	22
1.9. Responses.....	23
1.10. Conclusion	25
2. CHAPTER 2: LITERATURE REVIEW	28

2.1. Gender Defined	28
2.2. Pre-colonial Times.....	29
2.3. Colonial Times.....	30
2.4. The Effects of Male Migration on the Family.....	31
2.5. During and After the War of Liberation	32
2.6. After the Guns Fell Silent.....	35
2.7. The Legal Environment	35
2.8. Marriage and Lobola	36
2.9. Culture and Tradition.....	38
2.10. Disputes.....	39
2.11. Land Ownership.....	40
2.12. Implications of Gender Inequities in the Era of HIV/AIDS.....	42
2.13. Limitation of Gender-based Theories	43
2.14. Some Behavioural Theories Relevant to HIV/AIDS.....	44
2.15. Scapegoating.....	44
2.16. Conclusion	44
3. CHAPTER 3: THE DATA COLLECTION METHOD	46
3.1. The Life History Method.....	46
3.2. The Feminist View.....	47
3.3. Explicit Self Disclosure.....	51
3.4. Ethics	54
3.5. Shortcomings of the Oral Narrative Method.....	56
3.6. Interpreting Maidei's Story	57
3.7. Finding A Participant.....	58
3.8. The Ground Rules	59
3.9. In the Field with Maidei.....	61

3.10. Conclusion	62
4. CHAPTER 4: MAIDEI CHIVI – HERSTORY	64
4.1. Maidei’s World.....	64
4.2. The Early Years	66
4.3. The Move to the Capital.....	67
4.4. The Working Years	67
4.5. Dating In Harare	68
4.6. Marriage	71
4.7. The Nightmare.....	73
4.8. Dealing with Her Husband’s Illness and Subsequent Death.....	74
4.9. Life After Taurai’s Death.....	75
4.10. Widowhood – A Life of Celibacy	77
4.11. Living With HIV Status – When You Know You Have It	77
4.12. Antiretrovirals.....	79
4.13. Tragedy in Her Natal Family.....	79
4.14. Tendai	81
4.15. Trying to Deal With It All.....	81
4.16. Religion.....	83
4.17. Conclusion	85
5. CHAPTER 5: DISCUSSION.....	86
5.1. The Early Meanings of HIV/AIDS in Zimbabwe	88
5.2. Challenging the Stereotypic Notions of African Sexuality	90
5.3. Other Sources of Vulnerability – Images of Zimbabwean Women	91
5.4. Issues of Sexuality.....	97
5.5. The Effects of the Economy	97
5.6. Conclusion	98

6. CHAPTER 6: CONCLUSION	100
6.1. The Need for De-stigmatisation	103
REFERENCES.....	105
APPENDIX 1:	116
APPENDIX 2:.....	118

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LIST OF FIGURES & TABLES

FIGURES	Page
Figure 1: Zimbabwe Estimated HIV Prevalence Rates 1985 - 2005	4
Figure 2: HIV Modes of Transmission in Zimbabwe	6
Figure 3: Age/Sex Distribution of Infected Persons 15 to 49, 2003	7
Figure 4: HIV Prevalence and Real GDP Growth 1985 - 2005	15
Figure 5: Inflation and % Change in Income – 1986 to 2004	16
Figure 6: Wages Adjusted for Inflation 1980 – 2004	17
Figure 7: Real GDP for Regional Economies (1997 – 2003)	18
Figure 8: Infant and Under Five Mortality Rates – 1985 to 2004	22
Figure 9: Map of Zimbabwe: Maidei’s World	65
TABLES	Page
Table 1: HIV Prevalence Rates of Selected Population Groups	10
Table 2: Women’s share of non-agricultural wage employment	41

LIST OF ABBREVIATIONS

AIDS – Acquired Immune Deficiency Syndrome
ANC – Antenatal Clinic
ARVs – Antiretrovirals
CDG – Centre for Global Development
CSO – Central Statistical Office
ESAP – Economic Structural Adjustment Programme
HIV - Human Immunodeficiency Syndrome
IMF – International Monetary Fund
MOHCW – Ministry of Health and Child Welfare
NAC – National Aids Council
NACSCUZ - National Association of Cooperative Services and Credit Union of
NGO – Non Governmental Organisation
P. F. ZAPU – Patriotic Front, Zimbabwe African People’s Union
PMTCT – Prevention of Mother to Child Transmission
PSI – Populations Services International
SAFAIDS – Southern Africa HIV/AIDS Information Dissemination Service
STI – Sexually Transmitted Infections
UNDP – United Nations Development fund
UNICEF- United Nations Children’s Fund
UNIFEM- United Nations Development Fund for Women
USAID – United States Agency for International Development
VCT – Voluntary Counseling and Testing
WHO – World Health Organisation
YAS – Young Adults Survey
ZAN – Zimbabwe AIDS Network
ZANLA – Zimbabwe African National Liberation Army
ZANU (P.F.) – Zimbabwe African National Union (Patriotic Front)
ZHDR – Zimbabwe Human Development Report

ZHDS - Zimbabwe Household and Demographic Survey

ZOPLWHA – Zimbabwe Organisation for People living with HIV and AIDS

ZRCS – Zimbabwe Red Cross Society

ZWRCN – Zimbabwe Women’s Resource Centre Network

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PREFACE

The reasons why I decided to do this particular research are both academic and personal. Academically, this piece of work is in partial fulfilment to the requirements of the MPhil in HIV/AIDS and Society degree programme. On a personal note, the motivation to do life history based research on an HIV positive woman was born of the pain of losing to the infection firstly, a beloved brother and then, two women – Tsitsi and Cynthia, who were highly valued colleagues and friends.

I grew up in racially segregated and intensely patriarchal Rhodesia and was socialised to, in many respects, accept my race and gender based inferior status. As a young girl, I did housework while my brothers played. Though I was unhappy with this state of affairs, I never questioned it. In comparison with some other girl children, I was, to a very large extent, a privileged child in the sense that I got as much education as my brothers did. It was much later in life as a grown woman that the concepts of masculinity and femininity started to have meaning in my life.

For many years I pursued a career in the field of human resources management. My positioning as a middle class highly educated woman operating at a senior level in my organisation afforded me the opportunity to closely scrutinise both my own experiences and those of my female colleagues. I became aware of countless cases of gender based discrimination against women. That awareness developed into what my colleagues at work described as an “obsession” with cases of gender bias. Occasionally my male colleagues would accuse me of being paranoid. In retrospect, I do believe that my colleagues were, to an extent, quite justified in their criticism because I actively sought to expose cases of discrimination against women within my organisation. I even commissioned research on sexual harassment in my organisation amidst concerted opposition from my male colleagues and indeed quite a few female ones. Tsitsi and Cynthia stood by me when I fought to have the research done. In my capacity as head of Industrial Relations I became privy to many a woman’s tale of both physical and

psychological violence in the home. I began to appreciate why, in Harare, there were shelters for abused women and none for men. It was not, however, until I embarked on this degree programme that I truly began to appreciate the concepts of masculinity and femininity and gender power imbalances.

The outbreak of the HIV/AIDS epidemic has served to highlight how diseases are experienced differently by men and women. My studies in the “Critical Issues in the study of HIV and AIDS” and “Gender Based Violence” made me truly appreciate the gendered nature of HIV/AIDS statistics not just in my country but in sub-Saharan Africa as a whole.

To an extent this work is dedicated to three women – the narrator of the story on which the research is based and my late colleagues and friends, Tsitsi and Cynthia. During my career I lost many colleagues to AIDS, but none of the stories of those I lost touched me as much as those of these two women. They were bright, talented, energetic and rising stars. They were at the forefront of the organisation’s HIV/AIDS prevention programmes and yet they, ironically, failed to practice what they preached. Their education and financial independence did not serve them well. At the end of the day, gender power dynamics took the upper hand. At work they demonstrated superiority over men while at home they resorted to being women who complied with their men’s wishes.

The three of us worked for a retail organisation which had 42 outlets scattered throughout the country. I joined the organisation long before they did. In fact, I recruited them into the organisation’s management training programme. Efforts to get women to stay in retail had always been difficult because of the long hours and the possibility of being transferred to an outlet far away from spouses and partners. Most women opted out rather than “lose their men”, as they often put it. Tsitsi and Cynthia stuck it out and had their stint at running stores in remote places. In time they rose through the ranks and following promotions they were back in Harare at the head office.

When HIV started to spread its tentacles, my organisation, as was the case with many others, put together HIV/AIDS prevention programmes at the work place which included the training of peer educators for each one of the organisation's outlets. Tsitsi was particularly passionate about it and liaised with several non-governmental organisations in search of information. Eventually we put her in charge of the company's prevention programme because she had proven to be more enthusiastic and more knowledgeable than anyone else. When she turned 28, Tsitsi started showing signs of restlessness about wanting to start a family. During lunch breaks that was all she would talk about. Her biggest problem was that she did not want to have children out of wedlock but her boyfriend of 5 years was not keen on getting married.

It so happened that one of the organisation's senior managers (whom I shall call Fred) had lost a wife to AIDS before Tsitsi joined the organisation. She dropped her boyfriend and started going out with Fred who proposed marriage six months down the line. In conversations, without me disclosing why I was concerned, she assured me she was being careful and would keep saying "you should know me better than that." I was heartbroken when Fred proposed marriage without disclosing his HIV status to Tsitsi. I begged him to tell her but despite promising that he would, he never did. Tsitsi always told her own staff to go for an HIV test especially before marriage. I asked her when she and Fred were going for tests and she kept saying they would. Fred eventually told her that he was not keen on going for the test and said he did not want children anyway so they could continue using condoms. Tsitsi took the plunge, regardless, and got pregnant. Her first child died when he was 4 months old and when I questioned the wisdom of her trying for another child her unexpected defence was that she did not think Fred was HIV positive. When I insisted that there was no harm in her going for the test she still opted not to. Her second pregnancy and subsequent birth of a baby girl took its toll on her. She died two years later. It was heartrending.

In the meantime it was as if Cynthia was in competition with Tsitsi. When Tsitsi tied the knot Cynthia had been temporarily requested to manage the company's second largest store in Bulawayo, Zimbabwe's second largest city. While in Bulawayo she started dating

a man whose wife was studying abroad. She initially said it was just for companionship. When she got pregnant I confronted her and said I hoped both of them had gone for HIV tests before then. I could not believe my ears when she said she too had taken a chance. She died of AIDS five years later at the age of 32. I suppose I have not stopped mourning these two wonderful women who had so much potential. I found it necessary to talk to someone of a similar background – a financially independent middle class woman who, through her own story, could give insight into her own vulnerabilities and help explain to me the tragedy of my two friends.

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CHAPTER 1: INTRODUCTION

The question of AIDS is an extremely important terrain of struggle and consternation...AIDS is the site at which the advance of sexual politics is being rolled back... (Hall 1992: 285).

Maidei Chivi (pseudonym), one of Zimbabwe's estimated 1.08 million HIV positive women was not driven into having unprotected sex by poverty or coercion. Answers to why she participated in an act that resulted in her being infected with a virus that has no cure, lie elsewhere. Through a story she tells in her own words and the positioning of Maidei within her own society, answers to this critical question will be sought.

The study examines how the respondent's gender and sexuality are perceived in her society and workplace to create vulnerability to HIV infection. It examines the challenges this presents to intervention programmes. In the context of Zimbabwe, assumptions about HIV/AIDS fail dismally to deal with the complexity of the disease. Educational and financial independence, while necessary as poverty reduction and knowledge enhancement mechanisms, are insufficient means to ensure change in sexual behaviour that can provide a level playing field in power relations during sex. Numerous evaluations have shown that while education campaigns often reach their target and improve people's knowledge and awareness levels, they rarely have a significant impact on behaviour. Issues of beliefs, values and attitudes also come into the equation (Coulson, Goldstein and Ntuli, 1998). HIV/AIDS awareness levels in Zimbabwe, at 98 percent, are approaching near universal levels and yet levels of condom use with casual sexual partners are way below 50 percent (NAC, 2004). As Farmer argues;

The dynamics of HIV infection among women reveal much about the complex relationship between power/powerlessness and sexuality. All sexually active women share, to some extent, biological risk, but it is clear that the AIDS pandemic among women is strikingly patterned along social not biological lines (Farmer, 1996: 24).

The question that needs to be answered is what role gender inequality, embedded within broader social inequality, plays in promoting HIV infection.

According to Treichler (1999), throughout the 1980s, deeply entrenched cultural stereotypes about sex, class, gender and sexuality confused perceptions about who could get HIV and how it could be contracted. As observed by a range of prominent analysts, HIV is more than a biomedical condition. It is also a phenomenon that is complexly embedded within the social paradigm.¹ As Treichler (1999: 6) aptly puts it, “while scientists, physicians, and public health authorities argued repeatedly that AIDS was nothing more than an epidemic of infectious diseases, it is in fact a cultural, political and economic phenomenon”. One case that best exemplifies how HIV/AIDS can easily enter into the political fray is the debate, extremely acrimonious in nature, generated by South Africa’s President, Thabo Mbeki when he questioned the link between HIV and AIDS (Van der Vleit, 2004). Analysts also argue that the Ugandan, Thai and Brazilian success stories are a result of HIV/AIDS being relentlessly put on the political and social agenda (Ortell:2004, Parker: 2001, Teixeira: 2004).

In Zimbabwe, the way safe sex sexual behaviour is promoted as a means of protection is problematic because being married is considered being safe. I will argue that the whole issue of lobola and the romanticisation of marriage endanger the less powerful of the partners in a marriage. As Treichler (1999) argues, the profound and ubiquitous social qualities of HIV/AIDS are ignored in policy development while meanings constructed around the disease tend to impact upon the responses to the epidemic. Therefore, the issue of social meanings of HIV/AIDS, which has its roots in cultural studies, is also crucial to the discussion. Meanings associated with a disease tend to play a key role in how it is understood and therefore responded to. It is the careful examination

¹ Treichler: 1999, Brandt: 1987, Plummer: 1994, Hall: 1992, Lindenbaum: 1992; Craddock: 2004, Kauffman and Lindauer: 2004, Parker and Gagno: 1995, Farmer, Connors and Simmons: 1996.

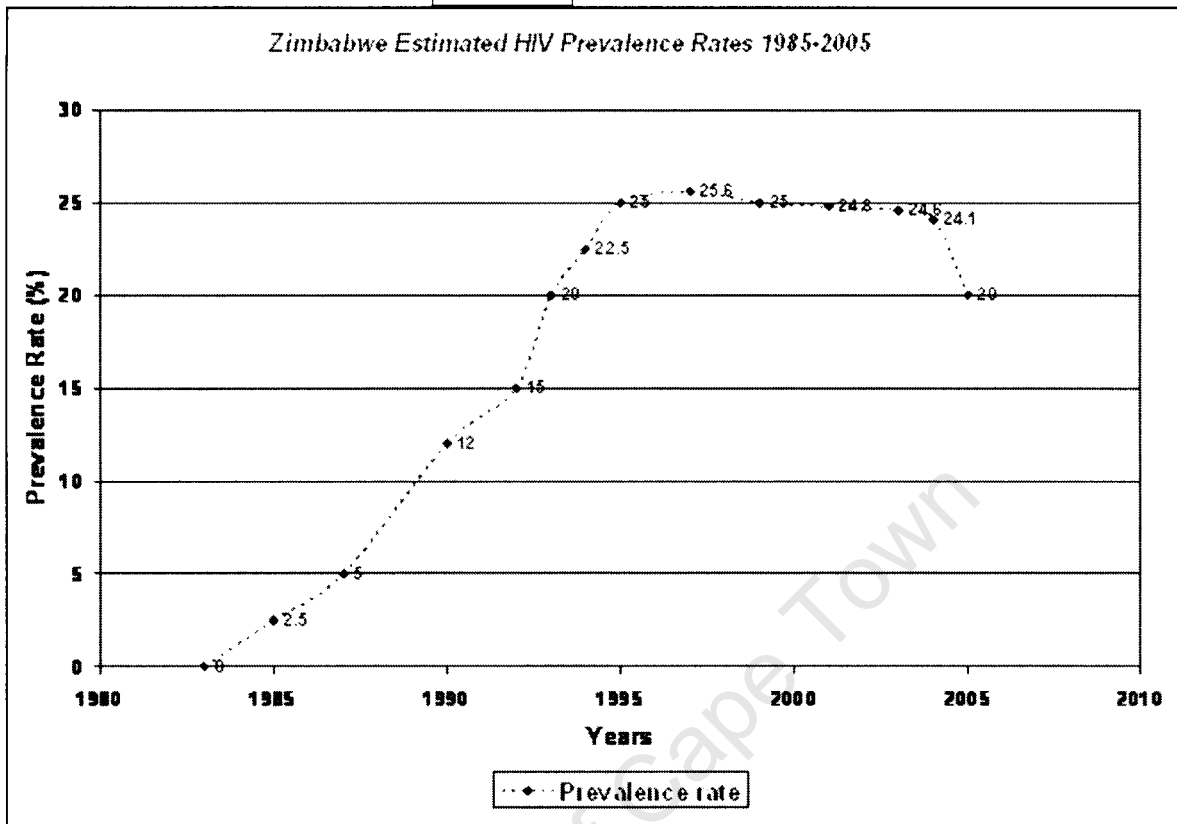
of language and culture that enables us, as members of social constellations, to think carefully about ideas in the middle of a crisis.

1.1. The Story of HIV/AIDS in Zimbabwe

The HIV/AIDS Epidemic is at its worst in the Southern African Region of which Zimbabwe is a part. An estimated 1.8 million of Zimbabwe's 11.6 million people were HIV positive in 2003. The Poverty Reduction Forum (PRF: 2003) and the Zimbabwe Institute of Development Studies (ZIDS: 2003) posit that the devastating impact of the epidemic is benchmarked against the historical context of widespread socio-economic vulnerability of the people over many decades. Socio-economic vulnerability itself is defined as a process in which people are exposed to economic and social re-engineering which leaves them with few or no options of pursuing sustainable socioeconomic survival strategies. The argument is that, vulnerable people are more prone to engage in risky behaviour, sexually or otherwise, whether or not they are knowledgeable about the dangers associated with taking such risks. Thus, when the first case of HIV was diagnosed in 1985 it found in place fertile socioeconomic ground in the form of this widespread socioeconomic vulnerability, which presented an ideal environment for its rapid spread (ZHDR: 2003).

The first case of HIV in Zimbabwe was diagnosed in a Zimbabwean male in 1985. Five years later in 1990 the prevalence rate had reached a worrying 12 percent. In 2000 the first fully implemented antenatal clinic (ANC) survey established that 35 percent of women attending ANCs were HIV positive. By December 2001 UNAIDS estimated that 2.3 million Zimbabweans were living with HIV/AIDS (Khumalo-Sakutukwa: 2001, and UNAIDS: 2001). Figure 1 graphically illustrates the progression of HIV in Zimbabwe from an estimated prevalence rate of 2.5 percent in 1985 to a peak of 25.6 per cent between 1997 and 1998.

Figure 1



Data sourced from the National AIDS Council, 2004.

Current estimates indicate that the prevalence rate has fallen to 20 percent from its peak of over 25 percent and the downward trend could have started between 1999 and 2000. The decline is being attributed to changes in sexual behaviour in some sections of the Zimbabwean population, increased use of condoms with casual sexual partners and an increase in the age of sexual debut. (UNAIDS and MHCW: 2005, Gregson: 2005). Although this is obviously a positive development, experts believe infection rates could start to rise again if the very underlying vulnerabilities which contribute towards unsafe sexual conduct that fuels the epidemic are not fully addressed. Of particular concern is the continued economic decline and the recent urban “clean up” operation undertaken between June and August 2005 which, according to the United Nations special envoy, left an estimated 700 000 people homeless and indirectly affected 2.4 million others (UNAIDS :2005, UNDP: 2005). The destruction of the informal economic sector on which the now homeless

population depended for sustenance has exacerbated poverty, which in turn increases vulnerability to HIV infection and hastens disease progression in those already infected. Apart from the exacerbation of poverty, a significant number of AIDS patients had their treatment plans disrupted and this could lead to the development of an ARV resistant HIV strain (Kajumulo-Tibaijuka, 2005). Beresford (2005) suggests that, given the unprecedented levels of economic decline in the past four years and the severe food shortages, increased numbers of deaths could be behind the apparent decline in prevalence rate. The other possible explanation is that the epidemic could be levelling off.

Furthermore, the downward trend was a result of two data points – 1999-2000 and 2002-2004. Gregson (2005) argues that two data points are insufficient to establish a trend. Besides, analysts believe the impact on HIV/AIDS trends of the displacement of 300 000 farm workers and an estimated 1.2 million of their dependents during the fast track land redistribution programme launched in 2000 is yet to be felt. This is because, apart from increased poverty brought about by unemployment, commercial farming areas had a history of higher HIV prevalence rates than rural and urban areas (NAC : 2004, Garbus and Khumalo-Sakutukwa, 2003).

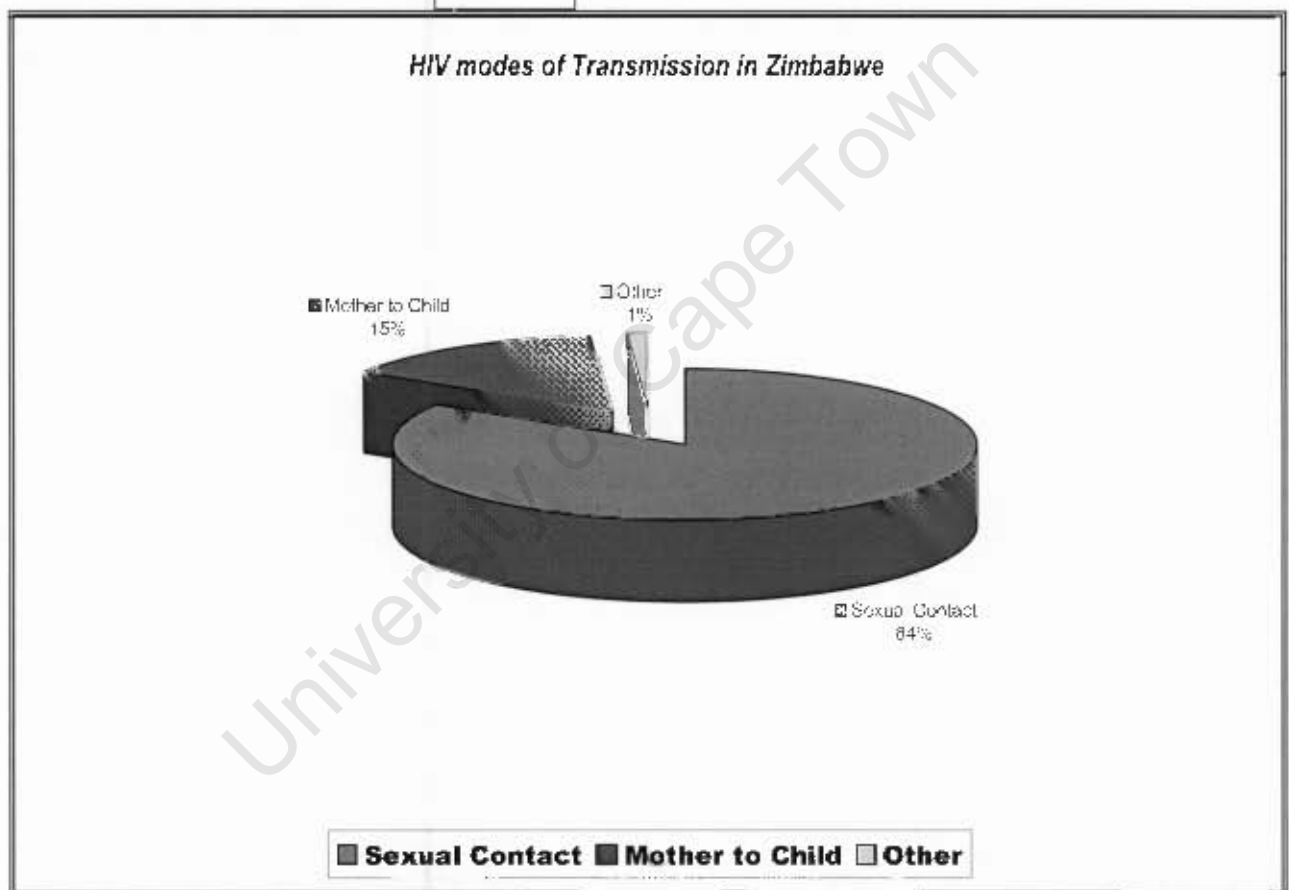
1.2. Modes of Transmission

HIV transmission in Zimbabwe is estimated to be 84 percent heterosexual (figure 2). A significant 15 percent occurs through mother to child, an indication that even though naverapine is widely used in pregnant women, many babies are infected through breast feeding.²

² I am aware of the fact that some analysts discourage the use of the term “mother to child” transmission in preference to vertical transmission. The argument is that vertical transmission is gender neutral while mother to child exclusively lays blame on the mother. I believe mother to child transmission is a more accurate description of how HIV infection occurs in babies. It has nothing to do with apportioning blame and is more to do with the biological relationship between mothers and their babies.

Garbus and Khumalo-Sakutukwa believe the miniscule 1 percent attributed to homosexual transmission could be a gross underestimation because of the government's homophobia which drives gay people underground, thereby making it difficult for research to be conducted openly. It is also rare for transmission to occur through blood transfusion because Zimbabwe implemented a hundred percent screening of all donated blood soon after the first case came to light (NAC: 2004).

Figure 2

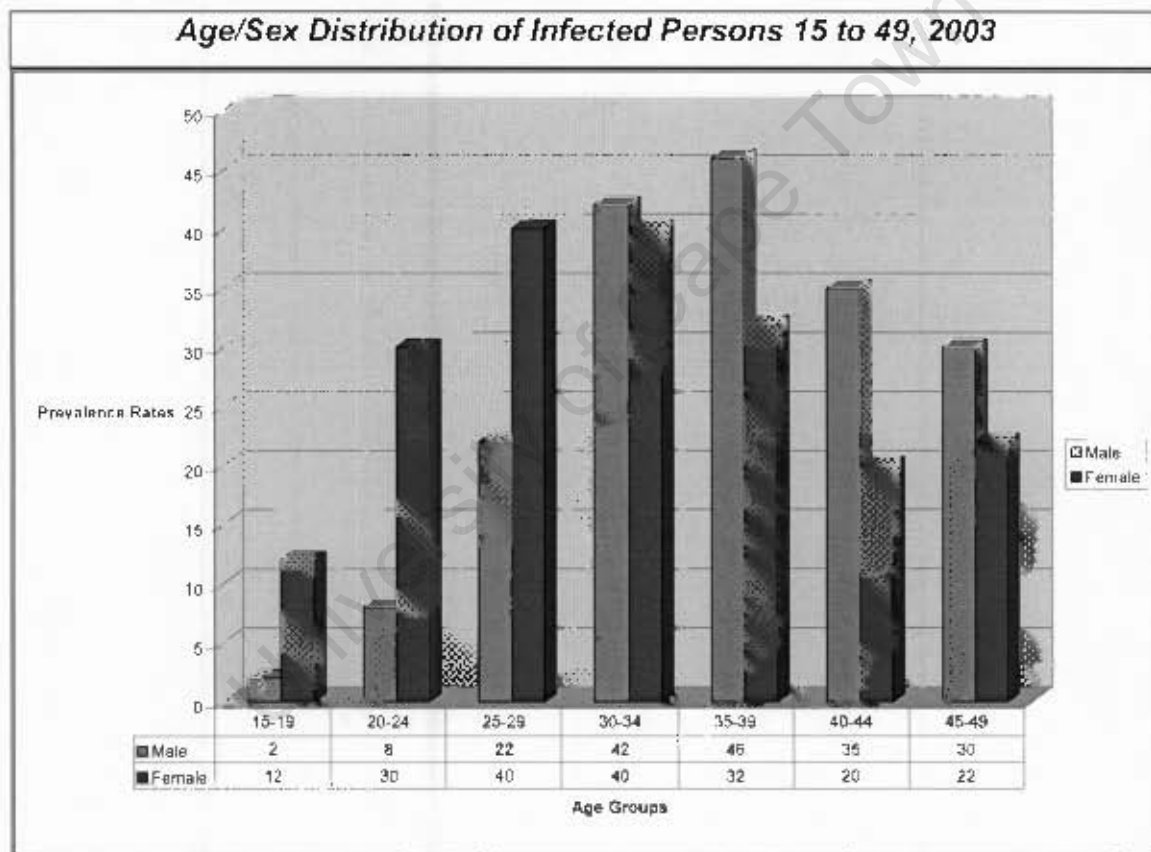


Source: National AIDS Council, 2004

The National AIDS Council estimates that taking the Zimbabwean population as a whole, on average, women are approximately 1.35 times more likely to be infected than men. Prevalence among women is higher in the younger age groups than it is among men and it also peaks much earlier. As illustrated in figure 3, in 2003 the prevalence rate for females in the age group 15-19 years

was 6 times higher than that of males. While female prevalence was highest between ages 25-34, male prevalence peaked within the 30-39 age group. The proportion of HIV-infected men is higher than that of women in the older age groups, a factor which partly explains why younger women who enter into sexual relations with older men are at higher risk of infection than their male counterparts or fellow women who have relationships with men of the same age or younger.

Figure 3



Source: National AIDS Council, 2004.

1.3. Condom Use

If condoms are used consistently and correctly, they constitute one of the most effective ways of preventing the transmission of both HIV and other sexually transmitted infections. Knowledge about condoms as a means of preventing

infection is reportedly high (over 95 percent) yet usage at last high risk sexual encounter is estimated at 42 and 69 percent for men and women respectively. The percentages are almost negligible with cohabiting partners – 4.3 and 6.5 percent (Zimbabwe Demographic and Health Survey [ZDHS]: 1999). A 2001 survey targeting the 15-29 age group found a 15 and 47 percent usage rate for women and men respectively at last sexual encounter. Seventy five percent of sexually active women in the same survey reported having a regular partner and only 11 percent reported regular condom use with this partner. Unprotected sex with non-cohabiting partners is often associated with increased risk of HIV transmission (NAC, 2004).

The low rate of condom use is attributable, among other things, to various myths and taboos surrounding their use. They are often associated with prostitutes hence the reluctance of those who consider themselves “virtuous” women to use them. Some men cynically refer to condom use as an attempt to “eat sweets in their wrappers” because they believe it makes sex less pleasurable. Other men report that they experience itchiness. In some studies women said even if they might wish to use condoms it often depends on the willingness of their partners to cooperate while others reported that requests to use condoms often result in violence. Still others argue that unprotected sex is a sign of love, commitment and trust in one’s partner. At one time rumours circulated to the effect that condoms manufactured in the West were laced with poison (Garbus and Khumalo-Sakutukwa: 2003, ZWRCN: 2005, ZHDR: 2003). Research in South Africa and Kenya also highlighted similar myths and taboos associated with condom use (Bermudes Ribiero Da Cruz: 2004, Walker, Reid and Cornell: 2004, Mbugia: 2004).

The Young Adult Survey (YAS :2003) confirmed that the youth felt that older people tended to be judgmental towards young people who tried to secure condoms because of the lack of privacy in the places from which they are obtainable. Adolescents underscore the fact that their schools, even though they now embark on life skills education which includes use of condoms for protection, do not make them available within school premises. When they try

to secure them from places such as clinics where they are distributed free of charge, some health practitioners lecture them and even refuse to let them have them saying they are too young to be engaging in sex. Neighbourhood clinics are often problematic because they tend to be staffed by health practitioners known to some youths (YAS: 2003).

1.4. The Female Condom

The female condom was introduced in 1997. At a subsidised price of 24 US cents for two it was beyond the means of most people in a country where over sixty percent of the population lives on less than US\$2 per day. There have also been reports of commercial workers re-using them, contrary to the recommended practice of disposal after being used once. This is done in order to save money, rendering the whole exercise of prevention useless to men who will be unaware of the situation. The NAC reports that though the female condom is considered effective both in terms of protection against STIs and HIV, 30 percent of the men surveyed and 57 percent of the women disliked it. They raised issues of discomfort during sex, the sounds that it makes and excess lubrication. The female condom has therefore not gained much prominence (NAC, 2004).

The findings around the use of condoms are particularly important because they have been placed at the cornerstone of efforts to prevent HIV infection. As has been pointed out, UNAIDS attributes the decline in prevalence rate that has been witnessed in Zimbabwe partly due to condom use.

1.5. The Affected Groups

While the average 2003 HIV prevalence rate was estimated to be 24.6, there were both regional and population group variations as indicated in table 1. The worst affected areas were large scale commercial farms and mines.

Table 1: HIV Prevalence Rates of Selected Population Groups

<i>Year of Survey</i>	<i>Population Group and Place</i>	<i>HIV prevalence Rate (percentage)</i>
<i>1995 USAID</i>	Female sex workers in major urban centres	86.00
<i>1995 USAID</i>	Male STI patients	71.90
<i>1999 (Family Health International)</i>	Beit Bridge Antenatal Clinic Attendees ³	41.40
<i>2001 (Tiripamwechete Study Group)</i>	Sex Workers in Mining Settlements	55.70
<i>2002 (SAFAIDS)*</i>	Military	50.00
<i>2002 (World Bank)</i>	Male Teachers	19.00
<i>2002 (World Bank)</i>	Female Teachers	29.00
<i>2003 (WHO)</i>	Mines and Commercial Farms	34.90
<i>2003 (WHO)</i>	General Urban Population	28.10
<i>2003 (WHO)</i>	Rural Areas	20.90

Adapted from National Aids Council (NAC) May 2004 Report and WHO (2003).

* Southern Africa HIV/AIDS Information Dissemination Service (Sourced from UNAIDS: 2004 and ZHDR, 2003)

Zimbabwean men and women are disproportionately affected by HIV/AIDS. According to the World Health Organisation (WHO: 2003), the estimated number of women living with HIV/AIDS has been higher than that for men since 1989. Since then, the number of new infections has been higher among women and girls who are now estimated to constitute 60 percent of the country's HIV positive population. Young women and girls make up 80 percent of HIV positive people in the 15-24 age group.

³ Beit Bridge is a border town which has been singled out because research has identified it as a hive of sexual activity due to high volumes of cross border trading. Female cross border traders (as many as 500 per day) reportedly use sex to purchase duty exemptions from customs officials and transport from truckers whose numbers can average 20000 a month. Women also reported that though condoms are easily obtainable, some men refuse to use them and become violent if women insist. These findings epitomise the intersection of mobility, poverty, gender, sex work and violence (Family Health International, 2000). The narrator of the story in this thesis believes her younger sister was infected here; "Now that I think about it, she used to tell adventurous stories that included crossing the border without a visa or meeting some kind men who would offer her and a friend free rides into South Africa."

The MOHCW (1998) and ZHDR (2003) state that the impact of HIV/AIDS in Zimbabwe includes the following;

- An estimated 1.5 million AIDS deaths between 1985 and 2003.
- A declining life expectancy (now estimated to be a mere 33 years).
- Rising Mortality.
- Increase in the care burden on women and children.
- A rise in the number of orphans. Current estimates put the figure at 980 000.
- Loss of productive labour force.
- Pressure on health services with 75 percent of hospital admissions being HIV related.

1.6. Background

The relationship between HIV prevalence rates and socioeconomic indicators is a highly complex one. Nevertheless, vulnerability to HIV infection is recognised as being linked to both behavioural and socioeconomic variables (Garbus and Khumalo-Sakutukwa: 2003). Though the decade starting 1990 was not characterised by high levels of economic growth, it was not until 2000 that Zimbabwe started experiencing an unprecedented deterioration of the economic and political situation which includes massive food shortages.

Formerly known as Rhodesia, Zimbabwe was under British rule for 90 years starting in 1890. Colonial rule, deeply resented by the indigenous population, was characterised by land and cattle seizures, use of taxation to force Africans into lowly paid wage labour, discriminatory pricing of peasant agricultural products and elaborate administrative and legislative machinery which ruthlessly suppressed opposition and deeply entrenched colonial rule. The massive labour needs of white commercial farms and mines were met through coercive and exploitative means. Upon retirement the workers were dumped onto the rural family without retirement benefits. Over time these policies led to the impoverishment of the communal areas from which labour was drawn (Rubert and Kent: 2001, Croke: 2003, Bernstein: 1997, Wolpe: 1972, First:

1983, Davison: 1997, Ranger: 1967, Ranger: 1970). Independence was attained in 1980 after an armed liberation struggle.

The nationalist government headed by the then Prime Minister and now President, Robert Mugabe introduced a set of progressive policies (including free primary education and health care for the lowly paid and the unemployed) which resulted in increased spending on health and education. The government also granted financial and material support to African farmers and raised minimum wages of underpaid African workers. As a result of a combination of increased productivity in agriculture and industry following the lifting of sanctions and the end of the liberation war, the economy literally soared. There were massive opportunities for employment of skilled workers and black Zimbabweans joined the ranks of the middle class in large numbers (Rubert and Rasmussen: 2001). Zimbabwe's socioeconomic indicators improved to an extent that earned it international accolades and was even referred to as the "bread basket Africa" (Geer: 2003). However, the euphoria did not last. Increased spending on the war in Mozambique where Zimbabwean forces were fighting on the side of the government of the late President Samora Machel, and open hostility by apartheid South Africa, had a negative impact on the economy. At the same time the rivalry between the liberation war parties, the ruling ZANU (P.F) and P.F. ZAPU degenerated into open conflict in the provinces of Matabeleland and Midlands where an estimated 20 000 people were reportedly killed by government forces between 1982 and 1987 (Catholic Commission for Justice and Peace, 1997).

The economic slump that had started in the late 1980s intensified in the early 1990s, resulting in the adoption of a World Bank (WB) and International Monetary Fund (IMF) sponsored Economic Structural Adjustment Programme (ESAP). Some of the IMF and WB suggested remedies under ESAP included the withdrawal of state subsidies on basic foods and social services. This marked the beginning of deterioration in the circumstances of the poor who could no longer afford the market related prices of basic commodities. When ESAP did not bring tangible benefits, both the IMF and the WB blamed the

government for its failure, citing a range of costly populist decisions such as the 1997 pay out of an unbudgeted Z\$4.5 billion dollars to veterans of the war of liberation and the sending of Zimbabwean troops to the Congo at a cost of US\$1 million per day. The refusal by the Zimbabwean government to fully comply with the prescribed recommendations resulted in the withdrawal of financial support by the IMF and WB. This action by the two institutions in turn triggered a domino effect as other international investors reduced their participation in Zimbabwe. The ensuing decline in both domestic and foreign confidence in the economy at the end of the decade resulted in increased unemployment (Rubert and Rasmussen, 2001).

The liberation war had been fought on a platform of social justice which included equitable distribution of land. However, after the new government came into power, nothing was done to restructure the economy in a manner that would have benefited the majority. Apart from initial efforts made to provide social services, the state machinery increasingly came under the control of the ruling party elite who have benefited enormously from the current economic order while the rest have sunk into abject poverty (Raftopolous: 1997, Sithole: 1994, Makumbe: 2003). In a desperate move to cling to power, in February 2000 the government embarked on an unplanned land redistribution programme whose consequences have been dire. Food production has plummeted by 60 percent since then. With it came increased political repression which included the creation of a youth militia accused of heinous human rights violations among them the murder and rape of opposition supporters (The Solidarity Peace Trust, 2003).

1.6. Contemporary Zimbabwe: HIV/AIDS and the Economy

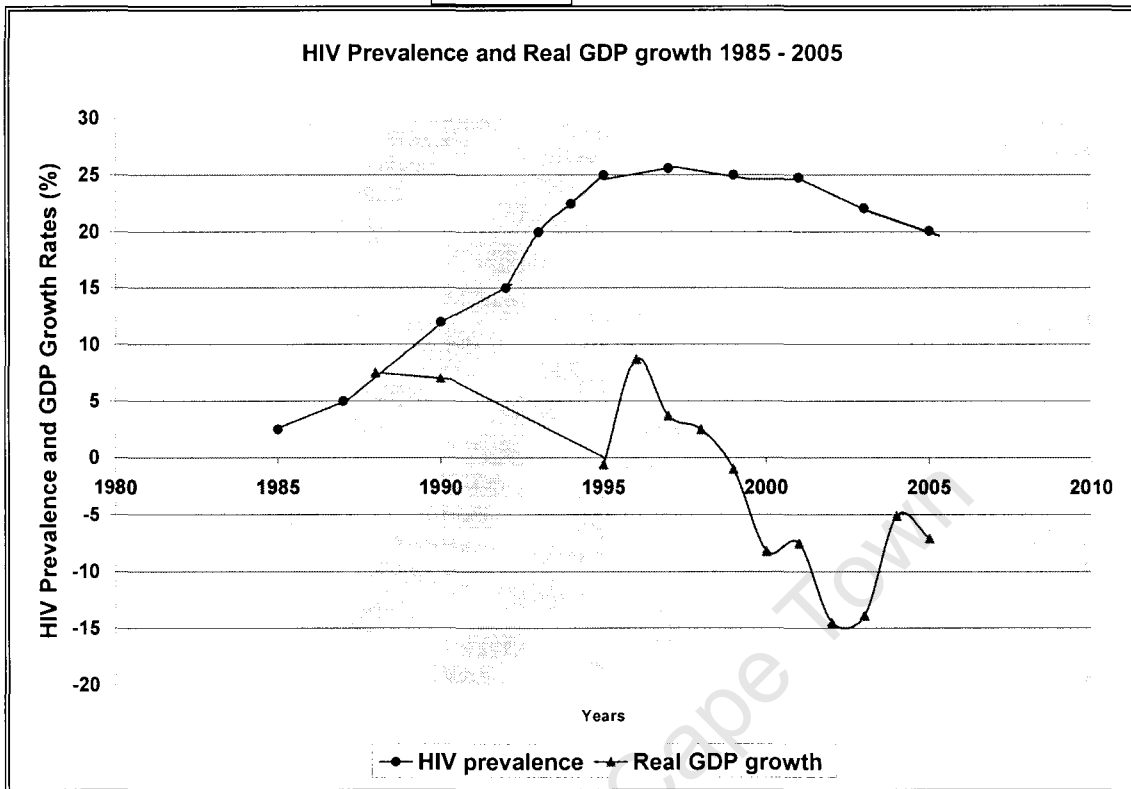
The HIV/AIDS epidemic is happening in a socioeconomic environment characterised by declining economic performance, political polarisation, dwindling donor support for both humanitarian and developmental projects and a marked deterioration in the capacity of the social service sectors to serve those in need. Zimbabwe has the fastest shrinking economy in the world, and no other country has experienced such a decline in peace time. Unemployment

is estimated to be between 75 and 80 percent. Food shortages are intense and worsening with an estimated 5 million people needing food aid. There is a chronic shortage of foreign currency, fuel and many other imports that are necessary to keep manufacturing, mining, commerce and agriculture running. The withdrawal of official development assistance and the drying up of foreign direct investment has accelerated the shrinking of the economy. A severe shortage of electricity has resulted in a haphazard rationing which affects the viability of the productive and service sectors. (UNICEF: 2005, World Bank: 2005, Geer, 2003; Robertson 2003).

While analysts have consistently highlighted economic mismanagement as a characteristic of the Mugabe regime, they attribute the current economic crisis to the largely chaotic land reform programme embarked upon since February 2000. Apart from destroying 4500 viable businesses, 300 000 jobs were lost, a total of 2.1 million dependents were left with no means of financial support. Export earnings plummeted at an unprecedented level and the need to pay for food imports exacerbated the situation by draining depleted foreign exchange earnings. Furthermore, the largely populist economic policies have resulted in the continued withdrawal of credit lines by international financial institutions (Robertson: 2003, Makumbe: 2003, World Bank: 2005).

Figure 4 shows that the economy has shrunk by 40 percent since 2001, while the HIV prevalence rate remains high. Government's ability to contain the epidemic and mitigate its effects is severely constrained when its coffers are dry.

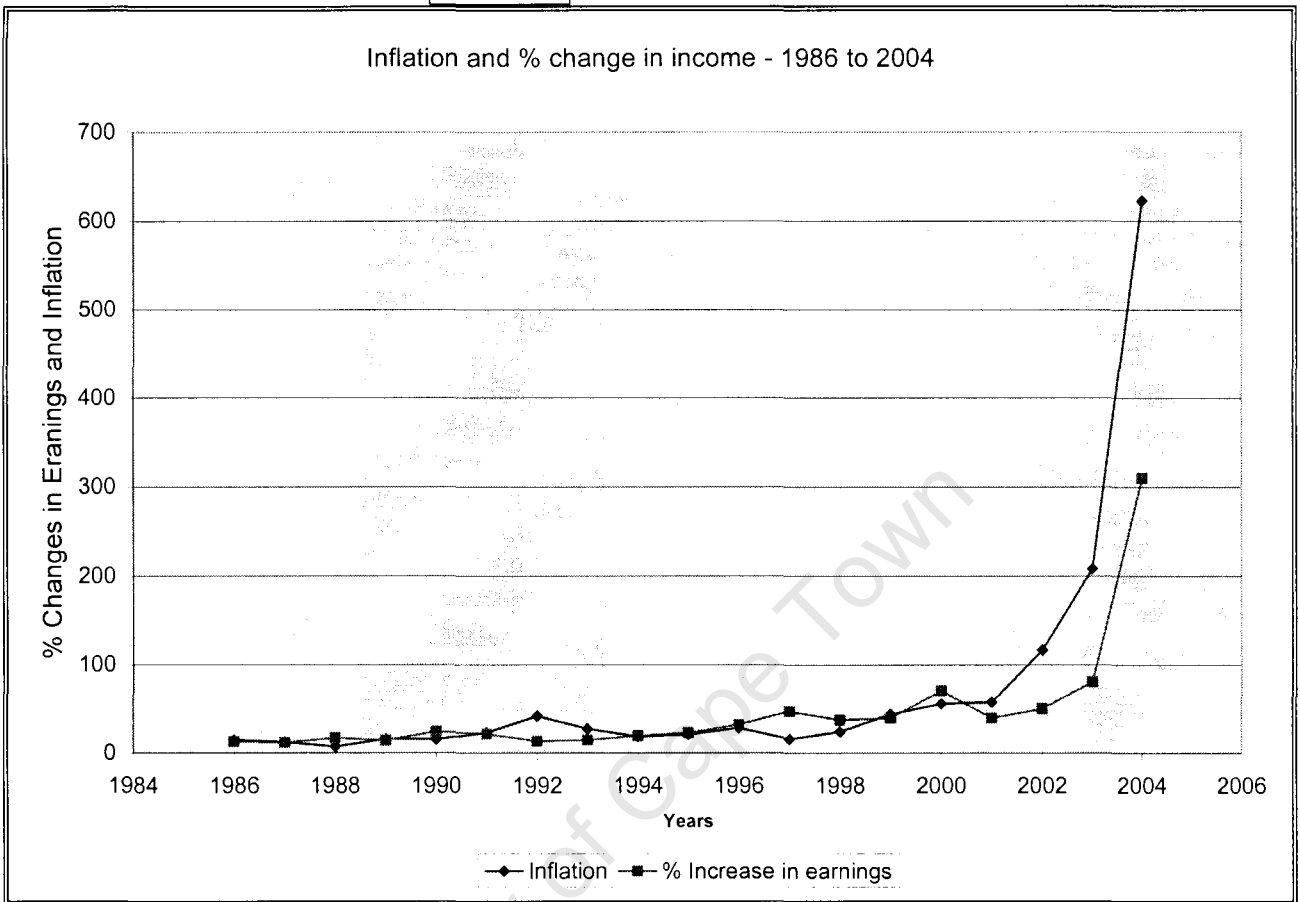
Figure 4



Data Sourced from NAC and Robertson Economic Services (2004). Data for 2005 are estimates.

Robertson Economic Services (2004) attributes the temporary upward swing witnessed between 1996 and 1997 to the increase in the export-oriented horticultural farming activities.

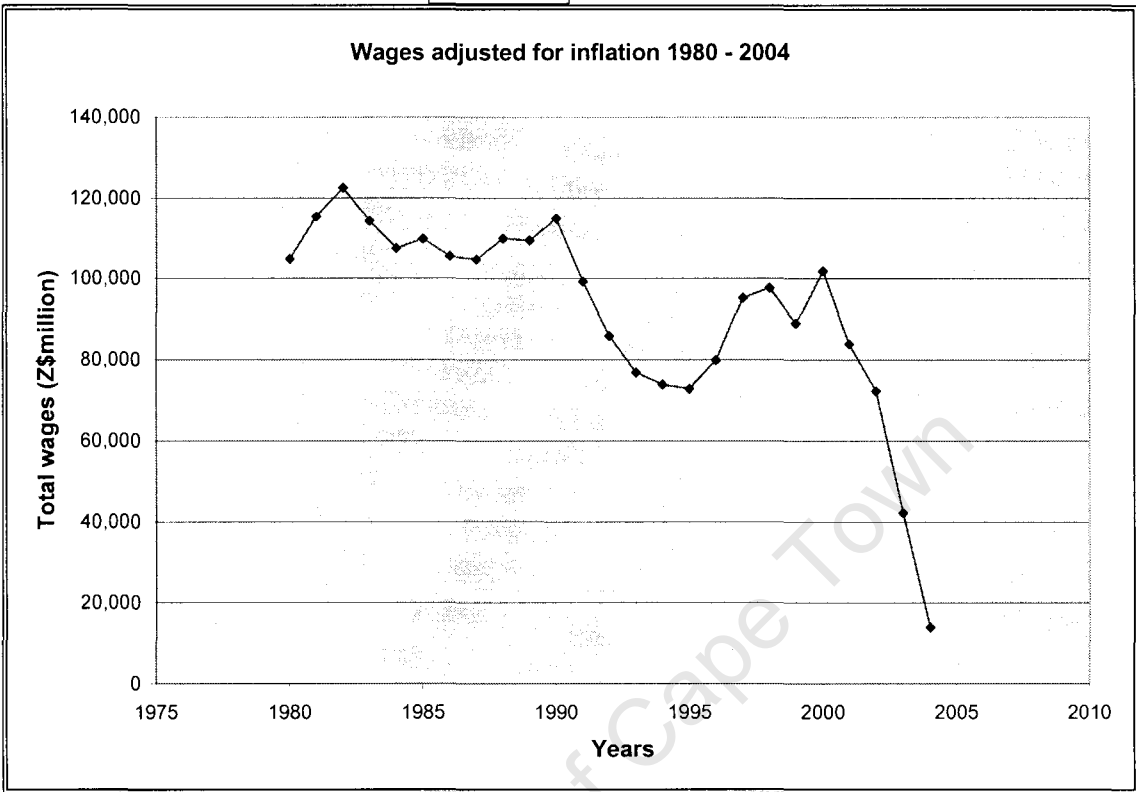
Figure 5



Data sourced from CSO and Robertson's Economic Services

Figure 5 highlights the fact that increase in income is lagging behind inflation while figure 6 illustrates that wages adjusted for inflation continue to decline, thereby pushing the population deeper into poverty.

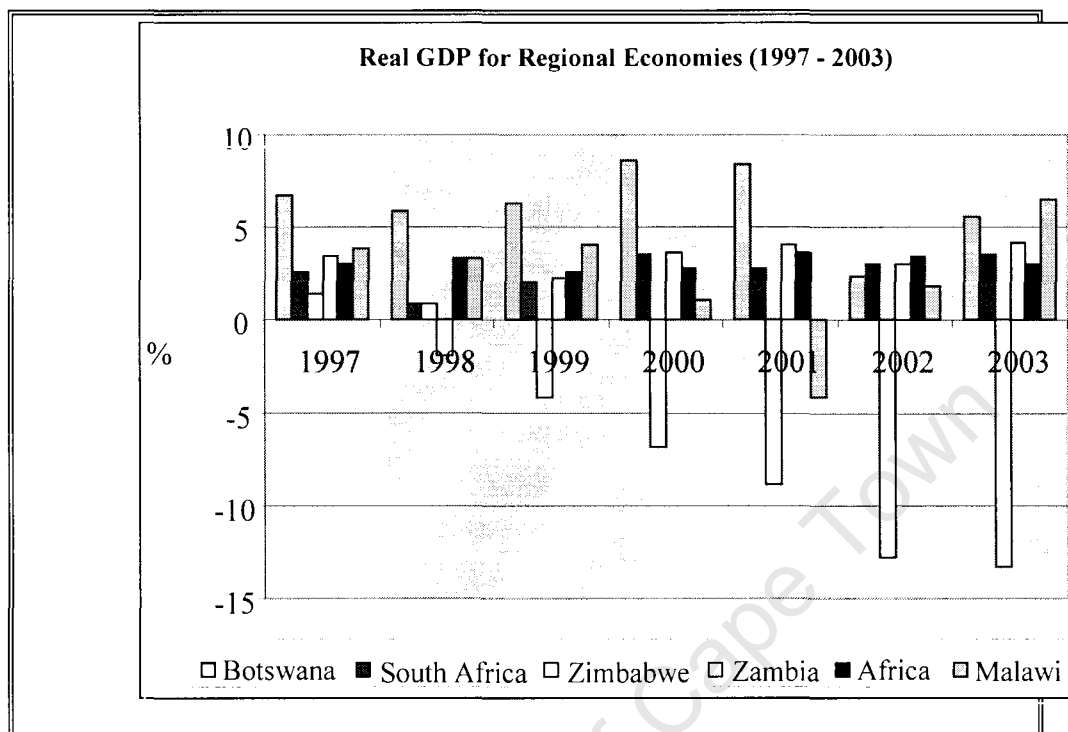
Figure 6



Data Sourced from Central Statistical Office, 2005.

Figure 7 shows how Zimbabwe's economy has performed in comparison to selected regional counterparts and the African continent as a whole.

Figure 7



Data Sourced from the Confederation of Zimbabwe Industries, 2003.

1.8. The Socioeconomic Consequences of Zimbabwe's Economic Mal-performance

1.8.1. Poverty

Poverty in Zimbabwe started increasing sharply in the first half of the 1990s. This calls into serious question the efficacy of the Economic Structural Adjustment Programme which the country embarked upon in 1991. In 1995 the Zimbabwean economy ceased to create jobs in sufficient numbers and types to absorb the large numbers of school leavers being churned out by the largely expanded education system. In 1997 in excess of 60 percent of Zimbabwean households were living below the national food poverty line. This proportion was estimated to have risen to 69 percent by 2002. A year earlier the Gini coefficient had

peaked at 0.56 indicating one of the most unequal distributions of well being in the world (Alwang et al, 2002).

In terms of the Total Consumption Poverty Line (TCPL), the 1995 Poverty Assessment Study estimated that 74 percent of Zimbabweans lived below that line. In 2002 it was estimated that the percentage had risen to 80 percent (ZHDR: 2003) At the same time, a 1997 Poverty Assessment Study found that nationally, 74 percent of female headed households were classified as poor, compared to 57 percent of those headed by men. (Tichagwa: 1998).

Conditions of poverty result in poor nutrition and exposure to disease. Once the immune system is compromised by poor nutrition, the body's ability to fend off HIV is severely reduced. Apart from increasing vulnerability to infection, poverty also has a bearing on the progression of the disease leading to earlier onset of AIDS. Being poor also limits people's access to ARVs and treatment for opportunistic infections, and without treatment they may quickly succumb to the disease (Usdin: 2003, Fawz: 2003, Friis and Michaelsen: 1998 Piwoz and Preble: 2000, Van Lettow, Fawz and Semba: 2003).

HIV/AIDS also exacerbates poverty. The epidemic hits at the most economically active age groups and families experience reduction in their standard of living due to loss of income when breadwinners get sick. A study by FAO (2001) established that caring for an HIV positive family member and his/her funeral expenses often exceed the annual income of a farm labourer. Many such families end up selling their few assets to meet the costs, driving the family even deeper into poverty.

The consequences of Zimbabwe's economic meltdown on its people are best illustrated through an example. At the time of writing a Zimbabwean primary school teacher takes home a monthly income of 3 million

dollars. With the black market exchange rate pegged at 100 000 Zimbabwean dollars to the United States dollar this translates to a mere \$US30. Prices of commodities in Zimbabwe tend to increase in line with black market exchange rates because that is where businesses source their foreign currency requirements. Zimbabwe's Consumer watchdog, the Consumer Council of Zimbabwe put the September 2005 poverty datum line at Z\$9.6 million (\$US96) for an urban family of six. A Zimbabwean primary school teacher with a family therefore earns less than a third of what is required to meet a family's very basic needs. At a combined income of Z\$6 million, two Zimbabwean teaching spouses still earn below the poverty datum line. At the same time, the September 2005 monthly pay for the lowest paid factory worker is Z\$1.5 million, also way below the poverty datum line (Zimonline: 3 October 2005).

1.8.2 Mortality Rates

According to Clemens and Moss of CGD, in 1990, largely before the HIV/AIDS epidemic started producing disastrous increases in mortality throughout Southern Africa, Zimbabwe's infant mortality rate was 53 per 1000 live births. By 2001, by which year Zimbabwe's HIV prevalence rate had reached 25 percent, the infant mortality rate had risen to 73 per 1000 live births. Clemens and Moss argue that the rise in infant mortality rate between 1990 and 2001 is attributable to the HIV epidemic. It is their view that the effects of the economic melt down which worsened after the year 2000 land invasions are yet to manifest themselves. This is because the effects of a deteriorating economy on such socioeconomic indicators as infant mortality rates tend to manifest themselves several years after the start of the deterioration.

1.8.3 Malnutrition

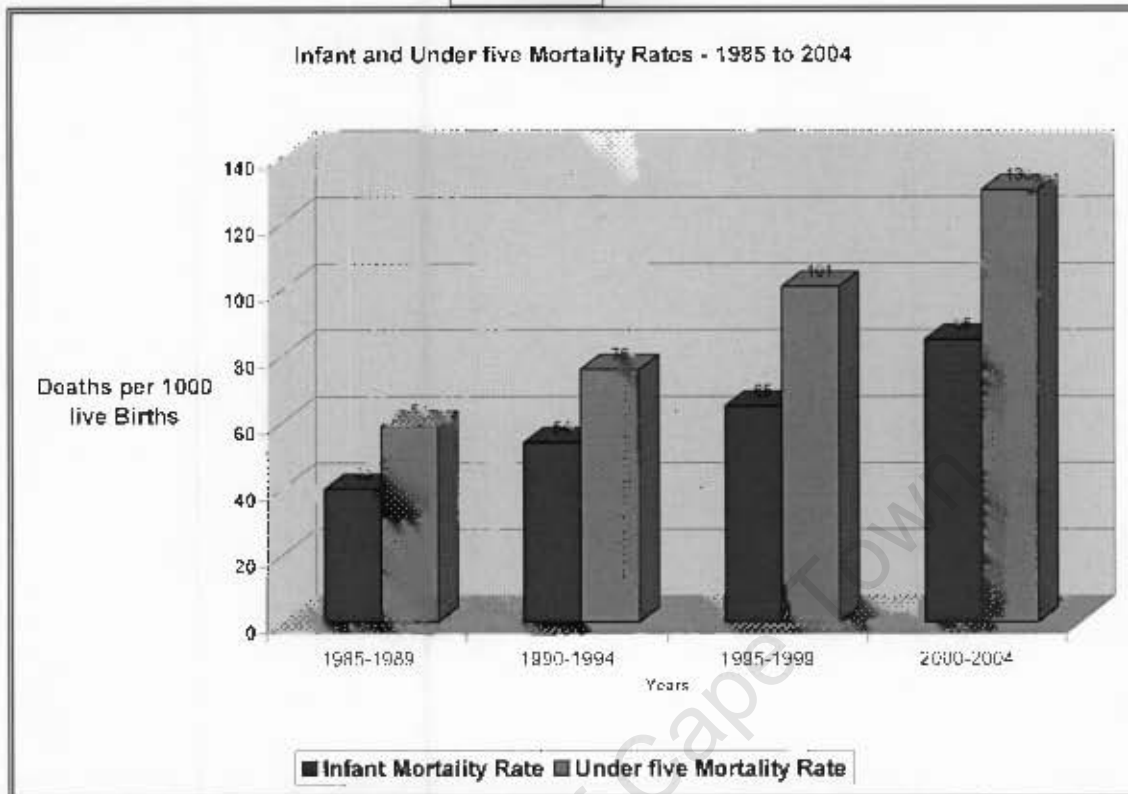
One major problem that arises in situations of poverty is child malnutrition. The June 2002 National Nutrition Assessment Study established that 11 and 26.5 percent of children in urban and rural areas

respectively were malnourished. UNICEF and the Food and Nutrition Council estimates now put the mid 2005 malnutrition figures at 32 and 53 percent respectively. As has been pointed out earlier, a malnourished population is more susceptible to infection because the immune system will already have been compromised.

1.8.4 Access to Health Care

According to the 2001 Central Statistical Office Income, Consumption and Expenditure Survey, eight of Zimbabwe's ten provinces experienced a decline in access to health care between 1995 and 2001. Three of the worst affected provinces experienced a massive 60 percent decline. On average, the country experienced a 43 percent decline in access to health care. This is a worrying development in the context of a high HIV prevalence rate because HIV positive people often suffer from a plethora of opportunistic infections which if left untreated result in death. Linked to poor access to health facilities are issues of infant, child and maternal mortality rates. High infant and child mortality rates are often linked lack of immunisation against diseases while absence of obstetrics results in increases in maternal mortality rates. Figure 8 illustrates the extent of the decline especially considering that the early eighties had witnessed an improvement from the 1970s rates of 86 (infant) and 138 (child) respectively per 1000 live births. The health care delivery system has virtually collapsed due to under-funding and attrition of qualified staff. As of February 2005, the vacancy rates for Doctors, Nurses and Pharmacists were 44, 39 and 59 percent respectively. The annual staff mortality rate is estimated to be a staggering 2.5 percent (WHO, 2005). For more detail on the deterioration of Zimbabwe's health delivery system (see appendix 1).

Figure 8



Data Sourced from UNDP Human Development Report, 2005

1.8.5. Maternal Mortality

Maternal mortality was estimated to be 283/100 000 for the period 1984 to 1994. It rose sharply to 695/100 000 between 1995 and 1999 – a massive 140 percent increase. It rose yet again to between 700 and 1100/100 000 between 2000 and 2004. The Zimbabwe Human Development report attributes it to the rapid spread of HIV (ZDHS: 1999, HDR, 2005).

This by no means exhaustive list of indicators of the continuous slide of Zimbabweans towards abject poverty spells very dire consequences for efforts to stem the tide of HIV infection. Head aptly highlights this point when she provides past examples of a link between conditions of poverty and ill health which tends to “undermine resistance to infection of all sorts, including HIV”. For example, there is a definite link between the spread of cholera and contaminated water. The spread of tuberculosis is

linked to a weakened immune system emanating from malnutrition and inadequate shelter (Head, 1992:1). Disease tends to be patterned along class lines. Those occupying the lowest social strata typically bear the highest burden of infectious diseases.⁴ In the developed world, mortality rates from such infectious diseases as cholera, scarlet fever, measles, diphtheria, tuberculosis and whooping cough declined sharply as living conditions improved. Waterborne diseases such as cholera, typhoid and dysentery all but disappeared with the improvement of sanitation facilities. Less overcrowded housing played a crucial role in the reduction of transmission rates of contagious diseases (Sanders: 1995, Health Systems Trust: 2000, Croke, 2003).

Sadly, the breakdown of the water supply infrastructure in Zimbabwean cities where refuse is piling up due to a shortage of fuel, and burst sewage pipes go unrepaired, has resulted in an upsurge of waterborne diseases such as dysentery as urban populations resort to untreated water supply sources. In Harare 200 people suffering from dysentery were hospitalised during the first week of November (Citizen, 22/11/2005). It is within this context of declining living standards, growing malnourishment and economic collapse that the growth of the HIV/AIDS epidemic has to be considered.

1.9. Responses

Government has been accused of being slow to respond to the epidemic. After the first case came to light in 1985 official pronouncements created the impression that worries over the possibility of HIV growing into epidemic proportions were misplaced. It was not until 1990, when the prevalence had reached an estimated 12 percent that government started to spearhead an information campaign. Government has been castigated for lacking the political will to deal with the problem (ZWRCN, 2003). Prior to the year 2000

⁴ Appendix 1 provides a classic example of how the urban clean up exercise exacerbated overcrowding and the spread of dysentery.

the only person among the political leadership who talked openly about HIV/AIDS was the Minister of Health and Child Welfare. President Mugabe treated it like a taboo subject, to the extent that when he eventually started mentioning it on the periphery of his speeches, it would be treated as the news scoop of the week (Garbus and Khumalo-Sakutukwa, 2003)

Nevertheless, the government was not wholly inactive on the HIV/AIDS front. The 1991 launch of HIV sentinel surveillance was followed by the introduction of AIDS education in schools in 1991 and life skills education in 1993. Other measures include the 1995 labour regulations barring testing for HIV for purposes of employment, establishment of voluntary counselling and testing centres⁵ (VCTs), and the 1999 launch of an AIDS levy⁶. The National AIDS Policy came into existence in 1999. In 2002 a state of emergency was declared⁷ with regards to HIV/AIDS and prevention of mother to child transmission (PMTCT)⁸ (NAC: 2004, WHO and UNAIDS). As regards treatment, as of June 2004 only 6000 of the estimated 290 000 people needing treatment were receiving it. Of this number, 760 were being catered for by NGOs while the rest catered for themselves. The government's national treatment target of 55 000 by the end of 2005 is unlikely to be met because of shortage of funds and skills coupled with inadequate infrastructure (WHO, 2004). MOHCW officials, confirmed that in November 2005 only 20 000

⁵ Such centres have tended to rely on NGOs. The first such centre was opened by Zimbabwe Association of Population Services Organisations in 1998. The United States Agency for International Development and Population Services International opened 10 New Start VCT centres in 2001 and the centres claim to test 50 000 people per annum. The biggest shortcoming is that these are concentrated in urban areas.

⁶The move to launch an AIDS levy earned the government of Zimbabwe international accolades as it was viewed as a demonstration of seriousness to tackle the epidemic. The levy, which has continued to this day, consists of a 3percent levy on individual and corporate taxes. Millions have been raised but AIDS NGOs have criticised the lack of transparency surrounding the disbursements of the funds and the failure to reach those in need. There is evidence that AIDS funds are being channelled through the very same ruling party structures that have been accused of politicising food distribution (Garbus and Khumalo-Sakutukwa, 2003).

⁷ This was meant to increase the availability of and access to generic AIDS drugs.

⁸ According to WHO in January 2002 only 4percent of women who needed PMTCT received it. The Health Ministry funds 60percent and coordinates all PMTCT initiatives. Failure to achieve 100percent coverage has been attributed to shortage of trained staff and funds.

people were on the government sponsored ARV treatment programme (Jongwe, 2005).

The problem is that the measures have tended to merely scratch the surface of what would be required to achieve the desired results. The Zimbabwe AIDS Network (ZAN) directory lists in excess of 300 organisations involved in the fight against HIV/AIDS. Much of the burden of prevention, care and support has been carried by internationally funded community-based organisations, churches and academic institutions.⁹ Zimbabwe's strained relations with the international community have negatively affected funding and even though the Global Fund for AIDS, Tuberculosis and Malaria has approved some of the country's projects, it has not been quick to disburse funds. It also has to be pointed out that a very small percentage of HIV/AIDS (organisations?) are based in rural areas where 80 percent of Zimbabwean women live (Garbus and Khumalo-Sakutukwa: 2003, ZAN: 2005).

HIV/AIDS community based care has been lauded as one of the most successful ways of fighting stigma and a cost effective way of caring for PLWHA. It is being scaled up in Zimbabwe as it is constantly being argued that it is a positive thing when infected people continue to enjoy a family environment (ZRCS: 2005, UNAIDS, 2003). ZWRCN (2005) has however criticised home based care programmes for exacerbating women's workload while little is being done to incorporate men. ZRCS notes that only 10 percent of its 1042 home based care facilitators are men.

1.10. Conclusion

In this introductory chapter I have tried to describe the context in which the HIV/AIDS epidemic has grown in Zimbabwe. This is one of sharply declining living standards. I also suggested that HIV/AIDS, largely a sexually transmitted disease, is a complex phenomenon. It is related to levels of poverty

⁹ The decision by government to pass legislation that allows excessive interference in the operations of NGOs has also resulted in some of them winding up their operations. Sections of the population dependent on NGOs for supplementary feeding and medical support have been deprived of this essential means of support.

which increase vulnerability to infection. In conventional literature, it is this economic distress that helps explain the rapid spread of the disease. However, this is only part of the explanation. As Maidei's story will show, she was not greatly affected by Zimbabwe's economic decline at the time that she contracted HIV. She was largely insulated against it because of her professional qualifications and status.

Since Maidei, and Tsitsi and Cynthia before her were not economically vulnerable, sexuality and the complex web of gender relations in which it is situated are critical issues. This is a very intricate issue. Social psychologists are agreed that the phenomenon of sexuality is shaped and constrained by a variety of factors that include one's deepest psychological needs for intimacy and happiness, the complex and unequal relationships between men and women, and between the wealthy and economically disadvantaged (Campbell: 2003, Gupta: 2002). In similar vein, Boler and Aggleton (2004) argue simply that human sexual behaviour is influenced more by underlying social and cultural structures. Hoosen and Collins (2001) argue that since gender is culturally constructed, cultural practices are closely linked to the organisation of gender roles and therefore influence sexual practices. Both men and women are influenced by cultural constructions of sexuality.

In this thesis, through Maidei's story, I shall argue that the key to understanding the spread of HIV/AIDS has to be located in the complex web of gender relations that embrace a range of our most deep seated human emotions, those indeed that define our humanity.

This study is divided into five chapters;

Chapter 2 examines gender relations in Zimbabwe. The inferior status of women within Zimbabwe's legal framework is highlighted. Cultural practices such as lobola are discussed and analysed. It is argued that they have become mechanisms for purchasing women's labour and reproductive services. This, I suggest, worsens power imbalances between men and women, even among economically independent women.

Chapter 3 discusses methodological aspects of the research project. The reader is taken through the journey of the researcher's experiences of looking for a participant, why the researcher was drawn to the life history method and the practical experiences in the field. The merits and shortcomings of the method are also discussed.

Chapter 4 is a summary of Maidei's story as it was narrated to the researcher and verified by the narrator. Covering her childhood, school years, dating, marriage, living with HIV and widowhood, the chapter highlights what in the researcher's view were the highlights of Maidei's life. The focus is on aspects that have relevance in shaping her identity as a woman and her sexuality. The biggest challenge was to reduce a story told in 7 hours to a few thousand words.

Chapter 5 discusses the meaning of Maidei's story. The aim of the chapter is to suggest that the issue of gender inequality was central to Maidei's vulnerability to HIV infection. The story is interrogated and the words that she used are analysed to provide an understanding of how she understands her own identity as a black Zimbabwean woman. From her own words, an attempt is made to position her within her society and establish sources of her own vulnerability to HIV infection.

Chapter 6 consists of the concluding remarks and explores possible areas of research for the purposes of coming up with prevention programmes that can result in halting the spread of HIV while empowering women to participate in decision making within sexual relations.

CHAPTER 2: LITERATURE REVIEW

"Marriage laws abrogate the freedom of woman by enforcing upon her a continuous sexual slavery and compulsory motherhood", Margaret Sanger, 1914 (in Mc Phee and Fitzgerald, 64).

"I am worried about increases in rape cases. Young women need to dress up properly. Our girls are moving around naked and this attracts negative attitudes towards sex", Kenneth Mutiwekuziva, Zimbabwean Minister of Transport during a parliamentary motion to discuss increases in the number of rape cases in the country, July 2005.

This chapter seeks to discuss gender dynamics in Zimbabwe in the context of the various phases of the development of the Zimbabwean society. It highlights how colonialism set the roots for the feminisation of poverty and examines the positioning of women on the political, legal, economic and cultural fronts.

The issue of gender has assumed a central position in the fight against HIV/AIDS since it became apparent that the epidemic was spreading faster among women and girls than among men, particularly in Southern Africa. It is believed gender inequalities have provided and continue to provide a fertile environment for the disproportionate way in which women and girls are infected and affected by HIV/AIDS (UNICEF: 2003, Gupta: 2002, Mataure: 2001). The 1999 Zimbabwe National Policy on HIV/AIDS does assert that "gender roles and gender relationships predispose females to HIV/STIs because of unequal power relations", as do the Commonwealth Secretariat (2001) UNAIDS (2003) and UNIFEM (2005), among others.

2.1. Gender Defined

While sex is biological, gender is socially-ascribed. It has a bearing on how individuals and society perceive what it means to be boys, girls, men and women. It influences roles, attitudes, behaviours and relationships - aspects of personal identity that have a direct bearing on sexual decision-making and the HIV/AIDS epidemic. Meena defines gender (1992:1) as;

“...socially constructed and culturally variable roles that women and men play in their daily lives. It refers to a cultural relationship of inequality between men and women as manifested in labour markets and in political structures as well as in the household. It is reinforced by custom, law and specific development policies.”

Mbilinyi (1994:49) concurs with Meena when she refers to gender as “social relations between and among women and men, usually asymmetrical divisions and attributes, connoting relations of power domination. Gender is a relation of domination.” Primarily, gender relations are between men and women but also between men and men and women and women. In addition, according to Imam (1997:3), there is a need to recognise the embeddedness of gender relations in social phenomena. She further asserts that while biology cannot be denied a place in the relations between women and men, gender relations owe less to biology than is frequently assumed (Imam, 1997).

Mama (2005:1) posits that “these days we know that even biology is not absolute and unchangeable, but read and experienced through socially and culturally constructed meanings that vary with time and place and culture. The assumptions about male sexuality and female sexuality are far from fixed along Western universalist lines.” Also appropriate to this discussion is Scott’s definition (as cited in Imam, 1997:3) of gender as the social organisation of sexual difference. He goes further to say:

This does not mean that gender reflects or implements fixed and natural physical differences between women and men; rather, gender is the knowledge that establishes meanings for bodily differences. These meanings vary across cultures, social groups and time since nothing about the body, including women’s reproductive organs, determines univocally how social divisions will be shaped.

2.2. Pre-colonial Times

Gaidzanwa (1992) argues that the vulnerability of black women to poverty and exploitation to a greater extent than their male counterparts, (as is the case with most of Southern Africa), has its roots in a history of colonialism. Without seeking to romanticise the past, though pre-colonial Zimbabwe was patriarchal, the division of labour was such that women did not have to carry the burdens that characterised the colonial and post colonial times simply because the

economic activities were organised around the premise that all members of the community resided together. Women had traditional secondary land rights which were respected. What this meant was that within every piece of land allocated to a man as head of the family, a portion of the particular piece, without fail, would be set aside for the exclusive use of adult women. The produce was theirs to dispose of as they wished.

2.3. Colonial Times

During colonial times local institutions were transformed through the imposition of laws, practices and new value systems that destroyed and corrupted them. As discussed in Chapter One, in order to create a pool of labour for new forms of production in the mines, cities and capitalist agriculture, the Rhodesian colonial government passed laws that confiscated land and livestock and removed access to irrigation water. Indigenous peoples were concentrated in agro-ecological regions characterised by low rainfall and poor soils. In no time these areas became overcrowded and overgrazed. One of the most negative outcomes of this situation was that women lost their previously respected traditional secondary land rights thereby making them dependent on husband and fathers for land, among other things. As will be discussed later on in this chapter, a lot of the social changes that came about as a result of colonialism ended up being depicted as “our culture” as they became entrenched in societal norms and practices.

Though rural – urban migration was not confined to men only, the sex ratio in urban areas and mining establishments was skewed in favour of men because opportunities for women to secure employment were fewer. The majority of women could only secure employment as domestic workers and even then, they still competed with men in this sphere. This pattern of migration left and continues to leave women as de facto heads of households in the rural areas but without sufficient decision making powers on how to utilise the land or dispose of the income earned through their own labour. Both access to employment and pay were determined along racial and gender lines thereby deepening existing inequities, and thus started the systematic deprivation which led to the

gendered nature of poverty still being experienced today (Ranger: 2000, ZHDR: 2003)

2.4. The Effects of Male Migration on the Family

As discussed in chapter 1 (page 19), male labour migration was initially forced through the introduction of cash based taxes. The only way cash for taxes could be obtained was through the sale of one's labour on commercial farms, mines and other sectors of the developing economies. Migration in search of wage employment later became voluntary as the cash economy took root. Spouses were forced to live apart because in the majority of cases there was no family accommodation in the cities in addition to the fact that wages were too low to sustain families. Interestingly, when it became clear that some men were unwilling to migrate to towns because they feared that their wives would engage in adultery, the colonial government passed the Native Adultery Punishment Ordinance of 1916 whose sole purpose was to criminalise adultery by African women in the rural areas in the absence of their men. Men on the other hand were not punished for liaisons with prostitutes in the urban areas (Barnes, 1999). The law sought to reassure male migrants that their marital unions would not be affected by their long absences. Thus, it later became "our culture", even when men earned enough to secure adequate family accommodation, for them to work in town and then retire to villages when they were no longer productive.

This system of dual homes which has continued to this day, created a culture of employed men who throughout their working lives moved between urban and rural areas during holidays and weekends. This is thought to create an efficient transmission route for HIV and STDs. Laurie (2000) argues that migration in sub-Saharan Africa has been an important determinant of the spread of infectious diseases and has contributed to the rapid spread of HIV. A study by Voeten et al (2002) in rural eastern Zimbabwe between 1998 and 2000 found that men and women who had moved in and out of the study area in the last 10 years had a higher HIV prevalence than residents. This was corroborated by other research by the NAC (2002), Muzvidzwa (2001), and Ntseane (2002).

Another outcome of rural urban migration was what the Zimbabwe Institute of Development Studies (ZIDS) refers to as the “feminisation of rural areas as well as the feminisation of poverty.” Eighty percent of Zimbabwean women reside in rural areas. Apart from farming on poor soils rural women do not have authority over the produce – they cannot sell it without consulting their absent husbands. It therefore means they maintain men’s stake in the rural economy which is effectively “a depository for spent out male labour discarded from the workplace in the absence of a comprehensive social security scheme” (ZHDR, 2003:4). This practice, whereby a man, after losing his job for whatever reason (retirement, retrenchment, dismissal, or ill health including the ones wrought by HIV/AIDS), ends up in the rural areas, continues up to this day.

With the monetisation of the economy came the strengthening of patriarchy as the gender based migration system ensured that money was in the hands of men and women became economically dependent on them. The value systems that emerged exalted the virtues of married women who stayed and farmed in the rural areas while stigmatising those who migrated to cities as being loose (ZHD Report, 2003:35).

2.5. During and After the War of Liberation

An analysis of gender dynamics in Zimbabwe would be incomplete without touching on the role of women in Zimbabwe’s war of liberation. This is because, all too often, it is assumed that when women take up arms side by side with men it results in a levelling off of power relations. This assumption could not be further from the truth. Zimbabwean women are not the only ones who participated in an armed liberation struggle. Women in China, Vietnam, Cuba, El Salvador, Algeria, Sri Lanka, Iran and Mozambique, amongst others, were actively involved in guerrilla movements. In the context of El Salvador, Algeria, Sri Lanka and Iran, Sajjad (2004:4) observed that although armed conflicts do provide a unique opportunity for armed women to merge the roles of ‘fighter’ and ‘nurturer’, they do not create a permanent space for women in

the new process of nation building. She further asserts that the relationship between the state and women guerrillas often becomes highly acrimonious in an environment where nationalism relentlessly exerts control over these women as they struggle to renegotiate their gendered identities in the post colonial era. Research has established similar experiences for Zimbabwean women guerrillas. ZANLA's [the guerrilla movement that gave birth to the ruling party ZANU (P.F.)] public pronouncements of equal involvement of men and women were not matched with reality on the ground. Women's responsibilities tended to be a replica of their roles at home - cooks, nurses, porters and carriers of war material. The millions of tons of weapons that were pushed into the country, sometimes over distances of 180 kilometres, were mainly carried by women. Moreover, the content of ZANLA's lectures on revolutionary ideology in the camps did not address the issue of gender inequality. (Nhongo-Simbanegavi: 2000).

Nhongo-Simbanegavi however acknowledges that to an extent gender dynamics during the war did usher change in the sense that it was the first time ever in the history of the country that women had been involved in actual combat. At international forums the then guerrilla leader Robert Mugabe was often quoted exalting the role of women in the war and how his movement was determined to change women's situation from one of being oppressed to that of total equality with men;

If women are not drawn into public service, into political life, if women are not torn out of their stupefying house and kitchen environment, it will be impossible to even build democracy let alone socialism (Nhongo-Simbanegavi 2000:3).

Because combat roles were the main criteria for promotion within ZANLA, women simply did not get promoted because they were precluded from roles which would have enabled that to happen. There were also reports of widespread sexual abuse of women as highlighted by Nhongo-Simbanegavi (2000), Win (2004) and Margaret Dongo (2004) – herself a former ZANLA combatant. Senior officers often abused their privileged positions of being

distributors of scarce basic commodities. To add to their woes women were not allowed access to contraceptives and this resulted in unwanted pregnancies which in turn hampered women's full participation in the war.¹⁰

Teurai Ropa (also known as Joyce Mujuru, now Vice President) the most senior female combatant was in agreement with the ZANLA practical view (which differed from the theoretical and propaganda position) that saw women as nothing more than an auxiliary back up force. She went on an offensive supposedly to appeal to women's nurturing instincts;

Since we can't go home (i.e. to the war front in Rhodesia where fighting was going on), we have a lot of duties to do here. We came here to help keep the well being of the boys, washing their clothes cleaning their homes and to treat them when they are sick. We also have the duty of carrying materials for the boys (Nhongo-Simbanegavi 2000:3).

In interviews Teurai Ropa often advanced the official line, pointing to herself as an example of the non-discriminatory policies of ZANLA.

Gaidzanwa (1992:107) posits, and Nhongo-Simbanegavi agrees, that a lot of these attitudes had their roots in the fact that the guerrilla movements were being run by men who had received gender-biased education in missionary schools back home which emphasised the idea of women always playing the God-given supportive role of housewives. There was therefore a concerted, almost arrogant drive to domesticate women.

With reference to the women who participated in the Algerian war of liberation, Marie-Aimee Helie-Lucas had this to say;

What makes me angry is not the mere fact of confining women in their place, but the brain washing which did not allow us ...to even think of questioning the women's place. And what makes me even angrier is to witness the replication of this situation in various places in the world where national liberations are still taking place. (Helie-Lucas 1991:57).

¹⁰ Nhongo- Simbanegavi established that contraception was prohibited because the leadership was of the view that there was need to replace those whose lives were being claimed by the war.

2.6. After the Guns Fell Silent

When fighting ended in 1979, women constituted 30 percent of the liberation war combatants yet at independence there were only 8 women parliamentarians out of a total of 100. One woman was appointed to a Cabinet post – that of Minister of Youth, Sport and Recreation. Two other women were appointed to deputy ministerial posts in Education and Culture and Posts and Telecommunications. This was the reward for women's participation in the war. Twenty five years later there are still only 24 women in the 150 member legislature (16 percent) while only 4 of the 26 cabinet ministerial positions are held by women. In local government there are 123 women councillors out of a total of 1275 incumbents and only 3 of 261 chiefs are women. (Newzimbabwe, April 2005). Parliamentary representation is crucial because this is where laws are enacted. Without sufficient numbers to make a difference women have to rely on men to push for legislation that is favourable to women.

For the majority of women guerrillas, coming back home did not change their situation. Because they had little education, many struggled to get jobs. Some had children whose fathers, though known, were not responsible for their upkeep. Many more were abandoned by men who had married them during the struggle in favour of the more “feminine” brand of woman who had not been hardened by war (Krieger, 2003).

2.7. The Legal Environment

Zimbabwean statute books have many laws that discriminate both against and in favour of women. Stewart, Ncube, Maboreke and Armstrong¹¹ (1997) carried out an analysis of the legal situation of Zimbabwean women and found that apart from the problem of the constitution itself, women could experience discrimination on the following basis, with respect to the laws;

¹¹ The authors note that discrimination can result even where rules seem to be sex-neutral, because, in spite of its apparent neutrality, the law in question either does not specify that women have the same rights as men, or fails to make provision for the different experiences of men and women. This often works against the interests of women as it is assumed that they are protected by the law (p65).

- With regards to the manner in which the laws are formulated and worded.
- How the laws are applied.
- Because of the de facto inferior status of women within society.

There is legal dualism where customary law or the law of indigenous people of Zimbabwe operates side by side with the general law. The Zimbabwean constitution does not forbid discrimination on the grounds of sex hence effectively permits gender based discrimination. The eradication of such discrimination has tended to be reliant on ad hoc legislation.¹² Customary law does not recognise the right of the wife to inherit from her husband's estate. The heir is the eldest son. The contribution of women in the acquisition of property is not acknowledged. The spirit of customary law, followed properly, means that the heir acquires the property and then uses it to maintain the deceased's dependents. This does not usually happen as relatives often threaten both widows and widowers with "ngozi" (avenging spirits) if they do not give up the deceased's property (Ncube et al: 1982, Armstrong 2000).

2.8. Marriage and Lobola

Some researchers have theorised that marriage itself is a source of vulnerability to abuse and therefore HIV infection for women especially where the cultural practice involves payment of lobola (Mpofu: 1983; Gaidzanwa: 1992). Gaidzanwa argues that in cultures where lobola changes hands, it is a misnomer to talk about couples getting married. Rather, *murume anoroora mukadzi* (Shona for the man marries the woman) and *mukadzi anoroorwa* (the woman gets married). One cannot therefore talk about a man getting married; he does the marrying and pays lobola. The amounts charged, (in either money or cattle) have tended to increase in line with inflation. Mpofu also posits that the determination (without consultation) of the exchange value of the women

¹²Constitutional law expert Welshman Ncube (1998) is of the view that it is simply impossible for piecemeal legislation to completely close the gap created by the constitution itself and therefore this kind of scenario makes discrimination on the basis of sex possible.

by their men folk in lobola transactions is a very clear statement on the buying of women's labour, sexual and reproductive services;

The central problem of women's subordination by men is marriage; the subordination is strengthened by the lobola system which has turned women into commodities with a definite exchange value.....The lobola system has become part of wealth accumulation by male heads of the family (1983,6).

Armstrong (2000) concurs, "The effects of lobola on the status of women in marriage is phenomenal and in many respects commodifies women. One cannot claim equality with one's husband if bride wealth has been paid." In research some women have confirmed succumbing to sex and violence by their husbands after being constantly reminded about lobola payment (Armstrong: 2000, Dengu-Zvobgo et al: 1997). In addition to the issue of lobola Mpfu also theorises that the following are sources of inequity;

- Property rights that are largely vested in the hands of men (i.e. in the case of marital or family property), excluding women and daughters who also contribute towards the accumulation of family property through their labour or income earnings.
- Because widows are a distant fourth in the inheritance line after sons, fathers and paternal uncles, and brothers and their sons, the laws of intestate succession tend to create and perpetuate a class of relatively rich eldest sons and younger brothers of the deceased. This is one of the major mechanisms of the reproduction of male dominance in society.

Furthermore, the ideology of certain aspects of customary practice is based on what Ncube terms "religiostic mysticism".¹³ It however has to be pointed out that women's subservience within relationships and during sex is not confined to societies where marriage involves payment of lobola and that not all women are subservient.

¹³ Under customary law children belong to the husband's clan and they take up his totem. This is legitimised through the payment of lobola. A widow neither has the authority to charge lobola for her daughter nor bury her child because she belongs to a different clan. When issues of lobola and totems are brought into the equation widows find themselves virtually incapacitated as they fear that fighting their in laws could bring misfortune to their children through "ngozi" (the avenging spirit).

Zimbabweans over the age of 18 can legally get married without parental consent while under customary law girls as young as 12 can marry with the consent of their guardians. While lobola is no longer a requirement in order for a marriage to be considered legal, the heavy socialisation that occurs within society continues to result in women allowing their fathers to negotiate for and receive lobola (Gaidzanwa, 1992).

Marriages can be contracted under two different pieces of legislation – the Marriage Act which is monogamous or the African Marriages Act which allows polygamy. Under the African Marriages Act the husband cannot legally commit adultery. In addition, property rights of African parties to a marriage under both laws are governed by customary law which stipulates that all property acquired during marriage belongs to the husband. Although the Matrimonial Causes Act was passed in an attempt to bestow the courts with the power to distribute property between divorcees fairly. In reality it depends on the judge's attitude.¹⁴

2.9. Culture and Tradition

Research describes the Zimbabwean society as being varied, changing and contradictory with hugely contested definitions of “culture” and “tradition”. Women are socialised and sometimes controlled by “culture” but sometimes choose to subjugate themselves to cultural practices that disadvantage them. The picture that emerges is that of a multidimensional, often confused and confusing group of people as women tend to be both victims and actors in their own subjugation. Researchers tend to find that people speak of culture and tradition as if they are one monolithic institution easily identifiable and immutable yet cultures tend to vary from area to area and within classes (Armstrong : 2000, Dengu-Zvobgo et al : 1997, Stewart and Ncube : 1992,

¹⁴ Armstrong (2000) argues that while in accordance with the Matrimonial Clauses Act the courts have power to distribute property between divorcees equitably, if applied by a conservative and sexist judiciary, the wide discretionary powers of the courts can lead to the denial of equitable property rights for women. The main problem is that the wide discretionary powers of the courts inevitably lead to the lack of fixed legal rights, which in turn leads to uncertainty in the law. The majority of Zimbabwe's judges are men.

Women and Law in Southern Africa Research Project : 1995). Armstrong argues;

Culture and tradition are contested and negotiated between individuals, groups of people and institutions. It is always important to analyse who exactly declares "culture" and "tradition". In general, powerful men have been in control of defining "culture" and "custom" and this has inevitably led to versions which have an emphasis on men's rights at the expense of women's rights (2000, 28).

Thus, while culture may be viewed as a way of asserting a people's way of doing things and seeking identity, it is often used to empower individuals and groups. Culture can also be used as an excuse to justify behaviour that may otherwise be unacceptable.¹⁵

2.10. Disputes

Under customary law the family is supposed to be the institution that lays down the law and settles marital disputes of family members. In reality the family's power to settle disputes and enforce decisions very much depends on the extent to which family members are dependent on the family for resources and also on traditional power hierarchies and spiritual beliefs. A woman effectively belongs to two families – her natal family and her husband's - which owns her labour and reproductive capacity. Armstrong (2000) found that each of the two families may have different interests in the continuation or failure of her marriage. Eighty percent of the women interviewed in Armstrong's research revealed that family adjudicators to disputes often took the view that as long as the man provides for his family financially, his wife should not complain about other aspects of his behaviour such as infidelity, drunkenness and light beatings which do not cause injury. What is evident according to Armstrong is,

The tendency is reinforcement of gender role expectations whereby the wife is expected to modify her behaviour so as to avoid being beaten. Much

¹⁵ Dengu-Zvobgo et al and Armstrong, in different researches found that men often justify domestic abuse because they paid lobola and it therefore gives them the right to enforce discipline if the wife fails in her traditional roles of cooking, cleaning, looking after children and deference to the husband.

traditional wisdom is about the woman resigning herself to her fate. Parents often tell their daughters 'marriage is like that'. All too often ...your mother will start to relate her own marriage and what she had to put up with. They always tell you to stay for the sake of the children...

2.11. Land Ownership

Land constitutes the main means of production for the majority of Zimbabweans. However, as indicated above, laws, custom and policy limit women's access to land. In the era of HIV/AIDS, it serves to bring to the fore one of the main causes of women's vulnerability. In 1994 The Gender Dimension of Access on Land Use Rights in Zimbabwe established that out of the 4400 large scale Commercial Farms only 450 were in the hands of blacks. Less than 100 were in the hands of women and out of these only 11 were owned by black women. The other 3 million black farmers operated under the communal land tenure system. Zimbabwe Women Resource Centre Network (ZWRCN) established that out of the 10 600 small scale commercial farms, only 3 percent were owned by women. Everjoyce Win also found that only 15 percent of the beneficiaries of the fast track land reform programme embarked on since the year 2000 are women. The President of Zimbabwe is on record for saying if women want land then they should not get married.¹⁶

The communal lands are occupied by an estimated one million families and as already stated, 80 percent of Zimbabwe's female population resides there. Sixty percent of rural households are headed by women who run and manage but do not own the family plots. Seventy five percent of these areas are drought prone. A 1998 survey by the lands Ministry established that only 23 percent of female spouses resident in communal areas had special plots allocated to them by their husbands (Tichagwa, 1998). Chiefs allocate usufruct rights to adult males, irrespective of marital status while women can only access land either through husbands or male relatives.

¹⁶ The statement, quoted by the Herald newspaper of 13 March 2002, followed complaints from women veterans of the war of liberation who were unhappy about the fact they were not being allocated land. In response to the President's pronouncements they still pointed out that single women were not being considered and many resorted to finding men who would front for them.

In the resettlement sector, though on paper the process was not based on gender, only widows, divorcees and single parents were considered for land in their own names. A 1985 survey by the Land Commission revealed that this group was allocated smaller plots compared to male headed households. Where married couples are concerned, no permits have ever been issued in the wife's name or jointly.¹⁷ The problem is that the policy is premised on harmonious relations between married couples regarding land utilisation. The reality on the ground, as established by a ZWRCN (1994) is that husbands tend to prefer cash crops to an extent where insufficient land is left for subsistence.¹⁸

Apart from being reflected in the areas discussed above, gender relations in Zimbabwe also manifest themselves in the area of education where girls and women's share of enrolment decreases from nearly 50 percent in primary school to 30 percent at universities and other tertiary institutions (Robertson, 2004). At the same time, the female share of the non-agricultural wage employment is also low (Table 2).

Table 2 : Women's share of non-agricultural wage employment

<i>Year</i>	<i>Percentage</i>
<i>1990</i>	15.4
<i>1995</i>	17.2
<i>2000</i>	20.4
<i>2002</i>	20.6

Source: Robertson's Economic Services, 2005.

¹⁷ The application form itself is worded in a manner that presumes that the husband will be the registered owner and all rights and obligations to land use devolve to the person in whose name it is issued. Loans are issued in the name of permit holders as are housing loans issued by the Ministry of Public Construction and National Housing. In addition, married women who may be in a position to acquire their own livestock do not have grazing rights. Such livestock can only be accommodated if the husband registers them as his own through his permit.

¹⁸ The same research found that because customary law favours the eldest sons as heirs, only 16 percent of the widows in resettlement areas managed to inherit permits which allow them continued use of land following the death of spouses.

2.12. Implications of Gender Inequities in the Era of HIV/AIDS

As illustrated, gender relations are most importantly coalesced in material conditions. Apart from working more for less, a lot of the work done by women does not command payment because it is confined to the private sphere. Women therefore end up as dependents of the household members who work outside the home. Such dependence often manifests itself, both within and outside marriage, through sexual relations. Baylies (2000) refers to sex as “currency by which women and girls frequently pay for life’s opportunities, from a passing grade in school to a license or permission to cross a border”. Akeroyd (2004), places emphasis on the need to acknowledge that personal relations of intimacy and economic strategies for survival are intertwined in the sexual act;

The ways in which economic dependence features in sexual relationships takes many different forms that may not necessarily be classified under commercial sex, monogamy or multiple partnerships. The nature and extent of economic dependence often determines whether or not women are able to exert any control, and in particular, to insist on protection against HIV infection (p88).

Economic dependence, in a very profound and significant way, “brings the broader situation of women (informed by gender relations within the public sphere), into the private sphere”, Baylies (2000, 15) weighs in.

The very same cultural factors and underlying notions of what it means to be a social being in the public sphere inform intimate relationships. It is the very notions that determine the gendered division of labour, structure of employment and educational opportunities that influence how sex will take place. The manifestations of gender ideologies are apparent in both the wider society and intimate relations and tend to reinforce each other. They manifest themselves in very specific ways during sex and often involve prescribed passivity of women and initiative and decision making on the part of men. There is also tolerance of men having multiple sexual partners both within and outside marriage. While there are variations among different cultures, there are commonalities in many societies which prescribe women as givers of pleasure

and receivers of none. Men and women tend to be socialised differently in terms of how to express their sexuality. Such socialisation often includes even things like appropriate language, the way sex is approached, understood and valued between men and women. Having been socialised to be subservient it becomes difficult for women to exercise control (Baylies, 2000).

2.13. Limitations of Gender -based Theories

The dominant paradigm of female vulnerability due to gender-based power imbalances has created the impression that women are a homogenous group. For example, Geeta Rao Gupta, one of the most respected authorities in the field of HIV/AIDS and gender says “women’s economic vulnerability increases their dependence on men, constraining their ability to negotiate the use of condoms, discuss fidelity with their partners or leave risky relationships” (2001: 2). Women are often constructed as a homogenous group. The implication is that economically empowered women are portrayed as if they find it easier to both have a say in sexual relations and leave abusive ones. There is a tendency to generalise women’s situation without taking into account issues of class, race and personality differences. However, this generalisation needs to be challenged. The individual, as Maidei’s story will show, cannot always be read off from the group.

Nevertheless, the biological makeup of women increases vulnerability to HIV infection. Male to female transmission of HIV is more efficient than the other way round. All things being equal the probability of male to female transmission is estimated to be two to four times that of female to male transmission (UNAIDS 1997). Abdool Karim (2005), quoting Kaplan, puts the figure at 7 times. This is because infected semen contains a higher viral load of HIV than vaginal sexual secretions. Secondly, the exposed surface of women’s reproductive tract tissue is larger than the vulnerable surface area in men. Furthermore, the permeability of the mucous membranes of the vagina is greater than those of the penis, and there is usually a longer period of exposure of semen within the vaginal tract after sex (Baylies, 2000).

2.14. Some Behavioural Theories Relevant to HIV/AIDS

Gergen and Sermin (1990) note that theories of interpersonal relations focus on the social environment, in which individuals are born, grow and live. The factors that influence one's behaviour include one's class, societal value systems, family value systems and religion. Of critical importance are the shared beliefs that evolve through interaction among people resulting in the development of shared constructs of societal issues. Thus for example, if societal values tend to link condom use with those of loose morals, you then get those who consider themselves virtuous risking infection rather than use them or men threatening their wives with violence for daring to even mention them.

2.15. Scapegoating

HIV has shown that it is ideal for scapegoating. In the absence of logical explanations, some are simply concocted "so as to relieve the cognitive dissonance of there being an event with no logical explanation" (Skinner, 2004). A scapegoat is selected on the basis of being different either in terms of a purely physical characteristic such as race or a particular behaviour such as prostitution. In the early days HIV was labelled a gay plague in the West. In Zimbabwe as mentioned earlier, it was believed to be a foreign disease which was being brought into the country by long distance truckers. As was the case with syphilis in the 19th century (Brandt, 1987) prostitutes were also singled out for vilification because there was no clarity to the origins of HIV, spreading silently as it did.

2.16. Conclusion

This chapter has reviewed the literature on the legal situation of women in Zimbabwe. This shows that women are rendered economically dependent on their husbands and male relatives through laws that govern the inheritance of property and indeed through the constitution itself. Property inheritance and kinship are intimately entwined with marriage. Women's subservient legal position is reflected in their subservient role in the domestic sphere. However, the category "women" is not homogenous. Women are divided by class, race,

age, education, language, religion, to name but a few of the complex factors that render the category heterogeneous.

The next chapter discusses the data collection method utilised to have a dialogue with an economically empowered woman who contracted HIV even though she was insulated from poverty and gender-based violence.

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CHAPTER 3: THE DATA COLLECTION METHOD

The previous chapter dealt with the general aspects of gender relations in Zimbabwe. Before outlining Maidei's story I shall discuss the method and methodological aspects of the research project. Both the merits and shortcomings of the life history method are discussed. The reader is also taken through the researcher's practical experiences in the field, including the difficulties of staying emotionally detached.

3.1. The Life History Method

Life history has been defined differently by various authors. Also known as the biographical method, Watson and Watson-Franke define it as "any retrospective account by the individual of his life in whole or in part, in written or oral form, that has been elicited or prompted by another person" (1985:2). While Watson is of the view that the only direct purpose served by life history is "as a commentary of the individual's very personal view of his own experience as he understands it", Dallard (as quoted by Tierney) calls it "an attempt to define the growth of a person in a cultural milieu and to make theoretical sense of it" (2000:p539). Denzin on the other hand simply defines it as an "account of life based interviews and observations".1989:48). An analysis of the social, historical, political and economic contexts of a life story by the researcher is what turns a life story into life history (Hatch and Wisniewski 1995:125). What the authors seem to agree on is that life history is related to biography; it is a retrospective account and involves some form of narrative statement. It is a written account elicited through interviews by an individual who seeks to understand a life in order to gain a greater understanding of cultural notions or socioeconomic context and social change. The account itself is shaped by the narrator's choice and selective memory and "emphasises the placement of the individual within a nexus of social connection, historical events and life experiences" (Miller and Brewer, 2003).

Denzin posits that from a post modern perspective both the author and narrator are situated. Any text is co-produced and researchers participate in the creation of the data. Sometimes narrators do not speak coherently and it becomes necessary for the researcher to edit so it can be understood by the readers. For example this is what Maidei had to say about abuse of some of her classmates by the male teachers:

*..but somehow, especially in terms of **mamale** teachers, when it came to **vasikana**, the abuse **yacho**, I still remember , two of the girls **vatakanga tiionavo muform** two, **zviya zvekuti mamale** teachers **vaiti kuvana vechikro**, and still, **uchitarisa mateacher acho**, **anenge atori baba**, with their own children, **asi vachidistarator** education **yevana vechikoro**.*

The edited version of this passage, which is meant to render it more meaningful to the reader, is;

Some of the male teachers used to abuse school girls. I remember that two of the girls in my form two class were abused by male teachers who in fact were married and had children of their own and yet were not ashamed to distract those girls from their education.

Though the meaning is not lost, the need to translate some of the words results in loss of flavour and removes the emotion which is apparent in the original passage.

3.2. The Feminist View

My decision to do research based on oral narrative was inspired by feminist scholarship. While most writers on feminist research are agreed that there is no one method that can be characterised as the feminist methodology, there is affinity between women's lives and life history as a research method. Feminists are attracted to the life history method because it is useful for getting information about people less likely to be engaged in creating written records. It gives space to relatively powerless groups. First person accounts provide an understanding of the subjectivity of a social group that may be muted or excised from history and is often invisible in the official records. Oral interviews are particularly valuable for uncovering women's perspectives, because expression of women's unique experience tends to be ignored

especially in instances where women's interests are at variance with those of men. The idea is to make female experience part of written records (Reinharz: 1992, Edwards: 1993, Anderson and Jack: 1991).

Sandra Harding (1987) points to the fact that traditional theories have not been applied in a manner that makes it possible for society to understand women's participation in social life, or to understand men's activities as gendered. Traditional epistemologies, whether intentionally or unintentionally, systematically exclude women as "knowers" or agents of knowledge. The voice of science tends to be masculine while history tends to be written only from the point of view of men of the dominant class or race.

Maynard (1994) believes the life story method maximises the ability to explore experiences rather than impose externally defined structures thereby enabling researchers to delve into women oriented areas of research such as sexuality, child birth and domesticity, among others. Research based on questionnaires and interview schedules which churn out facts and figures tend to fracture people's lives, focusing on only a tiny portion of the person's experiences;

"Often, the result of such an approach is a simple matrix of standardized variables which is unable to convey an in-depth understanding of, or feeling for the people under study. Research practices which utilise either pre-coded or pre-closed categories are often of limited use when trying to understand women's lives. This is because they are often based on assumptions...that the researcher is already familiar with the phenomenon being investigated to be able to specify in advance, the full range of experiences being studied and how these can be encapsulated, categorized and measured."(p11).

The traditionally recommended objective research is premised on rationality and detachment. However, being detached and value free would not be much use where one wants to intrude into a private sphere and delve into some deeply personal experience. The behaviour involved in the story of an HIV positive woman is intimate, because;

"Sex leaves a sense of shame because of the embarrassment that arises from exposure of what one thought was private and intimate. The infection leaves a mark, a stain, a print, linking us to an act so private, so intimate, so sacrosanct, so emotionally and spiritually unguarded – the moment of sexual

coupling. Its external manifestation is an illness; its exposure to the world is deeply embarrassing and therefore shameful” (Edwin Cameron (2005: 71).

Edwards (1993) argues that women’s lives can only be understood if addressed in their own terms and there is a link between what transpires in women’s lives at the individual level and the way in which society is structured at a more general level. Furthermore, a feminist enquiry aims to provide explanations of women’s lives that are useful to them as a means of improving their circumstances. Such research should not objectify women and treat them merely as data providers.

One of the underlying assumptions in feminist research on methodologies is that when in-depth interview is carried out woman to woman, it tends to be more or less non hierarchical. Oakley (1981) posits that there is a cultural affinity between women interviewers and their respondents because they share a subordinate structural position by virtue of their gender. This view is shared by Finch (1984) and Phoenix (1994) who experienced that their interviewees expected them to understand what they meant simply because they were, like them, just other women. Black feminists argue that the issues of race and class come into the equation because women are not a homogenous group (Hooks: 1984, Amos and Parmar: 1984, Mohanty: 1988, Amos and Parmar: 1994, Phoenix: 1994, Maynard: 2001, Ampofo et al: 2004). Edwards (1993) concurs and adds that the racial and class divisions lead to different interests and priorities hence Oakley and Finch’s experiences may not apply in all situations of woman to woman interviews because simply being women in the context of a research process is not sufficient to establish rapport. Maidei’s aversion to being interviewed by foreign white women bares testimony to this view (see below).

Though Phoenix (1994) points out that much of social science research on black people has rendered them pathological and tends to be an “exploitative production and reproduction of negative constructions of black people” (p 53), she however advises on the need to be cautious because it is not always methodologically better to have black on black interviews. Politically, argues

Phoenix, this may in fact lead to the marginalisation of research on black people and black researchers since it can then become easier for white researchers to consider that black interviewers can only contribute to research on black informants. It could also have the effect of rendering invisible contributions black people make to research which is not only on black samples or race.

Admittedly, the fact that Maidei had placed me as someone who was in the same class, race and sex and spoke her language did not put us completely on the same level. Though my interviews were designed to allow her own perspectives to emerge, I was not simply a recording instrument, robotic style. I was a variable in the interview process in the sense that I brought my own life experiences to the research and was responsible for structuring the whole process. The fact that I am studying towards a Masters degree was in itself a factor that placed me on a higher level. This was evident when in some parts during her narration she would say, "I suppose you know these things better than I do". When she was expressing her dissatisfaction towards doctors who did not take time to counsel her before wanting to send her for an HIV test she started by saying, "is it not the case that a good doctor should counsel you first?" This was an obvious way of seeking affirmation from one whom she perceived as being more knowledgeable. The interview was therefore necessarily an interactive process between Maidei and me. My attempts to reduce the social distance were sometimes futile because she kept resisting efforts to be treated as an equal partner. She kept saying - "I am sure you know better than I do".

The theme of "remembering" takes centre stage in Maidei's growth into a woman capable of reconstructing her history. Throughout her narration Maidei keeps saying "I remember...Now that I have thought about it, I suppose this is what he meant..." An example is when her husband was diagnosed with Kaposi Sarcoma. She did not know that it was a type of cancer that was normally associated with HIV until they moved to Harare from Mutare;

“I vividly remember the way he was when he came home. Then he said he had been diagnosed with this type of skin cancer. Then he mumbled something about the need to take precautions, just in case. And I said cancer was not contagious. Now that I think about it, he must have been told about the link but did not have the guts to tell me.”

Maidei remembers things which in retrospect, have made her question the logic of some of her decisions in the past and she hopes her daughter will not fall into the same trap, hence the statement: “I just don’t know what can be done about the naivety of women...I felt rather special when he used to tell his other women about me because it meant I was his true love. Just how stupid can one get?”

3.3. Explicit Self Disclosure

Oakley (1984) believes that feminist researchers should seek to equalise the relationship with women they interview as part of their commitment to sisterhood. One of the ways that I sought to show solidarity and instrumentality was through explicit disclosure of who I was. In a way, Maidei did not leave me much choice. The first time I picked her up from her office to take her to the interview venue – my home – she asked me very pertinent questions about why I was doing this research which could not be shrugged away by phrases such as “we should really be talking about you, not me”, as is recommended in text books. I disclosed my being student, mother, wife and one who had in many respects been also affected by HIV/AIDS through loss of a beloved brother, colleagues and friends. I shared with her the pain of prematurely losing people one valued in one’s life. I honestly believe that Maidei opened up to me and admitted me into her personal life because I was candid about who I was. Solidarity aside, I looked at it as a means of investing in a cherished outcome. I suppose arguments could arise with respect to which one was the more important goal – a desire to achieve a truly non-exploitative relationship or simply doing what was necessary to achieve what I as a researcher was looking for in the first place – to get my narrator to open up about a sensitive matter.

Having said that, I have to admit, Maidei did not exactly offer me her story on a silver platter. She asked tricky questions of her own. A good example was when I asked her why she had not thought of using condoms instead of birth control pills. She elicited a mischievous laugh accompanied by a rejoinder;

“Ah, interesting question. I have asked myself that question so many times. But, before I respond, which I will do in a moment, I must ask you, did you and your boyfriend use condoms before you got married?”

Response: *Not really.*

Maidei exclaimed: “You see! Why didn’t you? HIV might not have been an issue then but there were STDs then as now. Having said that, I will tell you why I didn’t, though I sometimes think that many people who do not contract HIV are just lucky....”

At another point I asked her whether or not she ever initiated sex or turned down her husband’s request;

Maidei: My elder sister told me that a woman never says no to sex as long as her husband wants it. I was even symbolically given a piece of soft cloth with which to clean his penis after sex!! I actually do not recall ever turning him down except on one or two occasions when I was really angry with him. On many occasions I simply pretended to be sick – headache or something. I never started it. It would have been too embarrassing for me. What about you? Do you initiate sex? Do you turn down your husband’s requests for sex? Tell you what; if I had another chance I would certainly change the rules of the game.

Abbie: Sometimes, but not very often.

Maidei: What would you do if your husband told you that he was going to have sex with someone else because you did not want to?

Abbie: Huh, tricky. I have never really thought about it. What would you have done if he had said that?

Maidei: I guess that was my sister’s point. I never had to deal with that.

The point is it was not exactly smooth sailing. It was as if Maidei was telling me that there was no way she was going to allow me to ask one sided embarrassing questions without her giving me a taste of my own medicine. I just do not see how the text book recommended tight rope, the one that stipulates that one should strike a balance between a certain level of friendliness to enable there to be some kind of rapport and the detachment necessary to see the narrator as an object under surveillance would have worked under those circumstances.¹⁹ If I had responded by alluding that we should not talk about

¹⁹ Moser and Kalton: 1971, Babbie and Mouton: 2001, Russell and Mugenyi, 1997.

me, no matter how diplomatically, I do not think the interview in intimate matters would have gone far. Anne Oakley poses the question;

..is it really practical to expect to establish rapport while refusing to answer questions from the respondent? Is it really possible to spend hours on end in someone's company, listening to their problems and at the same time remain detached, polite and largely uncommunicative? Should personal involvement be viewed as dangerous bias when it is in fact the condition under which people come to know each other and admit others into their lives? (1981:18).

On my part, as I became increasingly aware of what this woman had endured, I found myself emotionally involved. Is it at all possible to be aware of another woman's adverse situation and not experience some emotional response? At times we ended up crying together. On many occasions I was haunted with the possibility of her suddenly not wanting to continue with the interview, given the pain that she at times went through in the process of remembering certain details of her life. But, there was lots of laughing too, for instance when she joked about the sex games she would have asked her husband to engage in if she had been the one who had paid lobola. As discussed earlier, I asked her if she ever initiated sex with her husband. As she giggled and shook her head, she pondered on the kind of power she could have had to put all her fantasies into practice.

Wengraf (2000) advises that the research interview is not designed to "help" or empower or change the respondent at all. In reality, I found myself playing counsellor and providing information that has assisted Maidei. When she told me that 40 percent of her income goes towards medication because she also had to buy ARVs for her sister I ended up making contact with doctors known to me and asking them to assist in getting Maidei's unemployed sister onto the government sponsored ARV roll out programme. At the time of writing her sister was undergoing the required tests.

The issue of counselling came about because it was very clear that Maidei blamed herself for the fact that her sister had contracted HIV. The background to this (which will be explained in detail in the story itself) is that Maidei, who

is third born in a family of 8 siblings, effectively raised all 5 of her younger siblings. The sister, who was diagnosed with HIV in May 2005 and is now 29 years old has lived with Maidei ever since Maidei started working in 1989 – 15 years ago. Maidei feels that she could somehow have acted to protect her sister. I just found it difficult not to intervene. To me, this woman is an unsung heroine, the pillar of strength for her whole family. It would have been unfair not to tell her what a truly great person she was and how it is impossible to protect individuals from activities that happen in private even as they are aware of the dangers involved. I asked her a simple question – did she herself blame her parents or elder sister for the fact that she contracted HIV? If, as she had indicated in her interview that she felt entirely responsible for, in her words, having been “naïve and stupid”, why then did she want to blame herself? What was to be gained by it? Incredibly, we ended up laughing about it. Later that evening, she phoned to tell me that our discussion had lifted a heavy burden off her shoulders. She now accepts that she was not responsible for what happened to her sister. In another incident we ended up discussing the merits of her making friends with people of the opposite sex whom she had shied away from since her husband’s death. I ended up telling her the inspiring story of Lillian Mboyi²⁰, (among others) an HIV positive woman who had continued to make friends with people of the opposite sex thereby enjoying a full life.

3.4. Ethics

Finch points out that because women interviewees tend to identify more readily with women researchers it sometimes becomes too easy for them to reveal their deepest secrets. Feminists’ desire to employ techniques that hinge on egalitarianism do sometimes generate complete trust. “Each interview can take the aura of an intimate conversation and respondents can accept too eagerly what are rather flimsy guarantees of confidentiality”²¹ (Finch; 80: 8).

²⁰ Lillian Mboyi is a 37 year old HIV positive black Zimbabwean woman resident in South Africa (just a year older than the narrator) whose story was published in the book “HIV/AIDS in South Africa”. She describes herself as “a mother....., a lover and a partner” (p30) and is candid about her sexuality and desire to have a fulfilling sexual life.

²¹ It has to be acknowledged that once the final research report becomes a public document, the original data collector ceases to have control over how it will be used or interpreted by secondary users.

In this regard, apart from my being confident that Maidei is too headstrong to get her to discuss anything that she does not like, I have no intention whatsoever of using the information gathered for any other purpose other than what we agreed. Maidei is well aware of the fact that the thesis is an academic document which will be housed in the Sociology Department and the Library of the University of Cape Town.

At the end of the interview I asked her to take several days to think about our research project so she could give an honest appraisal of how she felt about the whole process. She admitted to feeling uncomfortable about some aspects of the interview, though she was quick to point out that she had found it, on the whole, quite therapeutic. She said telling her story had given her the opportunity to take stock of her life and put things into perspective to an extent that she had not done before, apart from benefiting from the knowledge that we shared.

She however wondered if she had the right to disclose her sister's HIV status. When we met for lunch the next day, amidst much laughter and joking, all I could tell Maidei was that I would have felt the same had I been in her shoes. This was her family and her sense of loyalty had to come to the fore. But then would it have been possible to talk about herself in isolation, as if she were an island? After all, as the Shona saying goes, "we are who we are because of other people". Her family is part of who she is. Indeed, Judith Stacey, in her criticism of the in-depth interview on sensitive subjects expressed concern about how it sometimes upsets and causes emotional harm to the respondents, which cannot be entirely resolved by the feminist view of reciprocity, mutuality and empathy of the woman to woman set up. She argues, "it represents an intrusion, an intervention into a system of relationships that the researcher is far freer than the researched to leave" (1988:4).

Kirkwood (1993) also points to the possibility of generating all sorts of issues in the respondent's mind, then abandoning them to come to terms with these on their own.²² I was all too conscious of the fact that I was the cause of Maidei's discomfort. One of the things that characterised Maidei's memory of her late husband was how she absolutely adored him and had very fond memories of their short life together. I was anxious that in retrospect, she could end up resenting him because my interview had the effect of causing her to re-live her life experiences and analysing how she ended up in this situation. I sought to minimise the anxiety by making myself available whenever she needed to talk. I told her she was at liberty to telephone me any time of day or arrange a face to face meeting whenever I was in Harare, or e-mail me. I have also kept in touch with her and occasionally e-mail so that she knows that her importance to me was not confined to her being a source of data.

3.5. Shortcomings of the Oral Narrative Method

The main criticism of oral narrative has been around issues of reliability, validity and representativeness. The Popular Memory Group (1998) raised concern over how biographical research tends to validate personal testimonies without question. One also does have to consider the possibility of not being told the whole truth. It is virtually impossible to verify personal experiences especially ones that have to do with sex. Given the sensitive nature of HIV/AIDS and partly because this was an individual's story, conventional triangulation was difficult. In Bozzoli's words, "of course, these testimonies need to be read with a critical eye and with enough knowledge of the context to make it possible to sift through the goal of true evidence from the bulk of ideology, poor memory and wilful misleading that sometimes occurs"(1991: 295). I had no reason to doubt any aspects of Maidei's story because, my own identity as a Zimbabwean woman enabled me to relate to her situation. Validation was difficult because Maidei had not disclosed her HIV status except to her in-laws. Where validation was possible, I took the trouble to go that route. For example, Maidei dwelt a lot on how close she was to her in-laws

²² Kirkwood reveals how one of her interviewees in a research dealing with violent partners refused to do a second interview because she had been traumatised by the first.

and how supportive they had been both materially and emotionally. This was indeed confirmed through discussions with her late husband's brother and sister.

HIV/AIDS is a complex, sensitive and challenging subject whose main mode of transmission, sex, is a taboo subject in Maidei's society. It was extremely difficult to probe around such an intimate matter but in the end it was worth the effort.

3.6. Interpreting Maidei's Story

Earlier I touched on Edwards' view that there is a link between what transpires in women's lives at the individual level and the way in which society is structured at a more general level. The interpretation of Maidei's life is based on her positioning as a black Zimbabwean middle class woman. In order to gain understanding of how she makes decisions that affect her life, her story has to be contextualised within Zimbabwean society and what it means to be a woman within it. The intention is to examine how these social and historical conditions shape Maidei's life. As Harding put it, "the bedroom and kitchen are as much the site of political struggle as are the boardroom and polling place" (1987:8).

The biographical method has proven to be valuable not only because it allows a link between the personal and the social, but also because it facilitates movement back and forth in time and space, documenting processes and experiences of social change through the analysis of both social history and the development of the individual's personality. It also allows an analysis of the ways in which social contexts govern choices and shape decision making processes (Chamberlain: 1975). Purvis (1994) Maynard and Purvis (1994) also found that, with reference to suffragettes, it was only through personal testimonies of their imprisonment that it became possible to challenge the mistaken views about what filled the history books during that period.

3.7. Finding a Participant

Once I decided I wanted to talk to an HIV positive woman it was not easy finding one who wanted to talk to me. I initially wanted to seek dialogue with an HIV positive female educator. I contacted the Zimbabwe Organisation for People Living with HIV/AIDS (ZOPLWHA). Gaining access to PLWHA proved to be a challenge. Dealing with the “gatekeepers” - i.e. the leaders of this organisation, was a significant constraint. They said they had been inundated with research requests and their members were tired of talking about their experiences and nothing positive ever came out of the endless research. I was asked if I was prepared to pay the respondent for her services and I answered in the affirmative. I eventually established that the overwhelming majority of the membership were either unemployed or were in the low income bracket.

I did not wish to talk to an unemployed woman because in Zimbabwe most of the research in the area of HIV/AIDS has been concentrated on those below the poverty line. The HIV statistics depend mostly on pregnant women who utilise the services of public health institutions. Stories of HIV positive women draw their participants from the poor and researchers often conclude that the vulnerability of this group is linked to poverty. I wished to meet with a woman who did not depend on a man for sustenance. I then recalled that in 2001 the Zimbabwe Association of University Women (ZAUW) – an organisation of which I was a member, organised a meeting during which two HIV positive women related their experiences of living with HIV. During the meeting I sat next to Maidei, a black woman who had arrived in the company of two white women but did not address the audience. During the tea break she disclosed that she was HIV positive and had in fact attended the meeting out of curiosity. The older of the two white women who had told their stories was in charge of an NGO which advocated healthy eating and had come up with various recipe books. Maidei had visited the NGO to learn more about healthy eating and when she heard about their trip to address ZAUW she had asked if she could be allowed to be part of the audience.

A year later I met Maidei in a supermarket queue for cooking oil. I ended up giving her my own allocation – having secured it through the store manager with whom I was acquainted. Though we exchanged telephone numbers it was not until I needed a participant for my research that I telephoned her. She agreed to meet for coffee and told me she needed time to think about my request. She explained that ever since she made contact with that particular NGO, mine was the sixth request she had received from people who wanted to talk to her about her experience with HIV. She had turned down all of them. “It was all very strange. They were all women and white and only one was Zimbabwean!” Three days later I received a call in which she agreed to narrate her story. Maidei narrated her story between the 15th and the 28th of August 2005.

3.8. The Ground Rules

She did not want her real name used. “Who knows, my daughter could end up studying at the University of Cape Town. Imagine the shock of learning just how unwise her mother had been from a thesis written by a stranger!” We agreed on pseudonyms – Maidei Chivi for the narrator and various others for the other parties in her story. She also did not want any of the interviews to take place at her house because, while it was school holidays and her daughter was visiting with one of Maidei’s sisters, two of her sisters and a brother were staying with her. We settled for my house as a suitable venue because we were guaranteed privacy. I was the only one residing there at the time. We also agreed that she would go through her story once summarised and that she would have access to the final report. She was at liberty not to disclose any aspects of her life story that she was uncomfortable with and also to use either English or her native Shona language. As it turned out she used both languages. In parts she spoke in English but for the biggest part of her story she used a mixture of the two. I observed that she tended to resort to Shona when she was a bit agitated.

All in all there were 5 interviews which translated to 7 hours of tape-recorded conversation. I gave an undertaking that I would personally do the

transcriptions. Apart from the issue of confidentiality, I was all too aware of what other researchers such as Price had experienced when they hired transcribers for a fee. Price found that transcribers had a “knack for curious interpretation, turning taped interviews into uncommon sense. One transcriber I used was determined to clean up my participant’s grammatical usage, thereby negating most of the colour and the pacing of their speech...If a passage was difficult to hear, the transcriber would kindly confabulate data.”(1999:13).

I made use of an interview guide rather than structured questions and simply asked the narrator to talk about her story under the following broad areas;

- Growing up as a girl child
- The school years – hopes and aspirations
- Relationships within and outside the family
- Dating and getting married
- Contracting HIV, finding out and how it changed her life
- Lessons that she believes can be drawn from her story
- Feedback on how she felt about the research process

Making use of a guide enabled me to ensure coverage of all areas of interest while allowing for free-flowing story telling with minimal interruption, thereby allowing Maidei to maintain control. The broad areas allowed her to adopt a style that she was comfortable with while use of a tape recorder enabled me to concentrate on listening and observing pauses, gestures and facial expressions. I took notes of all these scenarios and this allowed me to ponder on meanings, i.e. does a pause or gesture imply that the narrator is thinking of the best way to articulate an issue or does it in fact mean unwillingness to tackle the particular issue? Note taking, though not intense, also enabled me to take note of areas that needed follow-up through questions. I listened in a manner that communicated one thing only to my story teller – that she had my undivided attention. Fortunately for me, the many years that I spent in the field of

industrial relations provided me with ample training ground for developing listening skills. I wanted it to be Maidei's special odyssey.

3.9. In the Field with Maidei

After thanking Maidei for agreeing to tell her story, I started by seeking clarification on why she had not wanted to participate in similar research when requested to do so in the past. For me this was important because it enabled me to have an appreciation of the type of person I was dealing with so as to minimise areas of conflict. The words in bold letters are in Shona, our native language. She said;

*I just did not want to be used. These women come here and pretend that they care about us. How can they care about people they do not even know? **Ngatitii ndanga ndichikwanisawo kuenda ku** Europe (Suppose I had the means to go to Europe), and then I go to an NGO and ask them to put me in touch with an HIV positive gay person. I am saying gay because my Doctor was telling me that in places like Europe many of their HIV positive people are gay. Do you think the person, **Iye ari gay wacho**", (I mean the one who is gay), would talk to me and tell me their story? Look, I do not know any politics or sociology. My area is finance but I do not believe that those people in Europe would want to tell their stories to people from Africa. I guess I am just resentful. I went to Ireland for a course once in 1995. There was a news paper article about AIDS in Kenya. It was as if white people never have sex.*

*Of course, I am not naïve enough to think that my life will change because I have told you my story. But the thing is, you are a student, right? You are doing your research. If you do it well then you will get your degree, **handiti**, (isn't that so)? **Ndingatofarewo nazvo**, (That would make me happy). Besides, you will also be talking to your children and other women – your nieces and others, and telling them to be careful. But these issues of research, you ask yourself, **ko ivo varungu ivava kumusha kwavo hakuna here** black women **vari HIV positive**? (Does it mean that there are no black women who are HIV positive in their countries? And of course, some will even want to insult you, **vachiti vanokupa mari** (saying they will pay you). At one time, as a matter of interest, I asked this other woman the amount. It would not even have bought a pair of shoes! I suppose they think we are all a desperate lot.*

This bore similarities to what Edwards, a white researcher, experienced when she did her research amongst female mature students at Texas Women's University. The black students were suspicious of her motives while the white

middle class women had no problem whatsoever sharing their experiences with her.²³

Maidei's placement of me as a black middle class mother who spoke her language and had also been affected by HIV/AIDS through loss of relatives and friends was partly instrumental in her agreeing to share her experiences with me. Those were the ties that bound us.

At this point I realised that I had touched on a raw nerve. Emotions were running high. I suggested that we took a break while I organised a cup of coffee. This was one of several strategic breaks that we had to take during the research period. Others happened when we were both overcome by emotions at the times that she related, firstly, the passing on of her husband, then that of her brother and the day that her sister, the one who for all intents and purposes is her daughter's "mother", was diagnosed HIV positive.

3.10. Conclusion

My experiences in the field with Maidei served to underscore the difficulties of adhering to the text book recommended style of interviewing. It was not possible to remain detached. The process itself was in parts, as emotionally exhausting as it was rewarding. In the end, a bond of friendship was developed and I felt truly enriched and honoured by being taken into the confidence of this remarkably humorous woman of enormous strength and determination. It was simply not possible to get Maidei to tell all without reciprocating in kind. My own consciousness with respect to the difficulty of handling intimate details was raised in a very profound manner.

The main body of literature on women in Zimbabwe and indeed Southern Africa suggests that women's physical vulnerability to HIV/AIDS is increased

²³ Edwards (1993: p188) found that black women viewed her, first and foremost, as white and middle class, and therefore a representative of the oppressive class. The fact that she was a woman was irrelevant as class tended to take precedence in terms of the manner in which relations between black and white women played out.

by their economic dependence on men. The story of Maidei, which follows, challenges this over simple view. Maidei is a liberated woman, strong, forthright, and financially independent. Why did she (and by implication many others in similar situations) become infected with HIV? It is to this question that I shall try to answer. The next chapter presents Maidei's story.

University of Cape Town

CHAPTER 4: MAIDEI CHIVI – HERSTORY

Chapter 3 discussed the details of the method utilised to capture Maidei's story and the difficulties encountered. This chapter presents the highlights of Maidei's life story as narrated by herself to the researcher. The challenge was to summarise 7 hours of spoken words which when transcribed filled a 288 page A4 notebook into a mere 5000 typed words. The aspects of Maidei's life covered in this summarised version of her story were selected for their perceived importance in revealing what it was that shaped her identity as a woman and her sexuality.

4.1. Maidei's World

Below are the places, locatable on the map of Zimbabwe, which have a connection to Maidei in one way or another;

1. Harare – the capital city of Zimbabwe where Maidei moved to aged 18.
2. Masvingo – Morgenster, the Teacher's Training College where Maidei was born is located 30 kilometres from this city which is 297 kilometres from the capital, Harare.
3. Triangle (10 kilometres from Chiredzi and 550 kilometres from Harare) – the agricultural town to which Maidei's family moved when she was 4 years old.
4. Marondera, (70 kilometres from Harare) – Maidei worked there for a year.
5. Mutare – (267 kilometres from Harare). Maidei worked and lived there for two years after getting married.
6. Mutoko on the busy highway from Malawi and Mozambique and 170 kilometres from Harare – Maidei's husband worked there for three years (before they got married) before he moved to Mutare.
7. Beit Bridge, right on the border with South Africa well known for its higher than average HIV prevalence rate. One of Maidei's younger sisters resides there and Maidei's daughter sometimes stays with her

during school holidays. She also suspects that her sister got infected there when she had a stint at cross border trading.

8. Nyanga (80 kilometres from Mutare and 260 kilometres from Harare)
Home to Maidei's late husband's parents where her husband lies buried.
9. Bindura (90 kilometres from Harare) – Maidei's daughter Ruvimbo attends boarding school there.

Figure 9: Map of Zimbabwe – Maidei's World



Map sourced online from <http://www.maps.com>.

4.2. The Early Years

Maidei Chivi was born 36 years ago to a father of Malawian origin and a Zimbabwean mother, the third child in a family of 8 children. She started school in 1976 and graduated from high school in 1986. Throughout her school years her time was divided between the town of Triangle where she was educated and the rural areas where she and her siblings spent their school holidays. Their mother farmed during the rainy season and joined them in town during the dry season. Maidei's two elder siblings are a sister who got married at 16 and an elder brother who did not get much education due to ill health.

While her mother pushed the line that girls needed thorough training in housework in preparation for their future roles as wives and mothers, her father was of the view that all the children needed to share house chores because even boys needed to know how to look after themselves so as not to rush into marriage simply as a means of securing the services of women around the home. Her father's sense of fairness drew Maidei closer to her father than her mother.

A bright and popular pupil, she described her school years as the best days of her life. Though she dated boys while in high school, she did not have sex. Her father never tired of telling her to choose friends who would not lead her astray. Their home was always filled with guests – some related to them and some who were offered stop gap accommodation by their father by virtue of their being of Malawian origin. Her father had a reputation for being kind and loving, always offering a helping hand to those who needed assistance even though he did not make much from his tailoring business. She has vivid memories of him cycling to school at break time to bring his children their lunch boxes in the event of any of them forgetting them at home.

She related, with disgust, how some of her classmates dropped out of school after being impregnated, by, among others, teachers and officials from the nearby sugar manufacturing Anglo American Corporation. Only on a few occasions were the teachers disciplined for their transgressions.

There was no sex education other than the little they learnt in biology classes. However, talks on sexually transmitted diseases would sometimes be presented to the school's voluntary health and safety club by practitioners from the nearby hospital. All those aged 15 and over were free to attend. She attended a few such presentations though they held little meaning for her and her friends. She recalled how one of the well known prostitutes who lived in their neighbourhood had befriended her when she was in form three. She was illiterate and would ask Maidei to help her write letters to some of her boyfriends. In one such letter her prostitute friend had hard hitting words for a boyfriend who had supposedly infected her with an STD. She wanted money for treatment and she threatened that if he did not bring the money she was going to go to his house and tell his wife.

4.3. The Move to the Capital

Maidei moved to Harare when she was 18 where she stayed with a maternal uncle. Her intention was to study nursing but when she failed to secure a place she took up a Diploma in Secretarial Studies. In her uncle's home she shared a bedroom with Alice, her aunt's niece. Her two cousins, both girls, had a room each. Her uncle was a strict disciplinarian and the girls were not allowed to go out. They only left the house to go to school and then on Sundays when they were compulsorily taken to church. They were not allowed to date.

4.4. The Working Years

Maidei was 19 when she started working for an (NGO) called National Association of Cooperative Services and Credit Union of Zimbabwe (NACSCUZ) on 1 November, 1988. She immediately took up the responsibility of educating, clothing and sheltering her siblings. Her favourite brother Peter had dropped out of school before writing final school leaving certificate examinations. She then sent him back to school and he later obtained a Diploma in Agriculture but showed no interest in helping the family when he started working. By then their father's tailoring business was bringing

in very little income. The burden of helping the family thus remained squarely on Maidei's shoulders.

When she joined the NACSCUZ it was just starting. She was therefore secretary, receptionist and bookkeeper all at once. As the organisation grew, Maidei received training in various aspects of financial management and also got a scholarship to study for a Diploma in Cooperative Management in Malaysia. She soon became a key resource for the organisation and was responsible for the setting up of several of the NGOs new offices around the country. From her original post of receptionist/secretary/bookkeeper she moved to the position of Field Officer, Auditor, Finance Officer and then headed the Finance and Administration Department.

4.5. Dating in Harare

Maidei started dating Taurai (pseudonym) her future husband when she was 20 and he 23. He was a banker. When her uncle got wind of the affair he ordered her to terminate the relationship. One of the reasons he gave was that Taurai was well known in his neighbourhood for being a womaniser. Maidei observed:

Instead of taking heed of my uncle's concerns, I resorted to hiding the relationship. It did not take long for me to establish that my uncle was right about Taurai. However, when I confronted him, I was not even angry because it was something that I had been told to expect by both family and friends – that men invariably fooled around. I was confident that he loved me and the other women were a mere pass time. The funny thing is I am in no position to tell you why I felt so confident.

She was nearly 21 when Taurai brought up the issue of sex. That was the very first time she had ever discussed sex with anyone. She would have preferred to wait until after marriage but Taurai convinced her there was nothing wrong with them having sex since they were planning to get married, eventually. At that time he had left his job at the bank to join an elder brother who had started his own businesses. He had moved from Harare to Mutoko to run a business there. Maidei commented;

When I agreed to have sex, I never even considered possible consequences other than that of pregnancy. I knew Taurai had slept with other women before me but never considered the dangers of contracting STDs, let alone HIV. I naively associated STDs with certain types of people, just as I had done in high school and my boyfriend did not fit that bill. You just look at your nicely groomed boyfriend and say "not this one".

Due to the lack of education pertaining to reproductive health, a lot of what she knew was based on rumours. She did not want to use condoms, which she associated with prostitutes and settled for birth control pills instead.

When her boyfriend raised the issue of marriage, she was not too keen because she felt she still needed time to help her family. Judging by her sister's circumstances and the experiences that were related by her workmates and many members of her extended family, she did not think it would be possible to continue assisting her family once she got married. Among her friends was a mature woman, Joyce, who was 10 years her senior and it was this woman who always used to relate to her that married life could be complicated.

In mid 1991 she temporarily moved to the small town of Marondera where she had to set up a provincial office for her organisation. Taurai continued to visit her virtually every weekend. She started experiencing severe abdominal pains and foul smelling vaginal discharges. Her Doctor put her on antibiotics and without much explanation asked her to bring her boyfriend along. When she confided in Joyce, her friend was honest enough to tell her that her boyfriend had infected her with an STD.

Maidei was so incensed that she broke off the affair. Taurai sought the intervention of Maidei's elder sister and the two were reconciled at a meeting attended by Maidei's friend Joyce and Taurai's elder brother. Even though Maidei doubted the wisdom of continuing the relationship with a man she no longer trusted, her sister told her "that is how most men behave and you are mistaken if you think you are ever going to find a perfect one". When Taurai

involved Maidei's elder sister in the falling-out, she interpreted it as a sign of showing contrition and his deep love for Maidei.

At the beginning of 1992 Taurai moved to Mutare where his brother had bought one of the town's biggest bakeries. The matter of the STD was soon forgotten and they resumed their normal weekend visits. She was however uncomfortable over the matter of securing birth control pills. Because they were obtainable from pharmacies through a doctor's prescription, she was always overwhelmed with a sense of shame each time she went for a re-fill and had to present it in the presence of other customers. She was apprehensive over the possibility of being found out by her parents when she visited them;

I would picture my mother's horrified expression as she wondered what Harare had done to her daughter's morals. The fear of being found out haunted me each time I visited either of my parents. It was all very strange because, even though I tried hard to convince myself that I was a grown woman, where my parents were concerned I still felt as if I was a little girl.

The STD did not even trigger alarm bells with regard to the possibility of contracting HIV. She said at the time information was still scarce though a few posters had started to appear in public clinics;

"The truth is, I still chose to believe the rumours that said AIDS was a disease for prostitutes who slept with long distance truck drivers who travelled to foreign countries. Taurai was not a truck driver and so I convinced myself that there wasn't anything to worry about".

She had first heard about a mysterious "syndrome" way back in 1986 when she was still in secondary school after accompanying a friend to the hospital to visit the friend's sister-in-law. Rumours started spreading about how the doctor was supposed to have told her not to take her home as it could be dangerous for everyone. When the woman died in hospital, it was also rumoured that the family had been advised not to allow the body to be viewed as this could endanger the viewers' lives. The next time she heard about AIDS was when in 1989 a cousin's husband who was a long distance truck driver supposedly died of the disease. His death simply fitted the bill.

In 1992 Maidei developed herpes which affected her right leg and was excruciatingly painful. Ironically this happened a few days after she had returned home from formally introducing Taurai to her family. Her father, during the visit, had taken her aside and advised her that if she felt this man she had brought home was the right one for her, it would be better for them to settle down because “there were dangerous diseases out there”.

Even after the doctor diagnosed herpes the thought of HIV still did not cross Maidei’s mind. When Taurai came to see her, they both went to the doctor who, though careful to emphasise that herpes could result from excessive stress, advised them to go for an HIV test. They chose not to. She said because at the time HIV was associated with excessive thinness, they decided to attribute the herpes to stress since her boyfriend had in fact been putting on weight. Besides, in no time she had responded to treatment and both the pain and the spots had completely vanished.

After Taurai returned to Mutare Maidei had a lengthy discussion with her friend Joyce who indicated she had a bad feeling about the latest development. They discussed the issue of being tested for HIV and both could not come up with a clear answer. Uppermost in Maidei’s mind was the fact that there was no cure. “If I go for the test and I am told that I am HIV positive, what will I do next? Wouldn’t that kill me faster than not knowing?” Her friend had no answer but could only suggest that she should go back to the doctor for further discussions. Besides, there were also rumours about the possibility of being wrongly diagnosed as being HIV positive when one was not.

4.6. Marriage

There was a cooling off of the relationship following the herpes incident. Maidei stopped taking birth control pills. In February of 1993 she decided to travel to Mutare to end it all and collect her belongings. At the same time she was haunted by the possibility of failing to find a man who would want to marry her, or worse still, ending up with one who was even worse than Taurai. She had invested over four years into this relationship and was a mere three

months from her 24th birthday. Maidei felt rather old and wanted children of her own. She started evaluating the positive characteristics of Taurai's personality and concluded that he was sweet-natured and never abusive. Above everything else, she loved him deeply and just could not contemplate life without him. His apartment was full of her photos and she felt very flattered but resolved not to be swayed from her mission. Taurai responded that he was not prepared to lose her and would do anything she asked. At this point the Maidei lamented;

I just don't know what can be done about the naivety of women. It was in fact my dumb decision not to use condoms. Taurai would have done anything I asked. Even though I knew that getting back together would be a big mistake, I chose to believe that he meant what he was saying. In retrospect I always laugh at how one woman accused me of stealing her man. She would phone and write me letters. Instead of taking that as an indication that this guy was no good, I felt rather special over the fact that he in fact used to tell these women about me and therefore I was his true love. Just how stupid can one get? It is as if you are possessed. I had travelled to Mutare to terminate the relationship and yet deep down I was hoping that he would beg me not to leave him.

The well rehearsed resolution fizzled into thin air and that night they made love like they had never done before. Two weeks later she found that she was pregnant. Taurai was thrilled while she was depressed. They got married a few months later and she moved to her organisation's Mutare office to be with her husband. After finding out that she was pregnant she started seriously getting concerned about the possibility of being HIV positive and passing on the virus to her unborn child. Her gynaecologist never raised the issue with her, or she with him. On the 8th of November 1993 her daughter Ruvimbo (pseudonym) - named after Taurai's mother - was born. She was a healthy baby and all worries about the possibility of being HIV positive disappeared as she settled into motherhood.

Their married life was uneventful. She describes Taurai as a loving husband who would spend hours on end playing with his daughter. Most importantly, he did not stop her from providing for her family – something she was really grateful for. They also took in her younger sister Tendai who had failed her ordinary level examinations.

4.7. The Nightmare

Towards the end of 1994 Taurai was diagnosed with Kaposi Sarcoma. Maidei had no idea that this type of cancer was normally associated with HIV but said the mere mentioning of the word cancer got her extremely worried because she knew that there was usually no cure for cancer. They moved to Harare where Taurai received chemotherapy once a month. It was then that one of the surgeons told them of the possible link between Kaposi Sarcoma and HIV and suggested they get tested. Maidei suspected that her husband may have already known this bit of information but had not shared it with her because back in Mutare he had mumbled about “how taking precautions could protect her” and when she asked him how cancer could be passed on to the next person he did not say anything further. In her words;

Though I should have known, really, given our history, I was not prepared for this piece of information. We told the doctor we would tell him of our decision. Not a single word was said all the way home. When we got home I was grateful that our daughter, after the initial excitement of seeing us got back to playing with a friend. My husband lay down and I simply gazed into the ceiling.

Two hours later they discussed the way forward. They opted not to go for the testing. There had virtually been no counselling and they just did not see how being tested would change their circumstances. It was not until they went to a doctor who also happened to a family friend that they received proper counselling and there was a comprehensive discussion of what they could realistically expect. She also advised them that, in case they were infected with HIV, it would be helpful for them to start using condoms in order to avoid re-infection. They opted not to go for the tests but took up the advice on condom use.

From then on Maidei said her husband’s days were filled with regrets. She tried hard to get him to dwell on the positive aspects of their life but that was all in vain. As his illness progressed however, they both drew comfort from the support, both financial and moral, that they received from Taurai’s sisters and his mother. His younger brother, who was still attending university in South

Africa, came home and promised his brother he would look after his niece in the event of his brother's death. In days to come Taurai would keep telling his wife to count on support from his family.

For her part, Maidei resolved that she was going to make her husband as comfortable as possible. She supported and loved him in every way possible;

Though I kept wishing things could have been different for us, and privately wept for what could have been, I resolved to be brave for my husband's sake and never shed a tear in his presence. Whenever he felt well enough, we would take a drive and talk about old times. Though I sometimes could do nothing about the physical pain, I could certainly do something about easing the pain in his heart. He was a kind and gentle soul and I do not believe he would have intentionally infected me. True, he had been promiscuous before we got married, given the infections he had passed on to me but when we married he had been supportive of my family. I never had to experience the horror of having my income taken away from me, a story often told by many women known to me.

Taurai died on 7 March 1996 – a few weeks before his 30th birthday and Maidei herself was two months away from her 27th birthday.

4.8. Dealing with Her Husband's Illness and Subsequent Death

Maidei said the burden of dealing with her husband's illness was made lighter by the deep love and support demonstrated by her husband's family. The other thing that touched her was her husband's appreciation of her love and support which he kept saying he did not deserve. "It was as if he expected abandonment", she said. Her husband, though humorous in a quiet way, had always been a man of few words and Maidei believes that his acknowledgement must have taken a lot of courage.

Being at work was proving to be stressful. Rumours of the possible cause of her husband's illness started flying around the office. There were times when she truly dreaded going to work because her colleagues seemed uncomfortable around her.

She had this to say about her husband's death;

Taurai's death brought indescribable pain. For some time I was in a state of disbelief. I was numb but there were lots of people around me who were crying. When reality suddenly hit me I started to cry uncontrollably. My mother-in-law walked towards me, embraced me and assured me that the family would not abandon me. She, though she was evidently in great pain over the loss of her son and also needed to be comforted, chose to comfort me instead. She told me I had become her daughter the moment I had joined her family and would continue to be treated as such.

Maidei said she could never adequately describe how her mother-in-law's words made her feel. She was miserable but felt safe. Taurai's siblings stepped in to organise his funeral, and mercifully, she was given the chance to mourn her loss without having to worry about funeral arrangements. They buried him at his parents' home near Nyanga.

4.9. Life after Taurai's Death

After her husband's death Maidei felt bitter towards God;

What is it that I did wrong? As a child I was well behaved. As was expected of me I found a man and got married. After one child and a few years together my husband dies. Is there something that I did wrong to God that he is punishing me for? I critically evaluated myself as a person, as a sibling, as a daughter, as an in-law and as a colleague and a friend. I had always assisted my family, to the extent that I could, ever since I started working. I had always tried to be a good person. Why did this happen to me?

She stopped going to church completely. Both her mother-in-law and her own mother, and her colleagues and friends tried to persuade her to commit her life to God. She stubbornly refused.

As the pain of losing her husband waned, Maidei started to take stock of her life. "It dawned on me that I did have a lot to be grateful for." She thought about her mother-in-law who had always been an inspiration to her and had experienced the pain of losing her husband and three adult children, yet her faith in God had never wavered. Maidei tried to imagine the pain of losing one's children. Looking at her own daughter Ruvimbo, she could only imagine just how unbearable it had to be. While she had lost a husband, her mother-in-law had, in addition to a husband, lost children whom she had expected to bury

her, not the other way round. Yes, God had still taken away the children of this kind and extremely generous woman. She realised there was nothing special about her own sorrow.

She started to feel a little bit more positive about life and was grateful for her husband's family and the support they continued to give her. To this day the support has continued and Taurai's younger brother has kept his promise of looking after his niece. He pays her school fees, medical expenses and buys school uniforms while other family members chip in with money for Maidei's medication.

A few months following Taurai's death, Maidei started thinking about how she too could die and leave her daughter orphaned. Following a discussion with one of Taurai's sisters, she had taken a decision to go for an HIV test whose results were, not surprisingly, positive. She knew that her husband's family cared deeply and that in the event of her death, her daughter would be adequately provided for. She wrote to her brother Peter seeking assurance that in the event of her death he would play his role as Ruvimbo's uncle. She wanted her daughter to also have a connection to her mother's side of the family. He wrote back and promised he would always be there for his niece. That warmed her heart and to date she has kept the letter.

At work tongues were still wagging over the possible cause of her husband's death. "Though I pretended not to be bothered by it, deep down it was very painful to know that each time I left the office my colleagues would be gossiping about me," she commented. There was a time when she had become susceptible to all sorts of opportunistic infections such as a persistent soar throat and chest infections and missed work intermittently. She did not confide in any of her work mates but evidently they had reached their own conclusions. Her manager, without seeking to invade her privacy, assured her of his support. Nine years later they are still working together. The organisation has changed in many respects, quite a few of her colleagues have been lost to the epidemic and Maidei has still not disclosed her HIV status to her boss. She has not

disclosed her HIV status to her natal family either because she shudders to think what that knowledge could do to them, given their dependence on her:

I have thought about it countless times. I get torn between disclosing and merely leaving things the way they are. Deep down inside me I know telling the family would be the right thing to do. The problem is I would not know how to deal with the effects of that kind of information on my parents. My father would just die, Abbie.

4.10. Widowhood – a Life of Celibacy

A year after Taurai's death there was a ceremony to unveil his tombstone. Her husband's family told her that she was at liberty to maintain links with the family or simply go her own way. They advised her that she needed not feel constrained if she wanted to start a new life. It was made clear to her that choosing to go her own way would not mean that the family would abandon Ruvimbo. She chose to stay within the family and to symbolise the act that she was still their "wife", she handed over a bowl of water to Taurai's eldest sister. She then chose a life of celibacy because starting a relationship would mean either having to lie about her HIV status or disclosing it at the risk of inviting ridicule and abandonment. She posed a question, "Who would knowingly sleep with an HIV positive woman?"

From the proceeds of her husband's insurance policies she was able to buy a residential stand in one of Harare's low density areas. The intention was to build a house. Sadly the economic meltdown has rendered that dream impossible to fulfil, though she has so far managed to hold on to the stand. She now talks about it as possibly the only thing of value that will be inherited by her daughter when she passes on.

4.11. Living with an HIV Positive Status – When You Know You Have It

Maidei had this to say upon being told about her status;

There is a big difference between living under suspicion that you have the virus and actually knowing that you have it. Once your HIV positive result is

confirmed, you can no longer lie to yourself about the possibility of being HIV negative. When I catch a cold, I become all too aware that it could kill me. While the doctor did all he could to assure me that the result did not mean that death was imminent, I felt as if it was. I remember looking at the doctor and wondering if he had any idea whatsoever as to what it meant to be told that one had a virus for which there was no cure. I started to wonder if I was going to live long enough to see my daughter start school. She had not even turned 3.

Upon leaving the doctors' rooms, she wandered around for a while, not sure which direction to take. She sat down for a while, trying to take it all in. An hour later she asked her sister-in-law to meet her, and as always, she proved to be a pillar of strength. She then resolved to try and live for as long as the virus would allow her and started following the diet that the doctor had suggested.

She analysed her family's situation. Three of her youngest siblings were still wholly dependent on her while her brother Peter still did not help out. Her sister Tendai who failed to secure an ordinary level certificate a few years back, was working as an assistant at a boutique owned by Maidei's sister in law. "I then realised I just had to try with every means possible to fight this thing".

At the office she was increasingly feeling uncomfortable around her workmates. She seriously considered looking for another job. The papers were full of job advertisements for people with her qualifications. A closer analysis of her situation made her realise that joining a new organisation would not necessarily be in her interest. Would a new organisation be tolerant of her intermittent absences from work? She had invested in her current organisation by working hard and to an extent she was indispensable. Each time she missed work it was always understood that she would more than make up for it when she got better;

I could not imagine a new organisation being just as accommodating since I would not have the benefit of a history of dedication, thoroughness and loyalty. I couldn't help laughing to myself when I pictured the possibility of failing to report for duty on the second day of employment. What then? I therefore decided to stick around and with time people stopped talking. A few years down the line the talk became that maybe my husband had indeed

died of cancer. Basking in the comfort of the support that I was getting from my in-laws, and my family, time ticked away.

However, now and again I cannot help wondering why this happened. I think about what could have been and all the things that my husband and I planned to do. I think about how my HIV status has limited my horizons – how it has made me afraid of venturing outside this organisation and making new friends. I see what other young people who were not even half as talented as Taurai have done with their lives. Above all, I think of the day that my daughter will be orphaned and my heart bleeds.

Maidei worries more about her father than she does about her mother because she believes he would be more affected by her death than her mother. He often reminds her siblings that they owe her so much and that should she be in a position to need their assistance they should rise to the occasion.

4.12. Antiretrovirals (ARVs)

When her HIV positive results came out the doctor told her about antiretrovirals and how quite a number of people in the country had started taking them. However, the prices were way beyond her reach – they would have cost three quarters of her salary every month. She changed her diet and took vitamin supplements. Between then and the year 2000 she did experience bouts of illness but none were serious enough to warrant hospitalisation except once in 1998 when she had meningitis. This was successfully treated. She only started taking ARVs in 2000 when they were still unaffordable. Her in-laws made financial contributions. Apart from an occasional headache and a cold here and there, she has experienced good health. At the moment her biggest concern is that, although ARVs are being manufactured locally and the prices have fallen to a level that she can afford, the prices have been increasing at a rate which has not been matched by increases in her own salary due to the continuous loss in the value of the local currency.

4.13. Tragedy in Her Natal Family

Mention was made earlier on in the discussion of Maidei's brother Peter to whom she wrote a letter seeking assurance that he would keep contact with her daughter in the event of her death. When her brother started working their father had made an appeal to Maidei to warn him against a lifestyle of having

too many sexual partners which he had become infamous for in his home town of Triangle. Maidei travelled to Triangle and they had a lengthy discussion about the dangers of contracting HIV. He assured her he was being careful.

Tired of what he termed his father's non-stop interference Peter took a job elsewhere. For 2 years it was as if he had disappeared from the face of the earth until a friend of his told his father that he was not well. Maidei went to see him and found him in such a bad state that she took him to Harare for treatment;

The moment I set my eyes upon him I had this sinking feeling in my heart. It was like re-living my experience with Taurai. My brother had already developed full blown AIDS. I had no doubt in my mind that tragedy was about to strike once more in my family. I persuaded my brother to go for an HIV test and my worst fears were confirmed. Two months later, in December of 1999, he died. Like I had done in the case of my husband before him, all I could do was to try and make his last days comfortable.

Her brother's death was distressing and she kept asking herself, "why is my family so unlucky?" The discovery that her daughter was the only beneficiary of all three of her brother's insurance policies touched her deeply and made the pain of losing her brother much more unbearable. As children Maidei and Peter had been close. When he dropped out of school she had been the one to persuade him to go back and she paid the fees. "I guess it was his way of showing his appreciation", she said. It was too painful to discuss with the younger sisters with whom she shared her home and the thought of talking about it with her parents was a non-starter. She never even considered opening up to her best friend, fearful of what her reaction would be and instead, confided in her sister-in-law.

Fearful that the same fate would befall her sisters, Maidei became obsessed with trying to protect them. The subject of AIDS became topical in her home. Her sisters were ardent church goers. In desperation she kept telling them that even men who go to church and pray everyday could still give them the virus. In May 2005, to her dismay, Maidei was to find that the almost daily discussions about HIV/AIDS were not enough to protect her sisters.

4.14. Tendai

In 1999 Maidei's sister-in-law, her sister Tendai's employer left the country. With jobs hard to come by she ventured out of Harare and for a while worked in the town of Kadoma 140 kilometres South of Harare. When Maidei visited her she was absolutely horrified by the conditions under which her sister lived. She initially resorted to subsidising her income but upon realising that that was not a sustainable solution, she persuaded her to come back to Harare. In an attempt to reduce her dependence on her sister, Tendai resorted to cross border trading. It is worth mentioning that because of their having lived together since Tendai left school in 1993, the two sisters had become very close and she had become her daughter's closest aunt. Maidei's family joke about how Tendai is in fact Ruvimbo's "real" mother because at her niece's school she is better known than Maidei herself.

When Tendai started showing signs of ill health Maidei attributed it to fatigue emanating from too much travelling. When the doctor suggested an HIV test it was Maidei who responded that it was not necessary. When it became obvious that her sister's condition was not getting better and she then persuaded her sister to go for the test, "even though I was convinced that the result would be negative". To her utter shock and dismay in May of 2005 the results revealed that her sister was HIV positive and her CD4 count had already plummeted to 28. Maidei never sought to know who had given her sister the virus as she had never been introduced to any man in her sister's life. Her sister is now on ARVs and her biggest worry is for how long she will be able to afford buying for both of them. The devastation, pain and despair that befell her were even worse than what she had experienced following her brother's death.

4.15. Trying to Deal with it All

In terms of her own status, outside of her in-laws she has only disclosed it to one person, her best friend Rudo (pseudonym). Even then, she only told Rudo 2 years ago and this disclosure was most likely prompted by the gap that was created when her confidant, Taurai's eldest sister, left the country in January of

2003. Furthermore, it was not until Tendai had been diagnosed with HIV that she openly discussed her own status with her. Her intention was to strengthen her sister's resolve to be positive about her condition. As she had done with her husband nine years back, she desperately tried to hide her own feelings of helplessness and despair as she sought to assure her sister that that was not the end of the world. She admitted;

Even as I sought to assure my sister that I would help her through it all, I said it without much conviction. There is no telling how long I myself will be around. I have been on ARVs for almost 5 years now and who knows when resistance will set in? What if the other levels of treatment fail to work in me?

She then discussed the issue with her sister Chiedza - the one who comes after Tendai, who is now married with two children and resides with her husband in Beit Bridge. Chiedza agreed to include Tendai as a dependent on her medical aid. This came as a relief to Maidei because it at least means that the treatment of opportunistic infections will be taken care of. Because she needed time off when her sister was taken ill, Maidei also ended up confiding in her boss concerning her sister's status, but not her own.

Perhaps one of the saddest things about this whole story is the way Maidei, having virtually taken the role of parent over her younger siblings, tends to blame herself for what happened to her sister;

I keep asking myself, is there something that I did that resulted in her going astray? Did she go astray or some man simply took advantage of her? What could I have done differently?

She once again found herself agonising over how to protect the remaining siblings. Rugare (pseudonym) is in the final year of an undergraduate degree programme at the University of Zimbabwe. David (pseudonym) dropped out after completing two years of a four year degree programme but has since gone back. To her friend Rudo she could only say;

Mine does seem to be a cursed family. Do you realise the painful road that I have travelled since my husband fell ill in 1994? It's like my whole family is

going to perish from this disease. Sometimes I wish I could just die and then all this pain will be over.

The debate that is raging in her mind is whether or not to tell her parents about Tendai's condition. But then, "what right do I have? What if she were to ask me why I did not disclose my own condition to them?"

4.16. Religion

Maidei's father is a Moslem, but did not force his wife to convert to Islam. Only Maidei's late brother Peter attended services at the mosque and was taught to recite verses from the Koran in Arabic. Her father was against the idea of his daughters becoming Moslems because of the teachings that did not encourage education for girls. Maidei remembers how, as soon as they started menstruating the Moslem girls of her community would go on a month long rite of passage programme where it was rumoured they were taught the art of being good wives and mothers and pleasing their men sexually. Her father objected to the fact that many of the girls would be married off soon after their return even though some would barely be 12 years old. Maidei and her sisters attended their mother's Wesleyan Methodist church.

Earlier in the discussion mention was made of the fact that once she had dealt with her bitterness over the loss of her husband, Maidei started going to church regularly. She rejoined the Methodist Church. For a while she simply attended church services without participating in any of the other activities. All that changed when she struck a friendship with a middle-aged member of the church who, following one of their numerous friendly chats, persuaded her to get more involved as she believed she had a lot to offer. She is now a full member of the women's Ruwadzano (fellowship) movement. Members support each other in times of need such as bereavement and sickness. She sings in the choir and is also involved in women's discussion groups around such topics as marriage and HIV/AIDS, the life of a Christian, dealing with conflict and many other topical issues. She had this to say about her church in relation to HIV/AIDS;

If there is one institution which has a problem talking about HIV/AIDS it is the church because everyone tends to pretend to be a moralist and wanting to associate the disease with "sinners", people who do not know God. It is frightening how women still pretend to be safe from infection because they are married, even when their friends and colleagues are dying of AIDS around them.

As members of Ruwadzano they often visit fellow worshippers who either get hospitalised or are tended from home. They conduct prayer sessions and organise fruit baskets and flowers. Maidei has observed that invariably, each visit is followed with gossip especially if the nature of the illness is suspected to be HIV related. There is usually unbridled condemnation by some over the lifestyle that led to the infection. Maidei commented, "The amount of blame and scorn heaped on the individual is frightening".

Asked if she has done anything to try and change this perception she answered in the affirmative and said since she got involved in the HIV/AIDS prevention programmes in the church she has sought literature that is meant to demystify the disease. She said, following a decree issued by the Church headquarters some two years ago, attempts have been made to be open about HIV/AIDS. Though progress has been made in terms of changing attitudes, it has been slow. There are many instances where HIV positive church members bar visits by their colleagues due to the deep sense of shame that is still associated with the disease.

She has been raising a lot of challenging questions during discussions with her fellow women, in an attempt to make them realise just how vulnerable they all are but significantly, she has not disclosed her own HIV status. She still fears being treated like a leper, given the manner in which the disease is still stigmatised by her church. She lamented how it appears nothing has been learnt over the past two decades.

4.17. Conclusion

Many themes arise from Maidei's story – sex as a taboo subject, the stigma, denial and fear still associated with HIV/AIDS, the importance of counselling and support, and how poverty could have made her sister Tendai vulnerable. Lack of adequate information also led to myths surrounding the meaning of HIV while condom use is also stigmatised as it is associated with women of loose morals. Of significance is how, as was the case with my colleagues Tsitsi and Cynthia, Maidei's financial independence which is clearly demonstrated in the central role she plays in her natal family, did not result in her taking a decision-making role in sexual matters. In addition, the deep love that Maidei felt for Taurai clouded her thinking. She was torn between ridding herself of a man who had infected her with STDs while at the same time she felt that her own life would be empty without him. It is this theme of Maidei's own vulnerability which will be developed in the next chapter.

I was particularly struck by how advanced Maidei's father was in terms of the equal treatment that he gave to his children irrespective of sex. Her in laws are also quite unique in an environment where HIV/AIDS widows are often blamed for the death of their spouses and have all matrimonial property impounded as noted in chapter two.

CHAPTER 5: DISCUSSION

In the previous chapter I concluded that Maidei's vulnerability to HIV infection, while attributable to factors that included lack of adequate information also had a lot to do with the deep passion she felt for the man who infected her. In this chapter I will pick up the themes that arose from her narration and interrogate them further. Attention will be focused on the issues of stigma and denial, how Maidei understands her identity as a Zimbabwean woman, how it affected her relationship with significant others in her life and how it rendered her vulnerable to HIV infection.

In Maidei we have a woman who managed to attain financial independence and in terms of her positioning within her natal family, is a matriarch of note. Her vulnerability to HIV infection does not have anything to do with poverty, indulging in sex at an early age with older men, or being coerced into it. She received a good education and grew up in a family filled with love and support. Though she did not initiate it, her sexual debut was at age 21 with a man only three years her senior who discussed it with her before they did it. She even decided on the mode of birth control. Maidei is therefore very different from the stereotypical "AIDS victim" who is typically mired in poverty and often gets coerced into sex. She is powerful, economically independent and involved in a loving relationship based on mutual respect.

Maidei was born in racially segregated intensely patriarchal Zimbabwe and by the time she was 10 she was already acutely aware of her gender based disadvantaged position. At that time her uncle (her mother's brother) who was studying in Britain sent her gifts in the form of a doll and some clothes. She then said to her mother, "I wish I was a man. Because then I would be able to buy everyone clothes when I grow up." It is obvious that even though Maidei was, at that tender age, unlikely to be in a position to understand the basis for gender inequality in her society, she already knew that being a girl, she would be expected to marry one day and her priority would be the family she was

going to marry into. Judging by what she observed around her, she felt getting married and becoming a member of another family meant she would not be in a position to provide financial support to her natal family, hence her wishing she was a man at age ten. Fortunately for her, her husband did not stop her from assisting her family.

Two and a half decades since wishing she was a man, Maidei has done a lot more for her family than the uncle she envied ever did for his. The moment she started working power relations within her family shifted, with her becoming the key decision-maker, taking all five of her younger siblings under her wing. At the time, the youngest of the siblings was 5 and she is now in her final year of an undergraduate degree programme. Her father's tailoring business started faltering in the mid-eighties when higher incomes following independence resulted in the erosion of his customer base as it could afford to buy from the low cost clothing shops which mushroomed after independence. Maidei now wields enormous power in her natal family. She:

- Feeds, nourishes and provides shelter to her daughter and younger siblings.
- Decides on matters of schooling and career.
- When her late younger brother dropped out of school she brought him back on track.
- When the same brother got sick she nursed him till he passed on.
- When her younger sister Tendai was diagnosed with HIV she decided what was to be done, who should be informed and who should not.
- When her parents separated she brought them back together.

As an individual she worked hard to escape the poverty that beset many women. Inspired by her uncle who used to buy her clothes when she was a young girl, she was determined to work hard at school even though she thought that being a woman would prevent her from assisting her family after getting married. She acted as an individual to propel herself to the top of her

organisation. Yet her story shows that, however much one feels in control of one's life, it is impossible to escape the social forces that shape one's life. For example, Maidei's elder sister made sure that her younger sister understood and accepted that getting married and starting a family was important and that a man's infidelity was not sufficient reason for terminating a relationship.

Interestingly, when Maidei realised she was in a position to continue to assist her family even after she got married, she attributes it to the kindness of her husband and not to the fact that, as was the case with Taurai, she too had the right to spend her income as she saw fit. "Neither my sister nor any of my friends were allowed control over their own finances. I guess I was just lucky. Most of the women I have worked with say they only help their families secretly," she said.

5.1. The Early Meanings of HIV/AIDS in Zimbabwe

Maidei was 16 years old when the first case of HIV came to light in 1985. She graduated from high school the following year having never heard about HIV/AIDS, let alone being exposed to sexual matters and her own sexuality. In the absence of adequate information about the disease Zimbabweans came up with their own meanings and myths to explain this new disease which no one understood. Her knowledge of STDs was at best rudimentary. The little she knew had been picked up during her high school years when she attended voluntary lectures delivered by medical practitioners from the nearby Triangle Hospital, and from her illiterate prostitute friend referred to in Chapter 4, for whom she used to write letters. Condoms were stigmatised by being associated with prostitutes to the extent that she did not even want to consider them as a form of birth control when she started having sex.

When Maidei was in the final year of high school she accompanied a friend to hospital to visit the friend's sister-in-law who had been plagued by a mysterious "syndrome". Maidei recalls seeing a woman who was "all bone" being spoon fed by a relative. It was during their walk from the hospital that the friend talked about what her brother had told her about his wife's sickness

– that some “syndrome” had inflicted her. When the woman died, it was rumoured that she had been buried without allowing body viewing because the “syndrome” was so virulent that it could jump from the coffin.

A year after her move to Harare Maidei started hearing more and more about AIDS. It was, however, being referred to as a foreign disease that was being brought into the country by truck drivers from Zambia and Malawi. When in 1989 Maidei’s cousin who was a truck driver died of AIDS, it reinforced the belief that it was confined to this group of people. Even then there was disagreement over cause of death as some maintained that there was no way his death could be linked to AIDS since he was not a “ngotshani” (vernacular for homosexual). There was also the school of thought that this new disease was in fact nothing new. At the time it was being witnessed more among men than women²⁴, some said it was a disease called “runyoka” which resulted from a magical spell cast on men who had affairs with married women. Furthermore, a large proportion of the Zimbabwean population attributed the few cases of AIDS that were being witnessed to witchcraft. Yet others, especially the youth, talked about HIV as America’s attempt to discourage sex so that Africans would not have too many children.

The government’s silence on the matter coupled with instances of outright assurances that there was no need for people to worry, did not help matters. Maidei remembers that it was not until the early nineties that messages about the dangers of HIV started to appear on television and radio and posters carrying HIV/AIDS messages started appearing in public places. Thus, when she contracted an STD from her boyfriend the thought of HIV never even crossed her mind. Apart from being genuinely ignorant about the disease, “my boyfriend was, after all, not a truck driver”, said Maidei with laughter. Thus, to an extent Maidei’s vulnerability was a result of ignorance and stigma.

²⁴ Even then, the numbers were so small that many people argued that the disease was a figment of some other people’s imagination since they had never seen anyone suffering from it.

5.2. Challenging the Stereotypic Notions of African Sexuality

To a very large extent Maidei's story challenges Western notions about African Sexuality. In a 1994 US-based study of the social construction of black female sexuality Marshall found that whites tended to stereotype black female sexuality as evil, animalistic, diseased and lascivious. Drawing parallels with colonial Africa, Marshall notes how the icon of the sexually denigrated black female effectively legitimated the maximum exploitation of her reproductive labour and exonerated white men who abused her from guilt.

Stillwaggon (2003) believes that the preoccupation of westerners with African sexuality negatively impacted on the early efforts to research into the social context of AIDS on the African Continent thereby hampering prevention activities. There is a preference for the image of a "hypersexualised pan-African culture" while standard epidemiological cofactors (malnutrition, parasite load, inadequate health care and more) that influence disease transmission tend to be overlooked (p 811).

Cameron (2005), in a view similar to that of Stillwaggon, suggests that the highly distinctive form of AIDS denialism in Africa is rooted in the colonial "long and shameful history of salacious preoccupation with black sexual behaviour". Referring to the Sara Baartman saga,²⁵ Cameron goes on to say western violations of Africans and their culture have been "entirely lacking in subtlety" (p 97). Western stereotyping of black sexuality and sexual conduct has continued to this day and partly explains why any analysis of differential disease patterns in HIV/AIDS along racial lines easily becomes emotive. Cameron adds that the western conventional approach to HIV entails a damning judgment on Africans sexual behaviour, which leads them to adopt a

²⁵ Sara Baartman's story is a tearful and moving one. She was a Khoi Khoi woman who at age 20, in 1810, was taken from Cape Town to London where she was displayed naked in the streets and circuses for European audiences. Of particular interest were her protruding posterior and large genitals which in the view of European researchers symbolized savage black female sexuality. Following her death in France her sexual organs and brain were displayed in a museum in Paris till 1985. It was not until 2002 that Sara's remains were returned to her homeland for a decent burial.

defensive attitude which is detrimental to the fight against the epidemic. Indeed, as discussed at the beginning of Chapter 3, Maidei became very emotional as she recalled reading an article in an Irish newspaper which attributed the spread of HIV in Kenya to abnormally high levels of sexual activity among Africans. She herself had only one sexual partner all her life and yet she got infected with HIV.

5.3. Other Sources of Vulnerability – Images of Zimbabwean Women

In Chapter 2 under “behavioural theories” it was pointed out that individuals are influenced by the social environment in which they are born, grow and live and that the factors that influence one’s behaviour include societal value systems and family value systems. For example, Maidei shunned use of condoms which could have prevented both infection and pregnancy because the societal value system associated condom use with prostitution.

Following the herpes incident Maidei was convinced that it was in her interest to terminate her relationship with Taurai. She however confesses to having secretly hoped that Taurai would beg her to stay. Apart from the deep love she felt for him, she was haunted with the possibility of failing to secure a man to marry her. Having been nurtured to be that way, she had a strong desire to have children but believed that having them outside marriage would shame her parents. She recalled how when her elder sister got pregnant at the tender age of 15 their mother pushed for marriage because single motherhood would have shamed the family.

In an attempt to establish whether or not Maidei could be viewed as a unique woman, I looked at the portrayal of women in Zimbabwean literature. Literature is important because it mirrors and interprets women’s images from the point of view both of those who write about them and of the society from which they draw inspiration. Andre Brink (1996) argues that literature relies on narrative discursive structure and adds to symbolic field of national identity and has qualities that make it instrumental in support of hegemonic versions of national identity as well as in opposition to them. In this regard, one of

Zimbabwe's prominent sociologists Professor Gaidzanwa reviewed literature authored by black Zimbabweans between 1963 and 1985.

Not surprisingly, Gaidzanwa found that the dominant themes of what gives meaning to women's lives are marriage, which involves payment of lobola, motherhood and unwavering faithfulness to one's husband irrespective of circumstances. The ideal wife is one who sticks around to look after her children and husband irrespective of how she is treated by the husband and his family because in the end she earns accolades for not buckling under pressure. In one example, Tsitsi abandons her education to marry Matamba who later abandons her even though they have had three children together. Tsitsi stays with her in-laws and struggles to look after her children. She turns down many suitors who take an interest in her because her paternal aunt tells her "in our paternal clan no woman cooks for two husbands while the first husband is still alive" implying that no woman in their family remarries unless she has been widowed. Years later Matamba is abandoned by the town wife who runs away with all his property and is blinded by thugs set upon him by the wife. Left destitute, Matamba goes to the rural home where Tsitsi welcomes him with open arms and she declares her "shame erased" and her children have "a socially recognised and physically present father." It is astounding that Tsitsi even says her husband did not do much wrong, because those are the ways of men. (Gaidzanwa: 1985). In similar vein, Maidei's mother felt that her shame had been erased when the man who impregnated Maidei's elder sister at aged fifteen agreed to marry her. Maidei also alludes to the desire not to shame her parents by not getting married.

The theme of forgiving one's husband also runs in the veins of Maidei's story. She does not express bitterness for being infected with STIs and HIV but is determined to ensure that her husband's last days are comfortable. The fact that he was unfaithful has not tainted Maidei's view of him as a loving husband and father. This by no means implies that Zimbabwean women are unique in this regard as it is common in both developing and developed

countries for men to leave their wives only to return in order to be cared for in their last days.

The images of divorced and single women in Zimbabwe are not flattering as they are viewed with suspicion because they are seen as likely to “take away other women’s husbands”. Though they are portrayed as an empowered lot, that characteristic is not viewed in a positive light. Divorced women are considered failures while their mothers are also viewed in that light for their inability to instil good values in their daughters. Gaidzanwa argues that these images fit in with societal expectations, and “even women who have an income of their own do not consider their situation as legitimate and fulfilling as long as they are single. They still continue to define their lives in terms of whether or not they have been able to marry a man and keep him” (1985:53). Maidei fits squarely into this group as evidenced by her reluctance to let go of Taurai lest she failed to find a marriage partner.

The image of a single and divorced woman as an empowered group in sexual relationships is borne out by the life story of a woman of Maidei’s age – 37 year old Lillian Mboyi (Mboyi, 2005), also of a middle class background. Though Lillian does not relate her sexual experience during marriage, after her divorce she openly discusses her sexual needs and desires and is not ashamed to take the upper hand in a sexual relationship. Her story serves to illustrate two key issues. Firstly, the irrational behaviour that often accompanies passionate sexual acts even by individuals who should know better. Secondly, it shows that women, as discussed before, are by no means a homogenous group. While Maidei settled for a life of celibacy due to her HIV status, Lillian has not shied away from male companionship. Thus, the issue of irrational behaviour when overcome with love and passion is once again brought to the fore. The issues of love and desire need a great deal more research.

In the case of Zimbabwean literary works, it is female authors who create images of women which reflect the view that while society heaps praises on women who sacrifice their own happiness for the sake of their children and

husbands, women are far from happy. In one of Zimbabwe's world renowned literary works, "Nervous Conditions", the women complain about the heavy responsibilities that they have to carry. One of them laments, "This business of womanhood is a heavy burden...and these days it is worse, with the poverty of blackness on one side and the weight of womanhood on the other" (Dangarembwa, 1988:16). One can draw parallels with Maidei's self conscious act of linking race and gender as interlocking systems of the exploitation of women. Her refusal to be interviewed by white researchers within a relationship that she viewed as exploitative seems like a desire to be free of colonial relations. At the same time, in what appears to be a contradiction, when her sister advised her to forgive and get back with her boyfriend after he had infected her with an STD, she did not question the logic of it. The issue was further complicated by the love she felt for him.

To an extent Maidei does confirm the point raised by Mpofu, Gaidzanwa and Armstrong about lobola being a source of women's oppression. She jokes about the kind of sex games that she would have loved to have her husband play if she had been the one to pay lobola. She is in fact conveying the message that she felt constrained to play the role of a minor because her husband had paid lobola and expressing her sexual desires would have been inappropriate. Admittedly, in most cultures, it is men who take an upper hand in sexual matters and only a few women have the confidence to express their needs and desires. However, without the benefit of knowing how Maidei would have behaved if Taurai had not paid lobola for her, it is important to point out that she specifically felt constrained by it.

Another worthy example in the portrayal of Zimbabwean women can be drawn from the comments that were made through the media following the appointment of Joyce Mujuru as Zimbabwe's first woman Vice President in December 2004. The Zimbabwean media, which has a 100 percent male ownership, has always played a critical role in entrenching patriarchy through the manner in which it tends to give prominence to masculine views. The few examples of newspaper based comments confirmed that the various

stakeholders do not in fact consider Mrs. Mujuru as carrying a separate identity from her prominent husband, Solomon Mujuru²⁶. A few examples are as follows;

“It is difficult to separate Mrs Mujuru’s ascendancy to the Vice Presidency from her husband’s powerful influence within the ruling party”, said Eldred Masunungure, a respected political commentator (Reuters, 6 December 2004).

One newspaper columnist, Grace Kwinje said, “Yes, we are going to have the traditional women empowerment talk, sewing machines in this and that project, the usual ululations and dances. That is Mujuru’s mandate to be mother, with Mugabe as the domineering father, and Solomon the all powerful husband” (newzimbabwe:2005.)

Gugulethu Moyo of the Daily News Online remarked, “In many ways she is what some might call ‘one of the boys’. If there are any women out there who sincerely believe that Mujuru will campaign vigorously for a Zanu P.F or government shift in gender matters, then we urge them to read the small print. She is really just a team player who has never caused waves in the party.” (November 2004)

Yet others like Mavis Makuni of the Financial Gazette (2004) appealed to Mrs. Mujuru’s maternal instincts and hoped she would, as a mother who herself had experienced the pain of giving birth and therefore can relate to the pain of losing one’s children, help stop the senseless political violence often blamed on her party’s activists.

A male colleague, Didymas Mutasa had this to say, “The so called feminists should learn from Mrs. Mujuru. She is a respected wife and mother of six children who understands that her place is besides her husband. She could

²⁶ Solomon Mujuru was one of the commanders of the ruling party’s liberation guerilla army, ZANLA. At independence he became the first black general of Zimbabwe’s armed forces. Now retired, he wields enormous influence within both the army and the ruling party circles.

become Zimbabwe's first woman President while some of you are busy fighting a losing battle with men" (The Herald: 6 December 2004).

All these comments tend to lend credence to Tamale's views when she points out that traditional African wisdom teaches that what happens in the home is a private matter not for public discussion but in reality women's identities as the subordinate sector in the home follows them into the public sphere. She goes further to say;

Domesticity as an ideology is historically and culturally constructed and is closely linked to patriarchy, gender power relations and the artificial private/public distinction. The way patriarchy defines women is such that their full and wholesale existence depends on getting married, producing children and caring for her family...The domestic roles of mother, wife and home maker become key constructions of women's identity in Africa....While patriarchy defines women in terms of domesticity, it simultaneously draws an artificial line to separate the domestic (private) arena from the public one. Thus, women depend on their men to access the public...Any woman who wishes to transcend this sphere is forced to meet the male/masculine standards required in the public world (2002:3).

Tamale believes that in Africa it does not matter "whether a woman is a successful politician, possesses three PhDs and runs the most successful business in town," her identity is considered as incomplete in some fundamental way unless she is married, and has children. This designation becomes her hallmark even outside the home. Seibert and Roslaniec (1998) also weigh in; "as a result of social emphasis on the role of women as care givers, women find it difficult to gain full autonomy...Feminism has not yet liberated women from the domination of social expectations." It however has to be pointed out that this scenario is not peculiar to African women only.

One can draw similarities with Maidei. As she laments the loss of her husband, she feels life has given her a raw deal even though, as was expected of her, she had gotten married, started a family and adhered to the biblical commandment of loving and obeying her parents and basically just being what could be considered a model woman. As a well educated economically empowered woman, she still felt hollow without a husband and children. Her quest to be a respected wife and mother became a higher priority than protecting herself

from infection. Maidei admits that when she visited Mutare with the intention of terminating her relationship with Taurai, she secretly hoped he would not let her go. The possibility of not being able to find a man to marry her was at the back of her mind. Losing her husband left her feeling short-changed when she should have been rewarded for behaving “as expected”, that is, finding a man and getting married. Even Vice Presidents, as has been illustrated in the case of Mujuru, cannot escape social expectations. When Vice President Mujuru’s male colleague quoted previously sings her praises, he underscores how the vice presidency would have been hollow without her being a wife and a mother.

5.4. Issues of Sexuality

The issue of sex as taboo is underscored in Maidei’s narration. It was not talked about either at home or at school. She was therefore ashamed to express the desire to have sex and even the possibility of her parents finding out that she was on birth control scared her. The first time she had to confront it she was already 21 when her then boyfriend raised it. She also confesses that she would have been ashamed to have to initiate the sexual act with her husband. The sister’s symbolic act of giving her a soft cloth with which to clean her husband’s penis after sex emphasises her subservient role. She was also told that a good wife does not turn down her husband’s sexual advances (again an issue not necessarily unique to the Zimbabwean situation). It is such notions of gender roles that contribute to the endangering of women’s lives in the era of HIV/AIDS.

5.5. The Effects of the Economy

Maidei has vivid memories, at independence in 1980, of being sent to the store accompanied by her younger brother Peter. From a dollar they would bring home 3 loaves of bread which cost a total of 45 cents, a litre of milk which cost 15 cents and meat for the evening meal. A Zimbabwean dollar was worth US\$2. When she started working in 1989 she bought clothes for all members of her family from a single pay cheque. Currently one needs 90 000 Zimbabwean dollars to purchase a US dollar and a loaf of bread costs 40 000.

Maidei commented;

The economic situation is just changing everyday and this negatively affects my standard of living. For example, in January 2001 my rent was \$7000. By January 2005 it was \$600 000. Now (meaning at the time of the interview in August 2005) it is \$2 million. In January one could get a pair of shoes for \$250 000, now one needs between 2 and 3 million dollars. Now one concentrates on basic commodities. Clothing has become a luxury. I now spend 40 percent of my income on medication. The percentage goes up every month because the price of ARVs changes every month. I worry about the possibility of waking up one day and not being able to afford ARVs for myself and my sister, what will I do then?...I sometimes wish I had cheated my way into marrying a rich old man!

The last statement in the quote is particularly poignant. For the first time Maidei is beginning to wish she had married for economic reasons. The thought of losing her financial independence scares her. Ten years after the death of her husband, she is concerned about the possibility of ending up in a relationship because of financial need. As pointed out by Cohen (2003), the relationship between poverty and HIV/AIDS is far from simple because it has to be understood within the context of complex socio-economic processes at work within African societies. Maidei's concerns, however, do bring the issue of poverty as a source of vulnerability to the fore. She is not poor and thus far her capacity to cope with her medical condition has been dependent upon her considerable financial assets. She is well nourished and can afford the high fees for her membership to a premier medical insurance facility. Her situation can be contrasted with that of those who are HIV positive and poor hence unable to cope with the effects of HIV/AIDS. However, as the country continues on its economic downward spiral, her financial resources are getting diminished with each coming day due to inflation. If this trend continues, she could find herself unable to afford the life style that has so far cushioned her from the devastating effects of HIV/AIDS.

5.6. Conclusion

It is evident from this discussion that Maidei's desire to reflect the kind of image expected by family and society at large had a hand in the formulation of her identity. She had a strong desire to marry and have children and felt

cheated when her husband died and left her with only one child. Her strength of character as the key decision-maker in her natal family and the fact that she is a towering figure at her workplace is totally mismatched with the subservient role in sex which she was seemingly comfortable with initially as Taurai's girl friend and later as his wife.

Clearly, Maidei's story is that of one woman and her story may be unique, (though Lillian Mboyi's story referred to earlier suggests not). Apart from demonstrating that love and passion play a role in decisions about safe sex, it is a story of desire to fulfil one's feminine role as schooled by society - marry and have children.

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CHAPTER 6: CONCLUSION

The rapid spread of HIV/AIDS at a much higher rate among women than men in Zimbabwe and Southern Africa as a whole has been linked to the feminisation of poverty and power imbalances between men and women which renders it almost impossible for the subordinate sector (women) to practise safe sex. Through a life story of a financially independent, middle class woman, who had only slept with one man – the man she married – and whose sexual debut was age 21, I have demonstrated that poverty alleviation among women is not enough in the fight against HIV. Love, passion and desire, in addition to her subservience to her boyfriend and future husband, rendered her vulnerable to infection.

Maidei was in a relationship with a man who never coerced her into sex without her consent and who gave her leeway in terms of selecting the birth control method she was comfortable with. The choices that she made, which resulted in her being infected, were a result of both her deep love for Taurai and her own understanding of her identity as a woman and what was expected of her by her family in particular and society in general. She herself questions the rationality of her decisions. She shunned condoms when they could have prevented infection but following the doctor's advice she and her husband resorted to using them to prevent re-infection. When taking stock of the circumstances leading to her infection she has wondered;

"I have, time and time again, questioned the logic of my unwillingness to use condoms when Taurai said I was free to choose the type of birth control method that I wanted. If you were to ask me who exactly told me that condoms were the preserve of prostitutes I would not even be in a position to tell you. I just took that as fact and chose to abide by it. Yet, when the doctor advised us to use condoms as a means of preventing re-infection, we did exactly that. How dumb is that?"

The thesis main findings are;

- The complexity of sexuality and relationships and their link to role expectations. This raises the question of the extent to which an individual has control over her actions particularly during the sexual act.
- Stigmatisation – nine years after testing HIV positive Maidei has remained a closet person living with HIV/AIDS.

The story underscores the role played by socialisation in Maidei's life and also the need for research into issues of women's sexuality. She herself, as she thinks aloud, attributes her predicament to the issue of irrationality when overcome by love and desire and simply ends up saying, "I don't know what can be done..." The question is how to get a woman to have control even when they are in love. Much more attention needs to be paid to issues of love, respect, and trust – issues that lie at the heart of our humanity.

The story also underscores the need to research into the social structures that oppress women and render them vulnerable even when they have escaped poverty. In its analysis of Zimbabwe's national policies and programmes on HIV/AIDS and STIs, ZWRCN confirms government's unwillingness to go to the root of the social structures of this intensely patriarchal society (2003). As a people, we continue to inculcate aggressive sexual behaviours in boys and subservience in girls.

Added to this is the fact that Zimbabwe has not broken its silence about sex. Society continues to send mixed signals. For example, AIDS education in schools teaches adolescents to delay sexual debut and advocates condom use for those who are unable to wait. Yet no effort has been made to provide youth friendly reproductive services. The problems that Maidei experienced a decade and a half ago in accessing reproductive health services still persist today.

It is vital that Zimbabwe opens debate on the difficult issue of the cultural structures which endanger both men and women's lives. HIV/AIDS has brought to the fore the need to demystify issues of sexuality. As discussed previously, Gaidzanwa points out that even though lobola is not a legal requirement in marriage, no Zimbabwean woman has thus far had the courage to stop male relatives from charging lobola. The question is why do women doctors, lawyers, accountants, politician and many more professionals seemingly willingly participate in cultural practices that oppress them? Opinion leaders view lobola as sacred and something linked inextricably with the identity of black Zimbabweans. This practice needs to be researched so the nation can examine its effects on both men and women instead of clinging to it in the name of culture. It was indeed important to Maidei that her late husband had paid lobola thereby securing him unfettered rights over her body. She felt so constrained by it that she thought it improper to discuss her sexual needs with her husband.

The question of how to get people to act on their knowledge of HIV/AIDS so that anyone at all who has sex knows that they are at risk needs to be addressed. Though Maidei did not exactly receive AIDS education, her sister did but still failed to take note of HIV messages around her. Issues of sex and sexuality need to be demystified so that Zimbabwe stops treating sex as a shameful subject. Even as an adult Maidei lived with the fear of her parents finding out that she was sexually active. As long as sex remains under the realm of taboo subjects, halting the spread of diseases that are spread through sexual contact will continue to be problematic.

Tendai's experiences also underscore the need to beef up the country's counselling services. She received both pre and post test counselling services in May of 2005. At the time of the interview with Maidei, 4 months later, there had not been any follow up sessions. It appears the NGOs that provide these services simply measure success through the numbers of people counselled, but fail to look into the quality of the service being provided.

6.1. The Need for De-stigmatisation

Maidei's continued reluctance to disclose her HIV status is an indication that two decades into the epidemic there are still heavy penalties to pay for those who are living with the virus. Much as she would like to protect her sisters, she does not reveal her HIV status. Edwin Cameron (2005), who in my view is one of South Africa's greatest heroes in the fight against AIDS, confirms the difficulty of simply blurting out one's HIV status. He did not talk;

"to family or troops of friends. I feared their reaction with ghastly, sickening isolating loneliness. For three years I lived with it solitarily...stigma, a social brand that marks disgrace, humiliation and rejection, remains the most ineluctable, indefinable, and intractable problem in the epidemic. Stigma is perhaps the greatest dread of those who live with AIDS and HIV – greater to many even than the fear of a disfiguring, agonising protracted death." P53.

Coleman (1986) posits that part of the power of stigmatisation is that people who are stigmatised lose their place in the social hierarchy hence most people want to ensure that they are counted in the non-stigmatised majority which of course leads to more stigmatisation. Stigma creates obstacles to the acceptance of prevention messages by encouraging people to believe that they are not at risk (Anlay and Cosby: 1986, Becker and Arnold: 1986, Usdin: 2003, Cameron: 2005, Tallis: 2002). As discussed in chapter 4, stigmatising those at risk such as truck drivers, for example, made Maidei feel safe.

Cameron believes the eradication of stigmatisation of PLWHA could gain momentum if HIV positive people in positions of leadership disclosing their own status. So far only a few leaders on the continent have admitted to losing their children to AIDS; Buthelezi (Inkatha Freedom Party President and former South African Home Affairs), Nelson Mandela (South Africa's first post-apartheid president) and Kenneth Kaunda (former President of Zambia). Zimbabwe's late Vice President Joshua Nkomo, in 1996, also announced that his son had died of AIDS. None of those in positions of leadership have themselves admitted to being HIV positive and Zimbabwean newspapers

simply talk about death due to “long illness” – the national euphemism for AIDS.

Though Cameron commends these leaders for publicly announcing their offspring’s cause of death, one does get concerned about the fact that they only spoke out after their children had died, not while they were still alive. This may mean that the deceased were ashamed to “come out”. Zimbabwe desperately needs leaders – both political and religious, to be open about HIV/AIDS and preach the gospel that there is nothing shameful about having the disease. Maidei feels particularly let down by her church whose membership still continues to moralise about the issue. If everyone talks about it, then it can be normalised and be dealt with unemotionally and effectively, (Cameron, 2005).

To an extent the issue of ARVs is linked to the demystification of the disease. Maidei argues that she and her late husband were reluctant to go for HIV tests because they reasoned that without the possibility of treatment, knowing their status would only bring sorrow and pain while without being tested they could continue to bask in the glory of self-deception. ARVs have brought Maidei hope and supplying them to those who need them should be a matter of priority to the government of Zimbabwe. At a cost of Z\$2.5 million for a month’s supply, ARVs in Zimbabwe’s inflationary environment are increasingly out of reach of virtually everyone. The hope that they had brought is increasingly turning into a nightmare as failure to access them has already become a reality to some who had already started taking them.

The tragedy of the epidemic is highlighted in Maidei’s story, yet it is also a story of hope. Maidei hopes that ARVs will help her live long enough to see her grandchildren.

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10 families live like rats at Harare house

By our staff

TEN families are squatting at a house in Harare's Sunningdale suburb after the government destroyed their houses under "Operation Murambatsvina".

The yard resembles a refugee camp with make-shift shelters and shacks fashioned from just about any material surrounding the main house. An overpowering smell associated with an unclean environment lingers in the air.

When The Standard visited the house last week, a woman with a baby strapped to her back crawled from a shelter made from plastic sheeting. From several other shacks, people crawled in and out while children in various state of undress frolicked in the mud.

At regular intervals, water could be heard flushing down the toilet system.

Amid reports of disease outbreaks and reported deaths of children in many urban centres in the country, the house in Sunningdale is a disaster waiting to happen.

A woman, who identified herself as Amai Leon, described life at the house as a nightmare.

"I am a victim of Operation Murambatsvina and we had no option but to come and squat at this house when our house in Chitungwiza was destroyed," the woman told The Standard.

"The owners are related to my husband and that is how we ended here. We are living like animals and we hope the government can come to our rescue by providing decent accommodation," she said as she wiped sweat cascading down her face.

She shares a shack made of polythene sheeting with her husband and their three-year-old son.

The woman added that the conditions at the house posed a serious health hazard to inhabitants and she feared a possible outbreak of cholera.

Anilliah Masaraure, the Combined Harare Residents' Association's co-ordinator said the suffering at the Sunningdale house reflected the general conditions created by the Zanu PF government when it embarked on the "Operation Murambatsvina" in May.

"People are suffering and it is such a sad situation to see more than two dozen people using one toilet. This exposes them and their children to diseases," she said.

Even though HIV and Aids pandemic continues to be a major problem in Zimbabwe, several women at the house are reported to have resorted to prostitution for survival.

Outspoken Harare businessman, Paddington Japajapa, suggested government should declare a state of emergency in the light of the deteriorating situation in the housing and water delivery situation.

He said: "President Mugabe has been spending billions of dollars traveling all over the world. He should immediately stop his globe trotting and channel all the money towards building houses for the homeless and buying chemicals and equipment to improve water delivery."

Zimbabwe is facing a health disaster which has been created by a combination of government interference in local government administration and the after effects of the ill-conceived "Operation Murambatsvina" now derisively referred to as "Murambavanhu" (anti-people).

The HIV and Aids pandemic is wreaking havoc on the population with nearly one million people desperately needing Anti-Retro-viral drugs.

However, only 12 000 people are receiving the life-saving drugs amid calls that the government was not treating the pandemic as an urgent issue.

At Hopley Farm, a refugee camp for internally displaced people, there are 34 cases of chronically ill people who are cramped into the camp where they live under unhygienic conditions.

University of Cape Town

Appendix 2

By Lebo Nkatazo

Last updated: Tue, 22 Nov 2005 03:46:05 GMT

DOCTORS and nurses at Zimbabwe's largest health referral institution, Harare Hospital, are leaving patients to die due to the unavailability of essential drugs and equipment.

The institution's medical superintendent Dr Christopher Tapfumanei last Friday told the Parliamentary Portfolio Committee on Health, Child Welfare and HIV/Aids that health personnel at the institution is increasingly becoming frustrated due to lack of "tools of the trade".

"The person will just die. We do not want to say that, but it's happening," said Dr Tapfumanei.

Harare Hospital Principal Nursing Officer, Euphasia Marufu added that the institution faces closure due to staff exodus triggered by low remuneration.

"Their take home salary is \$2,5 million. Night shifts are not well paying yet they work 12 hours per night. If the issue of remuneration is not looked into I think we will be closing down," said Marufu.

The principal nurse added that over the past two weeks the institution has lost 30 nurses, and between 60 and 90 more are expected to leave by month end.

Staff in other departments is also leaving in droves. The hospital's nurse training school has two tutors out of the required 32 while the school of Midwifery, which requires 30 tutors, has a head only who conducts all the lessons.

Out of the 51 medical specialists needed, the institution has 17 creating a shortfall of 33.

In the casualty department there are 10 vacancies while in the X-ray department there are only three people out of the over 30 that are needed.

Equipment is said to be obsolete with the last having been brought 15 years ago.

Although the institution said it required over \$3 trillion in next year's budget, government said it would provide \$1,4 trillion.

The institution's Anti Retroviral Treatment Clinic's for those who are HIV positive is now turning away new patients, and would be closed in January if new drugs are not supplied.

At least 20 000 people had been earmarked to benefit from the treatment programme by year-end, but only 2 050 have been enrolled.

Those that have been told to come back in January, as there are no drugs have expressed fears that by then they would have succumbed to the pandemic by that time.

At Beatrice Infectious Diseases, the acting Director of Health services Dr Prosper Chonsi said they had run out of Tuberculosis drugs.

At its TB ward, some patients were lying while others slept, as if dead, and visibly with no signs of hope on their faces.

In pain, others just stared at each other.

The council run institution, which has only two doctors out of the required 10 is the referral centre for Harare's 56 clinics. Chonsi said they are faced with a critical shortage of vehicles, which has seen them using the same vehicle for carrying blood soaked hospital linen and patients food.

Two months ago, another parliamentary committee, that on Justice embarked on a tour of prisons and was told by inmates that the government was no longer supplying them with toilet paper.

As a result they have resorted to using bible pages.

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