PENTECOSTALISM AND HIV/AIDS: THE COMPLEXITIES OF TREATMENT CHOICE IN DAR ES SALAAM TANZANIA

Nipael Eliabu Mrutu
PENTECOSTALISM AND HIV/AIDS: THE COMPLEXITIES OF TREATMENT CHOICE IN DAR ES SALAAM TANZANIA

Thesis submitted for Masters Degree
By Nipael Eliabu Mrutu
Advisor Dr. Eileen Moyer

Amsterdam Masters in Medical Anthropology (AMMA)
Faculty of Social and Behavioral sciences
University of Amsterdam

Amsterdam, August 2006
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Acknowledgments</th>
<th>iii</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstract</td>
<td>iv</td>
</tr>
<tr>
<td>Abbreviations</td>
<td>v</td>
</tr>
<tr>
<td><strong>Chapter One</strong></td>
<td></td>
</tr>
<tr>
<td>Introduction</td>
<td>1</td>
</tr>
<tr>
<td>Study type and design</td>
<td>2</td>
</tr>
<tr>
<td>Setting</td>
<td>2</td>
</tr>
<tr>
<td>Data collection techniques</td>
<td>4</td>
</tr>
<tr>
<td>Sample</td>
<td>5</td>
</tr>
<tr>
<td>Ethics</td>
<td>5</td>
</tr>
<tr>
<td><strong>Chapter Two</strong></td>
<td>6</td>
</tr>
<tr>
<td>Being a native</td>
<td>6</td>
</tr>
<tr>
<td>Openness: Not talking about AIDS as a native</td>
<td>9</td>
</tr>
<tr>
<td>Privacy: why not a native</td>
<td>12</td>
</tr>
<tr>
<td><strong>Chapter Three</strong></td>
<td>15</td>
</tr>
<tr>
<td>From HIV negative to HIV positive</td>
<td>15</td>
</tr>
<tr>
<td>Stigma</td>
<td>18</td>
</tr>
<tr>
<td>Unemployment</td>
<td>21</td>
</tr>
<tr>
<td>Being sick</td>
<td>21</td>
</tr>
</tbody>
</table>
Scared to death 22

Chapter Four 25
The journey begins 25

Chapter Five 31
God’s medicine for AIDS 31

Chapter Six 39
Pentecostalism in context 41
HIV/AIDS and biomedicine

Conclusions 45

Bibliography 47
ACKNOWLEDGMENTS

Though my name appears as the producer of this work this production would not have been possible without many others who were kind enough to offer me assistance. First and foremost I would like to thank God almighty for seeing me through and enabling me to reach this point in my life ‘God your faithful.’

A handful of gratitude goes to my advisor Dr. Eileen Moyer for her critical yet friendly supervision. She has listened, discussed and contributed a lot of insight and ideas. She showed me the way when I was lost, gave me courage when I thought I couldn’t make it. ‘Asante dada.’

My greatest debt of gratitude is to my parents Eliabu Mrutu and Wemael Mrutu for their love and support. They were always there to encourage me and offered me a helping hand tirelessly. This work wouldn’t have been possible without their contribution.

Much of the content of this work was furnished by my informants. I thank them for their time, contribution and willingness to share their life stories with me. Family members and friends have also been generous with their time and ideas. I thank them all. Special thanks to my brother Stephen Mrutu, my uncle Amorn Mrutu, and Adeline Kapera.

I owe many thanks to Nuffic for sponsoring my studies of which this work is part.

Hartelijk dank.
ABSTRACT

This work is about Pentecostalism and HIV/AIDS. It concerns treatment choices as experienced by people living with HIV/AIDS (PLWHA) who are followers of the Pentecostal faith. It addresses how they search for a cure and demonstrates the way they understand AIDS, the available treatment options, and how they make use of them.

Purpose and intent
My intent is to portray things the way they were in the field without generalization and withholding judgment. I am not certain that this study will be of any help to those who were kind enough to cooperate and allowed me to make their private matters public. “If there is a call for art in this aspect of our work, it is the art of self-deception in perceiving ourselves as working in service to the community” (Wolcott 2001:135). The prime beneficiary, especially in academic work like this, is the researcher who climbs the academic ladder. Even then it is my sincere hope that this work will somewhere along the line help others gain new insights and further understanding.
ABBREVIATIONS

AIDS    Acquired Immunodeficiency Syndrome
ARV     Anti retroviral therapy
FBOs    Faith Based Organizations
HIV     Human Immunodeficiency Virus
NACP    National HIV/AIDS National Programme
NGOs    Non Governmental Organizations
PLWHA   People Living With HIV/AIDS
TACAIDS Tanzania Commission on AIDS
USAID   United States Agency for International Development
WHO     World Health Organisation
WHO-GPA World Health Organization Global Programme on AIDS
CHAPTER ONE

Introduction

Tanzania is located in eastern Africa, with a population of 37.7 million. HIV/AIDS is one of the major health problems facing Tanzania. People living with HIV/AIDS are estimated to be 1.6 million. The national HIV prevalence rate is 7% and for Dar es salaam, 10.9 % (Tanzania Care 2006). The first AIDS case was reported in 1983. Shortly thereafter the Tanzanian government, supported by the WHO-GPA, formed the National AIDS Control Programme (NACP) under the ministry of health (TACAIDS 2006). Later the Tanzanian national policy on HIV/AIDS acknowledged the need to deal with HIV/AIDS at a multi-sectoral level; it was then, in 2000, that TACAIDS was established in the prime minister’s office (USAID 2006). Currently the national HIV/AIDS policy calls for collaboration with international organizations, government organizations, NGOs and FBOs to address the issues of prevention, treatment, care (encompassing spiritual, social, moral and material support), and related issues (TACAIDS 2006).

The health care system in Tanzania is plural. There are three sectors: the popular sector, folk sector and the professional sector. The folk sector consists of individuals specializing in sacred or secular forms of healing or a combination of the two. The professional sector is made up of organized professional healers who have been legally sanctioned, for example biomedical practitioners. The popular sector is made up of informal un-paid healing relationships like self help groups and healing in the church (Helman 2000). These existing health sectors are utilized in varying combinations. This study is about treatment choice for HIV/AIDS answering the question as to why PLWHA turn to Pentecostal churches for faith based healing.
The main questions surrounding the research include:

1. Why do PLWHA turn to Pentecostal churches for faith-based healing?
2. What alternatives do PLWHA consider open to them regarding HIV/AIDS treatment?
3. What are the criteria they use in selecting among those treatment alternatives?
4. What influences their decision process?
5. How do the Pentecostal churches deal with HIV/AIDS treatment?

**Study type and design**

This work is a result of a fieldwork research conducted in Dar es Salaam, Tanzania, over a period of six weeks in Spring 2006. The research setting was in three different Pentecostal churches namely Elmaarufu church, Calvary church and Golgotha church.

**Setting**

Helman, writing about symbolic healing, suggested “the setting itself plays a crucial role in the healing process; setting the stage, creating a mood of expectation, and giving information to the clients about the healers” (Helman 2000:193). Similarly, the setting in the Elmaarufu Pentecostal church, where I carried out part of the research for this study, is designed for healing. This is apparent even before the healing starts. There are paintings of Calvary, where Jesus was crucified, on the altars, along with the words, “The one who performs wonders is here today.” Throughout the church one sees many posters with biblical quotations stressing the love and mighty powers of God.

In the three Pentecostal churches where I did my observations the mass began in a similar style. Mass would always begin with songs of praise, followed by songs of worship, then by prayers. The songs, sung by the church choir before
the word of faith and prayers, should be understood as a sort of sonic therapy, intoning in the soul God's mighty work, suggesting the miracles of the Bible are possibility for the faithful of today.

The singing is usually followed by testimonials offered by parishioners who have been cured. There are usually testimonials about the mighty things that God has done for people. People approach the altars where they talk about their problems and about how God helped them. Those who were sick usually come with their certificates or x-rays showing their problem before prayers and after prayers, using scientific evidence as proof of God’s mercy and will. Some come with pictures showing how they used to look like, while many others bring the pills they were using before they were healed. These accoutrements of proof serve as dramatic emphasis to their often stirring testimonials, causing even the most cynical observers to wonder about the possibilities of faith.

During one service at the Maarufu Pentecostal church a picture of Mr. Kiratu, who it was claimed had been cured of AIDS, was displayed on all the church televisions at the start of the third sermon, which focused on healing. Below Mr. Kiratu’s photo were words reading “cured of AIDS.”

This example shows not only the savvy of church officials at setting the scene for healing, but also their savvy with using contemporary forms of media. The uses of televisions and sound systems in Pentecostal churches have become routine. At the same time, Pentecostals churches make use of television, radio, and audio and video recordings to preach the word of God to a wider community. AIDS is a common subject in these mediatized representations, seemingly the perfect metaphor for warning about the excesses of humans, the consequences, as well as the infinite glory of God, who is able to cure this disease that has confounded science. The testimonials of people claiming to have been cured of AIDS are
routinely broadcast on church television programs. Video and audio tapes with these testimonials are sold in the church shop along with other testimonials.

**Data collection techniques**

Most interviews were tape recorded with the consent of the informants and notes were taken during all interviews. Primary data was collected through semi-structured in-depth interviews, informal conversations and participatory observations. Church video and audio tapes were used as a source of information along with television programmes on the church services.

Semi structured in-depth interviews were carried out with the informants and they lasted for a period of one to one and a half hour. These mainly took place in the informants’ homes; informants’ offices; in a hospital; and in restaurants. The interview venue was suggested by the informants.

Participatory observation took place in three Pentecostal churches namely Elmaarufu, Calvary and Golgotha. I attended the sermons in all the three churches to see how Pentecostal churches deal with HIV/AIDS treatment. I attended the church like any other church member with my bible, a note book and a pen. It was convenient for me to take notes of what was happening without looking like an outsider. Everyone had a note book like me, only I knew that mine was for a different reason. In these churches people went with note books to take note of the preaching, and I was taking note of what I observed and heard for the purpose of my research. In the Elmaafuru church they covered their hair with a veil of scarf while praying and I did the same. Another place where observation was conducted was in the Mtakuja Hospital where I observed the patient doctor interactions to gain insight on HIV/AIDS treatment in the biomedical model.
Informal conversations took place in many different settings where I did or did not go specifically for conducting the research. Sometimes the informal interviews took place before I started the in-depth interview with an informant or after we had finished.

**Sample**

In this study data is based on in-depth interviews with 11 informants. The informants were randomly chosen. A snowballing method was also used to obtain some of the informants.

**Ethics**

Participants were approached with respect. All the informants were informed about the nature and aim of the study. Participants’ well-being, both physical and emotional, was highly considered. Even though some of my informants were willing to be identified by their real names, for the sake of both privacy and uniformity I have decided to use pseudonyms. Tape recording did not take place without the consent of the informant. Since this is a sensitive topic the venue for the interview was selected by informants.
CHAPTER TWO

Being a native

Individuals have many identities ...being a native in one identity does not make one a native in all one’s identities. Nanda and Warms 2004:64

This chapter is concerned with the dilemmas as well as the advantages of being a native researcher. At the outset of this research I considered myself as an insider since I was a Tanzanian. With this identity I viewed myself as holding a key to my community. It did not take me long to discover, however, that the key I was holding could not open the doors of all the rooms I wanted to enter. To initiate the fieldwork for this project, I met with Mrs. Iwe, a family friend and the sister of a pastor in the Mwanza branch of the Pentecostal church. We met in the compound of a Pentecostal church in Dar es Salaam after a morning sermon, and Mrs. Iwe graciously offered to introduce me to some PLWHA who attended the church. I was happy things were going so well, though not surprised. I had made the most of my insider status, using family and friend-based networks to reach informants, so it made sense I was off to such a good start.

I know many PLWHA who come to this church. When my brother comes to visit us they usually come to him for prayers. I will talk to them, explain the nature of your research to them as you have explained it to me, then I’ll get back to you. --Mrs. Iwe

Mrs. Iwe, a young mother of two, likes to chat, joke and laugh. She is well-known in the church as she started attending it when she was still a young girl. She lived with her brother, ‘the pastor,’ before she got married. Usually after the mass she has many people to greet and talk to. She can even spend forty minutes before going home, just talking with people. When I told her about my research she jokingly said. “I can give you many informants, but what is in for
me? Are you going to pay your informants? I have heard that these types of research now a days are paying, money is involved.”

Mrs. Iwe’s statement about paying informants made me think about it more. I had included consideration for informants in my budget but I had not thought about it seriously. It would have been very easy if all my informants were younger than me, but unfortunately all my informants were older than me. If I were a foreigner I would just offer my informants money or gifts and it would be all right. Because I was a native, I was expected to know and behave according to social norms. If I made one mistake people would have misunderstood me. This became a dilemma that I have not yet managed to fully resolve.

For the male informants, I just couldn’t offer money. I know that it is not culturally right for a woman to offer money to a man. For women, I offered money to some and presents to others. I decided I could offer money to women who were not much older than me and that I would offer presents to older women. It seemed to work, but even this arrangement was not perfect. Some women refused my money and I felt so embarrassed; maybe they thought I was showing off that I had money. It was my own culture but I was wishing it wasn’t because it made it uncomfortable when I failed to know what people expected from me. I used my instincts and introspection, and even then I failed. I wished I could have asked what they would have liked as consideration for the time and corporation, but this I knew to be a taboo question in my culture. Lukundo, one woman I interviewed, talked to me about it once. I did not ask her for advice on this subject, but she brought it up. Lukundo was a family friend and a church leader who introduced me to some of my informants. She called me and asked me, “Are you offering them anything as consideration for their time and cooperation?” “Yes,” I replied. “Ok I just wanted to know, but If you are offering anything, do not ask them; just give it to them,” she added.
Through my experiences with the money issue I realized that human beings are individuals, and even though they might come from the same culture, they are different. Therefore I have strived not to make generalizations in this study. The issues that come up in this study are only applicable to this study and it would be wrong and inappropriate to draw a general statement about the results of this fieldwork. This is especially so because the research is primarily exploratory and based on a small sample. The results should therefore be read as tentative at this point.

Shortly after my meeting with Mrs. Iwe, I received a phone call from her saying that she had already spoken to the PLWHA and that she was going to introduce them to me on Wednesday at the church. Every Wednesday evening there is a sermon from 5 to 7. When I met her on Wednesday, however, the story was not the same.

Yooo! My sister I am sorry for letting you down. I spoke to a couple of people with this disease. At first they agreed to be your informants, but then they inquired more about you. They asked if you were a Tanzanian, and I said yes you were. Then they refused to meet you saying that you might tell your family and friends about them and that those that you tell will tell their friends and finally the whole church would know and it wouldn’t be a secret anymore. –Mrs. Iwe

Next, I requested an appointment with the Archbishop of the church and was told to submit a formal request to Mr. Mkubwa, who is also one of the church leaders. I met Mr. Mkubwa and told him about my research and he promised to submit my request to the bishop in person. He gave me his phone number and told me to call him the following day. When I called him he said he was busy with church activities so he couldn’t talk to the bishop. He said we should meet in church on Sunday after the morning sermon. I met him in the church and this is what he said:
I spoke to the Archbishop, he said he has a very tight schedule but he will call you. If you were a guest (a foreigner) he would have fixed you in his tight schedule. --Mr. Mkubwa

**Openness: Not Talking About AIDS as a Native**

Despite HIV high prevalence rates in Tanzania, rarely is HIV/AIDS mentioned as a cause of a death, or even recorded on the death certificate as such. Only once do I remember AIDS being announced as the cause of the death at a funeral. At university, one of our college mates fell very sick. He was hospitalized for two weeks or so before he passed away in the hospital.

Before transporting the body to his home region for funeral and burial, the body was brought to the University so we could pay our last respects. It was then that the chancellor disclosed the cause of the death. He said the man died from AIDS-related complications. The man’s family members were not present in that gathering.

That act brought about a debate thereafter as to whether it was proper to disclose AIDS as the cause of death. The debate never reached a consensus, but it was obvious that people found fault with the chancellor, especially because he was not a family member of the deceased. People do not want it to be in the open that they have AIDS or that a family member has AIDS or has died from it. This is because AIDS is perceived as a shameful disease, a result of adulterous and promiscuous behaviors. As Caldwell cogently suggested, “announcing AIDS victims in the family is like shouting their illicit sexuality to the world” (1994:223).

The above is the environment where this study was conducted. An environment where people could not imagine any positive consequences of disclosure. People used selective disclosure, meaning they disclosed their HIV/AIDS status only to
few selected people like doctors, nurses, other PLWHA, and people from distant communities (Geurtsen 2005).

This being the case it was not always easy to talk to people about HIV/AIDS, precisely because I was an insider. Being a native was more problematic than I had imagined and expected. I was an insider and yet an outsider. When it came to living with HIV/AIDS I was considered as an outsider. On the other hand, being a native was advantageous; it gave me access to the community easily. I also gained access to certain information through the back door. I bypassed the administration procedure, which was not only time consuming but also inconvenient. As Nada and Warms state, “being a cultural insider offers certain advantages for an anthropologist such as access to the community” (2004:64).

My first informant was introduced to me by Upendo (a resigned church leader), the wife of one of the church leaders, and also my neighbor.

I will take you to mama Matokeo, I spoke to her and she consented. She is very open about her situation unlike Mlibwende. You know Mlibwende? My next-door neighbor, she is also suffering from this epidemic. She has now joined our church. She started going to church after she fell seriously ill. We went to see her; we prayed for her and encouraged her to come to church. We gave her audio-tapes from the church on the word of God and told her to watch the church programs broadcast on television. She has never told us that she has “this disease” but everyone in the neighborhood knows that that is what is troubling her. --Upendo

It takes much more than just being a native to succeed however; one must also know the right people, the people in power. I paid a friend a visit; she is a doctor in Mtakuja district government hospital. I knew that with her on my side I would gain access to all the information I wanted without adhering to the administrative procedure.
This is my young sister; she is a student doing her research on HIV/AIDS treatment. She would like to speak to you. --Dr. Silazima to a couple of nurses.

No problem we will give her all the information she needs, we were on our way to get a drink, let her follow us but doctor, you shouldn’t come as you will prevent us from doing our things. --Response from one of the nurses

The doctor then addressed me, “follow them,” then shouted at the nurses as we were departing, “Hey, do not ‘squeeze’ her, she is my sister.”

The terms ‘squeeze’ and ‘doing our things’ sounded to me like there should be a financial consideration for the information I was about to receive. That being the case my mission was to find an opportunity to pay for that information before they even asked for it.

Nurse Siyangu and nurse Havintishi work in the ARV clinic in Mtakuja hospital. “Is Dr. Silazima really your sister,” nurse Siyangu asked me. “Yes, I call her sister since she is a friend of the family,” I replied. We went to a grocery shop inside the hospital compound, bought some soft drinks and sat down in the chairs arranged outside the shop. I offered to pay for the drinks, they refused and said, “you are just a student, keep your money you will need it.” I thought I would ask Dr. Silazima what exactly the term ‘squeeze’ meant. In Swahili kukamua is a slang word meaning “to squeeze,” a less vulgar way to talk about a bribe. On returning to the hospital Dr. Silazima asked me how it went and asked if the nurses took money from me. “No they didn’t, they didn’t even let me pay for the drinks. By the way what does ‘squeeze’ mean,” I asked.

“I would have swallowed them without chewing if they had taken anything from you; ‘squeeze’ here in the hospital means bribe or to get money from someone,” she replied.
Privacy: why not a native

It was at the hospital compound that I first understood why PLWHA refused to disclose their information to a native. Dr. Silazima, pointing with her eyes to a man dressed in a blue shirt, told me “that man is working here as a driver, he is HIV positive. If it wasn't for ARVs he would have been dead by now. I was just talking to him, he was complaining of experiencing memory loss.”

We went to her office, where she asked me to take a seat. Thereafter I started talking about my research. She was on duty that day, and during our conversation patients were walking into her office and she responded to them as if she were the only one who could see me and the patients couldn’t. I felt somehow embarrassed and uneasy, thinking these people deserved privacy. Sometimes patients had to wait for her to finish talking to me before she responded to them. Then I was really embarrassed. These people are sick, I told myself, they need immediate attention, but my presence is depriving them of that.

When I was pondering what would be the right thing to do, two women who were maybe in their late fifties walked in; one of them was carrying a baby. The woman holding the baby sat down and the other woman stood since there was no other chair. The doctor inquired as to what was wrong with the child. The woman holding the child removed a piece of cloth, which was wrapping up the baby. The child’s skin resembled that of a very old woman, she had wounds in her private parts and as a result she was not wearing any clothes. The doctor, addressing me in our shared ethnic language rather than Kiswahili, said, “Do you see this disaster, it is “this disease”, look.” She was holding the baby in such a way that I may have a better view of her.
I just took one glance. I couldn’t look twice. The doctor addressed me again in my mother tongue, “look at the skin, are you afraid? You're not looking?”

“I am fine but I think I have seen enough,” I replied.

She then said in Kiswahili so the women could understand, “I can see you are afraid of your patients.” This statement made it seem to the patients that I was a doctor as well. Facing the two women she asked, “which one of you is the mother of this child?” The two women said that they were the grandmothers of the child and that the mother of the child was sick.

The woman who was standing added:

Doctor let us tell the truth so that you may help us. I am this child’s grandmother on her maternal side and my friend here is the child’s grandmother on the paternal side. The mother is not really sick but she is 8 months pregnant. Mmh Doctor can you imagine? She is spoiling the child, the child is sick every day. Poor thing, at first her skin was peeling off as if hot water was poured on her body, now this. These children of today have no morals.

Some people in Tanzania believe that if a mother engages in sexual affairs while she is breastfeeding the milk will become poisonous to the child. As a result the child intermittently falls sick and doesn't grow. The women believed that this was what was happening to their grandchild. I thought that they, who were nursing the baby, had the right to know what was wrong with their grandchild. This illustrated to me an irony I would soon become familiar with. Strange as it may seem, those who should know a patient’s HIV status often do not know, and those who are not supposed to know often do. Without research clearance and questionable credentials, I was made privy to patients’ HIV status at the whim of the doctor, who just happened to be a family friend. Perhaps those who refused to speak with me from the church were right to be suspicious. How could they
know they could trust me to keep their secret when it was so obvious I was entangled in local social networks?

There were other informants who were not only afraid of the leakage of information. They were curious and questioned what I was going to do with the information. They were also conscious about politics in the field of HIV/AIDS.

My brother told me to be careful, he warned me about people who are using us to get money from donors that in the end only benefit them. People are really wicked these days, you might think they care but actually they don’t. Sure, one man’s loss is another man’s gain. --Hiyari

This chapter highlighted my experiences in the field drawing attention on the dilemmas, advantages and disadvantages of a native research. Giving a general picture on the themes such as privacy, openness and politics which surrounds HIV/AIDS in Dar es salaam Tanzania.
CHAPTER THREE
From HIV negative to HIV positive

Gender, poverty and HIV/AIDS

In the course of this study three aspects arose: Gender, HIV/AIDS and poverty. This chapter highlights how gender inequality and poverty lead to AIDS (Van den Borne 2005, Farmer et al. 1996) which then alters a person’s identity and changes the meaning of life.

Though both girls and boys get access to education there are many obstacles hindering girls from going far academically. Gender inequality in Tanzania exists at the family level and exercised on children. Culturally a girl child is expected to help with the house work this gives her less time to revise or do her homework compared to a boy child. As a result women get low grades and if the parents or guardians do not have enough money to send her to a private school, it means the end of schooling.

I am not really educated; I am just a primary school graduate. I never made it to secondary school. You know when I completed my primary education I did not get good enough grades to be able to join a government secondary school, and my parents didn’t have money to send me to a private school.—Tumaini

Pregnancy is another factor that hampers a girl child’s education; sometimes the pregnancy is the result of sexual violence. Van de Borne (2005), drawing attention on the issue of gender inequality and increased dependence among women in Malawi, argued that many women faced unplanned pregnancies which prevented them from completing school.
After graduating from primary school I joined a secondary school. In my first year in secondary school I was raped. By that time I was living in the city with my sister. I told my sister about the rape. They tried to search for the man but they never found him. I became pregnant hence I was not to go to school any more. --Shida

With limited education it becomes difficulty for women to obtain jobs.

In the village it was impossible to secure a job so I came to Dar es Salaam. With my level of education there wasn’t much I could offer, I secured a job as a house-maid. --Tumaini

Faced with difficulties finding a job or obtaining any financial assistance from family, women tend to look for an alternative means of survival. It is then that men are taken to be life savers and the only hope.

You know how difficult life is. I am not educated. I found a man who is ready to help me so I consented. --Havijawa

My daughter, I was not a one man type of a woman. I had different men, but this is all because of poverty. These men used to take good care of me as you can see by this house. How on earth would I have been able to build a house like this? --Matokeo

These sexual survival strategies increase women’s vulnerability to HIV/AIDS. When they look at men they see their helpers. It then becomes difficult not to adhere to the helpers’ wishes as it could mean a termination of the financial support. This leads to male dominance in matters relating to sexual relations: “Gender inequality has weakened women’s ability to negotiate safe sexual encounters, and this sapping of agency is clearly amplified by poverty” (Farmer 1998:223).

I heard someone knocking at my door; I opened the door to see the Bishop who had paid for my tuition fee. He walked in my room and sat down. I was embarrassed. He told me, “you listen to me and listen to me good, I will keep on paying for your tuition fee, I will send you anywhere
you want but you have to help me as well. I have been paying for your school fees because I love you and not otherwise.” I was shocked and told him “but you are a bishop.” He said “so what? Being a bishop is a job like any other job, there are so many people who are in need, why do you think from all those people I choose to help you?” At that time I did not know God like I do now, I thought I was lucky.--Shida

With an inability to negotiate safe sex and protect themselves against male pressure, women become vulnerable to HIV/AIDS as stressed in the National multi-sectoral strategic frameworks on HIV/AIDS 2003-2007. Most of the women in this study got AIDS in the process of trying to survive as expressed by Tumaini.

I then met a man, we became friends and I became pregnant. He never married me, but I was later married to another man. I became pregnant again but this time my child died of AIDS and I also tested positive for AIDS. –Tumaini

The stories of the men with whom I spoke were different; they did not directly link AIDS to poverty the way the women’s stories did.

I wanted every girl I could get my hands on. I was always attracted to women and I did not let it end there. I would try to do all I could to get them. I slept with different women; this is how I got the disease.
--Mhogo Mchungu

The devil got me well and good. My friends were not real good company I was tempted to be like them. I then started to sleep around and was caught in the web of AIDS. --Ayubu.

While women understood themselves to have contracted HIV/AIDS in the process of struggling to survive, for men it was in the process of pleasure and being a man. Indirectly men stories were also linked to poverty, as the link between gender, HIV/AIDS and poverty is a circle form of interrelation. While men looked at women as a source of pleasure and a way of showing their manhood, women looked at them as their financial saviors. In this circle AIDS is
transmitted and the way to stop further transmission is by breaking this circle. Cohen (2006) has argued that unless and until poverty is dealt with HIV transmission won’t decrease.

**Stigma**

Once one learns about one’s positive HIV status one gains a new identity which transforms one’s life. One then looks at life differently as the meaning of life changes immediately after receiving an HIV positive result. This change of identity is accompanied with a number of factors namely fear, stigma, becoming severely sick as well as unemployment.

Stigma toward PLWA still prevails, but generalizations cannot be made, as some PLWA face stigma, while others do not. Pastor Hekima and his wife, who is also a pastor, invited me to their house. I arrived in the evening to a big house still under construction. I was welcomed in the living room where there were two people seated, a man and a woman. Mrs. Busara (the pastor’s wife) was seated in the dinning room writing, a pile of books and papers surrounded her. The living room looked more like an office with books everywhere, a computer, television set, sofas and a coffee table.

Pastor Hekima was out when I arrived, but showed up after five minutes and took me and his wife to another room. There were two chairs in that room and a bed. I sat on the chair, the pastor sat on the other chair, and the wife on the bed. We had to go to another room as people were gathering for prayers in the sitting room. I realized that being a pastor is like being a doctor; people can knock at your door any minute in need of your service. As I was talking with them the issue of stigma came up when Mrs. Busara was talking about the position of the church in the fight against HIV/AIDS. According to her, a church should be a place of comfort and refuge but, she argued, that this was not always the case.
For example, Mr. Mwaluko, we pray for him and encourage him but he is stigmatized by one of his church leaders. That leader does not want to shake hands with him just because he is HIV positive. –Mrs. Busara

Others I interviewed also spoke about AIDS and stigma.

One woman, we go to the same ARV clinic, she told me how her neighbors stigmatize her. That day after clinic I was to visit her at her place. She told me before hand “you just wait, when we reach my neighborhood you will see for yourself.” When we reached that neighborhood there was a woman seated in the shade outside a house. Upon seeing us she raised her voice, addressing a child she said, “Rose, go get me a glass of water that I may take my medicine to prolong life”. Then my friend told me, “you see what I mean? They already know that I am coming from the clinic; in these tightly packed living areas there are no secrets.” --Shida

When I told my husband that the HIV tests for my daughter and I came out positive he said he would also go for testing. He came back home one day and told me that he went for the blood test and he is negative. Three months later he left me and married another woman, and they now have a child together. --Tumaini

When I was very sick, I could not even move. My sister took me to her house to take care of me. Children in the neighborhood used to come outside close to the bedroom window where I was sleeping and they would imitate to conduct the sermon for the dead. In that game of theirs they would say that the deceased died of AIDS. I don’t know how they came to know about my sickness. Maybe they overheard their parents gossiping about me or maybe my niece and nephew told them. –Shida

Before I learned about my status I was always gossiping about PLWHA. Now that I am affected myself I know how it feels. Last year my cousin’s sister was very sick, she had AIDS. When she was bed ridden her family was not very kind to her. Once her mother told her “you see now I have to be stuck inside to look after you; today I will just have to leave you and go attend to my duties after all you got what you were looking for. You have reaped what you sowed”. I felt sorry for her; whenever I had time I would go nurse her. She died in my arms when I was helping her shower. I was helpful to my cousin because I knew that it is a path that I shall
follow one day. I couldn't have done this before; my relatives thought I was very kind. They do not know that I am also infected as my CD4 count is still high. I am not sick at all but I do go to the clinic for counseling. --Havijawa

Echoing Morse and Johnson’s observation that, “until one is in the patient role, it is difficult to place oneself in the position of the patient” (1991:1), the above narratives seem to indicate that stigma often results when people are unable to imagine what the sick must be experiencing and sympathize with them. It can be seen as something that make PLWHA feel that they are really different and that they have lost their dignity in the society to the extent that even children make fun of them.

While there were many complaining about being stigmatized, others had different stories. Some who spoke of stigma in certain contexts, spoke about support in others.

My family has been very supportive, they always check on me to see how I am doing. My parents were also very helpful, especially my mother. When I was very sick my relatives took me to my parent’s house. At that time I could not even go to the toilet I had to do everything in bed. I have never really felt stigmatized within my family or outside. --Mhogo mchungu

We are three now in my family with this problem; family members just feel sorry for us. When I was very sick my brother took me to stay at his place. I am open about my condition but I have not felt that people treat me differently and if they do maybe they do it when I am not around.
--Matokeo

Though my boyfriend tested negative he didn’t abandon me, we are still together. --Havijawa

It has been argued that stigma attitudes originate in the perception that HIV is contracted through immoral behaviors like extra marital affairs which could be avoided (Nyblade at al 2005). Yet, not everyone living with HIV/AIDS faces
stigma, and it is not clear why people in the same community react differently to the same issue. It seems it is much more than a community and a cultural issue. It is more of an individual attitude towards others.

**Unemployment**

Loss of income accompanies PLWHA as when they fall sick they are forced to give up their work. For most, jobs were the only source of income.

I was working as a midwife in a private hospital. When I started to be sick my boss asked me to resign; he said I fall sick often so I better stay home and rest.

This man was working in a railway company when he fell sick his employer fired him. He took the matter to court.

I was a teacher in a secondary school but I had to quit as I couldn’t go to the office any more. I was too weak, so now I am unemployed.

Being employed is an achievement, which gives one a certain status and respect in the community. This is true for men more than women. It also means loss of income and it adds to stress and depression resulting in more suffering mentally and physically.

**Being sick**

I had terrible pains when I was in bed at night; it was so terrible I can’t even explain, I fell off the bed and fainted. I gained consciousness and found myself hospitalized and paralyzed. --Shida

Being faced with severe health problems is one of the things that PLWHA talked about. Living with HIV/AIDS often meant physical suffering, weakness and being dependant on medicine. The above comment from Shida and the exchanges with Mhogo mchugu and Matokeo outlined below make this clear.
“My sister, I fell sick, very sick. I couldn’t even move. I had wounds all over my body,” said Mhogo mchugu as he folded his trousers to show me the scars from the wounds. “I thank God that now I am doing well even though I am dependant on medicine. The only problem I am suffering from now is that sometimes I can’t feel my feet. I really thank God because I cannot say it is only the ARVs that helped me but God intervened. I know people who took ARVs but couldn’t get better.”

Mhogo mchungu’s statement about being healed resembles that of the Yoruba people in Pearce’s study who believed that doctor can doctor but only God can heal. “A repeated idea among the Ile-Ife informants was that all cures (including the doctor’s) come from the Supreme Being” (Pearce 1993:154).

Matokeo was another informant. She was weak and couldn’t walk long distances any more. She had had many opportunistic infections but fortunately she overcame them all. On her forehead you could see a scar from shingles. One cold evening as Matokeo was seeing me out, she pulled her blouse tight around her and folded her hands over her chest, saying, “It’s a bit cold today, I should protect my chest as pneumonia has been my weakness. I have had it twice. I should go back and get a sweater.’

**Scared to death**

Death is inevitable. When people learn they are HIV positive death they must face this inevitability, often for the first time. Some people lose hope and feel that their life has already come to an end. It is not so much that PLWHA are scared of death, however, but that they are scared to death. They are not afraid of dying as much as they are afraid of dying a shameful death and losing their reputation in society.
I met Ayubu for the first time in his house where he had welcomed me one rainy day. We sat in the living room as we conversed about God as well as about AIDS. He lived with his relatives and the day I visited him there were only two people in the house, Ayubu and another girl who was busy with the house work and kept mainly to the kitchen and the compound outside. Ayubu spoke as if he was preaching or lecturing. I am positive the women heard everything we talked about that day.

It was when I went to hospital with my three cousins to donate blood for my aunt that I learned about my HIV status. My blood sample was taken for testing. The doctor told me that my blood is not suitable. I asked why? He said my blood is too light. I was not satisfied with the doctor’s answer; I knew something must be very wrong with my blood. It was then that I decided to take a HIV test and the results were positive. I was confused; I decided to commit suicide. I went to a pharmacy and bought medicine, I bought valium. I wanted to use that medicine to commit suicide.

---Ayubu

When it came to my knowledge that I am HIV positive I became like a mad person. I wanted to kill my child who was also positive and then commit suicide. I bought some pills from the pharmacy ready for that act. I couldn’t kill my child, so I decide to just take care of her till she dies. I had already decided that once she died I would commit suicide right away. After the death of my child I attempted to commit suicide but was seen and saved by my sister. I tried again some other time and I was caught again. Then my sister decided to have people look after me all the time. –Tumaini

Suicide it seems was considered as a coping mechanism, a method of keeping a secret, preserving one’s dignity and avoiding dishonor. It is a logical solution, sought after predicting the expected future. Before one thinks about committing suicide he first thinks about his future as a person with HIV/AIDS. In thinking about the future, PLWHA anticipate stigma, sees themselves as severely sick people who cannot take care of themselves. They see themselves unable to work and earn a living, and becoming dependant on others. They picture how they will lose their dignity in the society. They see no hope, lose faith even that they will
be able to withstand what awaits them in the future. It is then that they reduce themselves to unworthy human beings, which makes it easy for them to think of committing suicide.

In general this chapter explains in context how the change of HIV status can change the meaning of life. It draws attention to the issue of limitation in the lives of PLWHA. Living with HIV/AIDS can symbolically mean living a limited life, limited from what one was and want to be. This pushes one to struggle hoping to find ways to get better and earn the lost identity back.
CHAPTER FOUR
The journey begins

Mfa maji haishi kutapatapa (a drowning person does not give up trying to help himself from drowning). --Havijawa

The search for treatment and cure is a complex undertaking for any individual. In the end, I would argue that it is the individual who must decide the best options for treatment. That decision does not take place in a vacuum, but is shaped by a number of circumstances as shall be shown in the coming chapters. One cannot act upon something if one doesn’t know that it exists. PLWHA tend to search for information concerning their health from different sources and then decide what treatment suits them best. What choice suits a person best depends on what one expects and wants to receive from certain modes of treatment.

Tanzanian’s tend to ask for advice concerning their ill health from relatives and friends. This is not always the case with HIV/AIDS. PLWHA often conceal their status not only from the community at large but also from family and friends.

No one in my family knows my status. I think maybe I’ll tell my sister one day, but you know it’s just a matter of time as this disease cannot be concealed. It’s like pregnancy; it has a way of revealing itself. --Havijawa

Despite concealing their status and not asking for help from others they still receive information from others. This happens when one falls sick. Neighbors, friend and relatives will visit the sick person, as it is a custom in Tanzania to do so. They will then inquire about the sick person’s well being and offer ideas on ways to get treatment and cure. Usually the treatment ideas offered result from ones past experience or from something heard from others.
It was during the time that my child was sick, she was falling ill often, one complication after the other. I took her to the hospital and she was given medicine to no avail. My husband decided we should have her tested for HIV. She tested positive. I also took the test and the results were the same, positive. I heard from people that they are traditional healers who can heal any disease, even AIDS. Of course I never told them that I was positive, but I think they brought up AIDS to show the power of the healer. --Tumaini

Pentecostals in Tanzania make use of the common practice of visiting the sick. They do so not only to see them and provide them with company and cheer, but also to preach the word of God and to encourage them to go to church. Some informants found out about Pentecostalism in this way. If people are too sick to go to church after being encouraged to do so the church visitors will often pray for the sick in their home. They might also provide them with tape-recorded sermons and encourage them to listen to church programs on radio or television. In extreme circumstances, they will even arrange for a pastor to visit them in their home and pray for them. In many ways, sickness is seen as a prime opportunity for evangelicalism, and every effort is made in these instances to preach the power of faith to deliver a cure.

She was very sick; she could not even leave the bed. They called me to go pray for her at her place. --Pastor Hekima

Mlibwende my next-door neighbor has now joined our church. She started going to church after she fell seriously ill. We went to see her; we prayed for her and encouraged her to come to church. We gave her audio tapes from the church on the word of God and told her to watch the church programs broadcast on television. --Upendo

Another source of information about existing treatment for AIDS is obtained from the media. Informants stated hearing about ARV about faith healing and about traditional healing from the media. Those who were members of certain associations or help groups received treatment information there. The clinic was also a place where PLWHA share treatment knowledge and information.
We joke, we laugh, we share knowledge about our condition, it is from such conversations that I learned about Aloe Vera and its efficacy in treating rushes. --Shida

Shida could talk for hours; as long as I was around her she would talk about many things and always say something about HIV/AIDS. Shida was knowledgeable about HIV/AIDS because she was a nurse by profession. She had faith not only in science, but also in supernatural powers. She believed that one day she would be cured and could give up using ARV. She said it was this faith that made her happy and smile all the.

I have confidence in my Lord; I believe one day I will be cured. I even tell those that I attend the same clinic with that one day I won’t be one of them lining up for ARVs. They laugh when I tell them this. One of my friends once told me jokingly, “Pray to your God that I too may not die, that I may stay alive to see this happen, to see you cured.” --Shida

Though many people seek and make use of scientific information, it seems they do not view it as the sole or the best way to acquire and confirm certain kinds of knowledge. Scientific truth is not necessarily perceived to be free from bias or corruption. It is not completely trustworthy and definitely not the final authority for truth (O’Connor 1995). Havijawa explained her doubts about science as follows:

This disease is confusing even to scientists. I asked my doctor one day about CD4 counts. They have been telling us that if one follows all the instructions, takes the medication on time and as instructed, eats well and lives a healthy life, the CD4 will rise. So I asked my doctor does it mean one day the CD4 will rise and go back to normal then I will test negative. He said that will never happen. I will never be HIV negative again. This to me did not make sense. I believe there are things that also doctors do not understand. --Havijawa
Havijawa keeps going to the clinic and follows all the instructions, but she is also still searching for more information and other alternative treatments. She attends a Pentecostal church with the faith that there her CD4 will rise and she will test negative to AIDS.

This combining of therapies was quite common among those I interviewed. “Sorry, just a minute it is time to take my medicine,” said Matokeo. She then took her pills in one hand and a glass of water in another. She said a prayer then swallowed her pills and thereafter continued with her story.

... I started to search for information concerning this problem. Before ARV were offered for free I heard about Chinese medicine for AIDS. I bought them. They were expensive but less expensive compared to medicine from South Africa. They did not help so I stopped using them. Even if they had helped me I would still have had to stop using them at some point. I couldn’t afford buying them every month. About church healing, one day in my search for treatment I saw preaching on television. It was Pastor Angley, his preaching was so alive and convincing and there were testimonies of people who were healed. I decided to write him. I was not a good Christian but I became one after that. When ARV started I heard about them in newspapers. I am now a member of two organizations of PLWHA; one of them is a Christian organization. From these organizations I learn a lot and I encourage other PLWHA to join them.

Matokeo is an activist in the fight against HIV/AIDS. She is open about her condition and visits PLWHA when she can to encourage them. She is a fighter who is not prepared to lose. What Matokeo wants out of this fight is that she may live healthy as long as possible. To her and many others like her there is no clear cut division between biomedicine and God’s way of healing. She attends a Pentecostal church but, unlike Shida, she doesn’t seem to have a very strong faith that she might one day be cured. On the other hand she sees her faith as a way of relaxing and surviving in the midst of suffering. Geertz explains suffering “as a religious problem, the problem of suffering is, paradoxically, not how to avoid suffering but how to suffer, how to make of physical pain, personal loss,
worldly defect, or the helpless contemplation of others' agony something bearable, supportable—something, as we say, sufferable” (Geertz 1973: 104).

“In this way, ill people frequently utilize several different types of healer and healing at the same time, or in sequence” (Helman 2000: 69). And I would add with different expectations. It is the desire to get better and to resolve the problem at hand that seems to make people go for different types of healing.

Havijawa used a Swahili proverb “Mfa maji haishi kutapatapa” to explain her search for treatment, information and cure. The proverb literally means “a drowning person does not give up trying to help himself from drowning.” Havijawa is very much concerned about her health; she is searching for all the information she can get about HIV/AIDS. Though she is not yet taking medications as her CD4 count is still high, she goes to the clinic for counseling.

Seated on the counter in her shop where she sells cosmetics she said in a low voice:

I learn many things in the clinic and I am trying to live a healthy life. I do not engage in sexual activities any more for my own good and for others. I also find a lot of comfort in the church. I have accepted my condition and I am able to continue with my life without losing my sanity because of the support from the church. There are special undefined powers in prayers than can sooth a dying heart. I have heard people get cured; I hope that I too will one day get cured, but if it doesn’t happen I won’t complain. It is for God to choose. I pray that God keeps me healthy, that I may go on with my daily life as a normal healthy person. I do not want to be bed ridden. There is a certain Pentecostal church where I heard people have been healed of AIDS; I will go to that church too.

When I first met Tumaini, she told me the following story about how she found out she was HIV positive and how she came to find hope in the Pentecostal church.
I visited two different traditional healers; we were given different types of medicines. Mmh, I was even told to drink urine, which I did. But at the end, it wasn’t meant to be; my child died. I did not end there. Then I learned about God and his healing power. It was then that I decided to also join the Pentecostal church.

Search for treatment is a purposeful undertaking. The purpose is for one to defend himself against the intrusion of an alien called HIV. The virus has taken over and conquered the immune system. In the search for information, treatment and cure people try to adjust to what has happened to gain control of their lives again (Johnson 1991). People search for information on treatment and cure hoping to be who they were before they got AIDS. They are searching for a meaningful life which was destroyed by HIV/AIDS. At the same time they are being responsible patients. Responsible patients are supposed and expected to seek help and get better.

In the process of searching for information on treatment and cure they learn about faith healing in Pentecostal churches from various sources as seen in people’s narratives in this chapter. It is then that they act upon the information they received about Pentecostalism and healing of HIV/AIDS.
CHAPTER FIVE
God’s medicine for AIDS

The Pentecostal churches in Dar es salaam have become healing institutions. People with different kinds of problems be they health problems, financial problem or any other problem go to Pentecostal churches for help. Going to these churches especially to the deliverance sermon is like going to a hospital for many. At these sermons there are sick people with different ailments everywhere throughout the church. Some are in wheel chairs, some on crutches, some lying down on the floor, too sick to sit on a chair even, and some are all bones. People from different walks of life with different faiths attend these sermons in which the preachers tend to welcome everyone, usually saying, God know partiality to Him; all people are equal and He is merciful. This chapter illustrates the Pentecostal HIV/AIDS treatment mechanism.

To get a better understanding of these ceremonies and what they mean to the church, I interviewed several Pentecostal church leaders, focusing specifically on the topic of Pentecostalism and HIV/AIDS. Below are their statements on this topic.

You see people do get cured of AIDS. What is AIDS by the way? It is just a disease name, just like malaria and any other disease. We humans are the one who are making a great deal out of it and make it look so different from other diseases. To God it is nothing, just as a headache is nothing to scientist. In our church when PLWHA come for prayers we teach them the word of God, we counsel them then we pray for them. - Lukundo

The statement quoted above seems to be carrying a massage of faith intended to reduce HIV/AIDS in to something small, manageable and curable. Such
statements are also expressed by church leaders in their preaching, probably with the intention to change people's perspectives about HIV/AIDS.

We pray for people with AIDS. We counsel them, teach them the word of God, then we pray for them. There are books on AIDS that I have written, like, God's medicine for AIDS; Condoms, Fear of God and How to Overcome Sexual Sins. It is just a personal initiative; I do not receive any funds for this. At the radio stations I also preach about AIDS (prevention and cure) every Wednesday. From a spiritual point of view AIDS is also a spiritual problem, sin is not just a behavioral problem but also a spiritual problem. So if you do not deal with the root cause of the problem then something will be missing in the AIDS treatment and counseling. There is for example the issue of bitterness, which comes up a lot among PLWHA. --Pastor Hekima

It is apparent that faith healing is based on individual spirituality. For it to work individuals must strive to understand the condition of self, that which causes upset, disharmony or disequilibrium. This means going beyond identification of symptoms and addressing them (Hutch 2000). The church seems particularly adept at handling psychological factors, providing the individual with a space to come to terms with his or her illness.

During counseling with women living with HIV/AIDS the issue of bitterness comes up a lot. A woman might come to me for prayers, then she tells me her story. In her story she complains with bitterness and pain that she has only known one man in her life, but now, due to that man, she is positive. That the man is now dead, having left behind young children, she might also die soon; how will her children live? Why should she die a shameful death? What did she ever do wrong to deserve that? Why should her children be orphans? This bitterness if not dealt with may be a source of other diseases like heart problems. For some--because of this bitterness, which leads to depression--their immune system drops very fast. --Pastor Busara

Dealing with emotions is another technique used to make a person come to terms with his or her situation. In dealing with emotions such as bitterness,
people are taught about forgiveness and the importance of the same. Biblical quotations are used to stress the need to forgive. It indicates the connection between mind and body that when the mind is not in peace the body can become sick as well.

Negative thoughts are often seen as a root cause of succumbing to AIDS, leading to lowered immunity, for example, but they are also understood to be a barrier in receiving healing and a cure from God. A bishop at one of the Sunday services preached that people should discard all negative thoughts about their condition and their life in general. He explained to the congregation that negative thoughts were the preaching’s of devil, intended to destroy a human being. He concluded by intoning, “refuse to listen to the preaching’s of the devil.” From this we can see that the individual has a great part to play in the healing process. As individuals, they must repent and change their lifestyles. They must do only what God wants them to do as prescribed in the Bible. In addition they should express faith in God and pray.

O’Connor offers a cogent discussion on the relation between negative thoughts and diseases. He puts forward the concept of psycho-immunity, which “rests on the theory that disease...is the product of negative thought forms which both create the conditions for disease and are themselves physically manifested as disease” (O’Connor 1995:137). The Pentecostal church’s method of healing seems to be based on a similar theory of disease, which links them to negative thoughts.

PLWHA in Tanzania are told by the biomedical establishment to live by hope (Kuishi kwa matumaini), which means though they have HIV virus in their body they can still live a normal life for many years if they adhere to medical instructions. In contrast, in the context of faith-healing the word hope is not used; instead they use the term faith.
We don’t just encourage people to live by hope, but that they should also live by faith. To live by hope is to expect something to happen in the future, but to live by faith is to have the assurance that God can do something right now in the present. We tell people that every problem has a solution. A creator cannot fail to solve any problem of his own creation. (Pastor Hekima).

The use of the term faith seems to be a way of getting the person out of the state of uncertainty. In Chapter Three it was shown that PLWHA see their future as precarious and uncertain. The pastor in the statement above seems to indicate that hope alone is not enough to eliminate the uncertainty, as hope itself is a form of uncertainty that something might or might not happen.

In our counseling equation we bring the word of God; we ask, what does the Bible say about that problem? I bring forward God because I do not have healing powers; it is God who heals. I can’t determine who will be healed when and how. What I do is to teach them the word of God, to increase their faith. --Hekima

In Tanzania there is no clear cut division between the power of the healers and the power of God. In most cases people define the power of healers as having originated with God. In faith healing it is not only that people perceive the power to heal as having originated with God but that the healers themselves see it to be so and openly claims it.

The testimonials of people who have been healed of HIV/AIDS seem to play an important role in faith treatment of HIV/AIDS. The performance of testimonials also seems to have particular meaning to those who offer them, perhaps providing them with an avenue for psychosocial healing as well as physical healing.

Did you listen to the radio program last week? I was in the studio talking about how I was healed of AIDS. --Hiyari
Mr. Kiratu’s testimonial was typical. He was HIV positive but he had faith that God would cure him. He prayed a lot for many days without giving up and he prayed for many hours in a day. Despite this, he got worse, developing “full-blown” AIDS. He had all the symptoms of AIDS, and everyone who saw him knew that he had AIDS. Even then he still kept on praying and finally he was cured. He went for HIV/AIDS testing to more than 3 different big private and government hospitals and the results were the same: he is now HIV negative. During his testimonial at the church he displayed all his certificates, those claiming he was positive from before he was cured and those of claiming he was negative from after he was cured. Mr. Kiratu’s story is well-know and when he was recently married to a woman named Hope, their wedding was even covered by newspapers. They offer the birth of their healthy baby girl as more proof of the glory of God.

In this same church Hope also testified of having being cured of AIDS. She is a nurse in an army hospital. Her first husband died of AIDS and she was also HIV positive. Everyone in her office knew that she was positive. She joined the Pentecostal church for prayers and has been healed. During her testimonial she also displayed all her certificates from before and after she was cured.

Testimonials were also offered by a family in which all the members had been cured of AIDS.

I went to a witch doctor and I took my whole family with me. The same razor blade that the doctor used to cut up my flesh and put medicine was used for my wife and my four children. By then I didn’t know that I had AIDS. Through that razor blade my whole family was infected. There was no hope; we were going to die. I started praying, I would go to an open space where there were no houses and start praying. I usually did that after working hours. I prayed in my mother tongue so people couldn’t hear what I was saying. I used to pray aloud, I cried a lot; I would even through myself on the ground. By the time I was going home my clothes were covered with dust. In the church also I prayed the same way. Finally
God answered my prayers he cured me and my entire family. --Mr. Jemedari

Before committing suicide I decided to read the bible first. Every line I read that day was about God’s healing power. I read the story of Naamani in the bible. Naamani had leprosy at the time when leprosy had no cure, but God healed him. Then I remembered that the bible says God do not change he is the same yesterday, today and forever and that he knows no partiality. I threw the pills away and started praying. I did not receive the healing in one day, or in one month. My situation got worse but I did not give up faith. I worshiped in different Pentecostal churches. One day I heard a pastor preaching on the radio station. He talked about God’s cure for AIDS, I decided that I will visit that pastor’s church. I visited that church saw the pastor, and received prayers and counseling. The week that I received my healing I was suffering from herpes zoster, upon receiving my healing the herpes zoster dried up. I went to a hospital and also to Angaza for blood tests and I tested negative. If someone is to tell me that God does not exist I will never understand. --Ayubu

As Pastor Hekima’s comments below suggest, Pentecostalism often offered proof, in the form of negative HIV tests, to emphasize their success in achieving a cure. In this way, we once again see how science and faith are woven together in every day practice and dialogue. In this same vein, prevention was also put forth as being an important aim of the church. Though, clearly built on public health discourses, prevention was also conceived as part of a psychological project, whereby the individual must be encouraged to alter his or her lifestyle in the name of God.

It is not something that we are trying to make people believe. This is not a trial on error thing, it is not hit and miss; it is something we have seen working. We already have 34 people who have been completely cured of AIDS. They went for blood tests and they have tested negative for HIV/AIDS. We now have a big number of PLWHA attending the church. People would keep on coming if they did not see any results or gains. The church has a lot to offer in terms of HIV/AIDS. It has the power to deal with both prevention and cure. Prevention is always better than cure; I suggest the church should put a lot of effort in prevention. The church can also help prevent further transmission of HIV/AIDS. When we preach and teach how to abstain from sexual sins we are preventing further
transmission. We also encourage people to test and know their HIV status. During the radio programs I talked about the twenty reasons why one should go for HIV/AIDS testing. --Pastor Hekima

The testimonials of people being cured of AIDS connote a number of things. It is first and foremost a method for making others believe. To make people believe - -have faith-- that HIV/AIDS can be cured, that HIV/AIDS is not an irreversible condition. The testimonials seem also to suggest a different way of perceiving HIV/AIDS and bringing forth new modes of hope and faith to replace those that were lost upon diagnosis.

Despite the conviction of church leaders and many parishioners of the Pentecostal church (including many PLWHA), there are many members of the public who freely express their doubts about Pentecostalism and a cure for AIDS. One of my best friends was getting married. The bridegroom to be and his relatives came to my friend’s family to introduce themselves and ask for my friend’s hand in marriage. A bride to be is not supposed to be around when the bride price is being discussed. When the elders were discussing the bride price I my friend and I, along with other relatives and friends of our age group were seated inside while the bride price discussion were going on outside in the garden. It was in this setting that I brought up the topic of God’s cure for AIDS.

This disease is terrible, may God protect me that I never get it. I have faith in God, and I know that God can cure diseases, but not AIDS. Those who are saying they have been cured of AIDS, hmm, something fishy must be going on. It is not true at all. --Rose

I really don’t understand but I would like to know more. From what I know AIDS has no cure, yes I do believe in God but AIDS, hmm, I don’t know what to say. What I find strange is that these people even have medical certificates. They mention the hospitals where they took the test; if it is not true why don’t those hospitals refute those allegations? And our government is silent about this issue. I think a research is needed in this aspect. --James
There are many things, which can't be proven scientifically but that doesn't mean they are wrong or that they do not exist. I am not a Pentecost I am not even a Christian, but I do believe in God. My mother is a Christian and my father is a Muslim. I chose to be neither of the two. But yes I do believe that God can cure AIDS or do anything else He wants. That is why He is God, if human beings fail and He also fails then He won’t be God He will just be like us humans. –Aisha

Though it is obvious from these statements that people have their doubts about God’s ability to cure AIDS (even when their faith is otherwise very strong), their doubts are not always clear-cut. They express some ambivalence, wondering about the nature of the evidence put forth by the church as proof of cure. It is precisely in this space of uncertainty and ambivalence, which seems to characterize AIDS in so many ways, where fertile ground exists for the sowing of conviction about the power of faith to bring about a cure to the disease.
PLWHA join Pentecostal churches for different reasons. One of the most important things seems to be testimonials of people claiming they were cured of AIDS through faith. As Helman has suggested, “… a doctor’s treatment is often evaluated ‘in the light of his past performance, with what other people have experienced, and compared with what the person expected the doctor to do’. In this way the ill people make choices, not only between different types of healer (popular, professional or folk), but also between diagnoses and advice that make sense to them and those that do not” (2000:69). In the context of Pentecostalism, it would seem that testimonials play an important role in informing parishioners and the public about the healing power of God, putting Him forth as the supreme healer, capable of subsuming the realm of the popular, professional and folk.

Other PLWHA go to Pentecostal churches simply to search for a cure. People living with AIDS strive to live their daily lives, but sickness constantly hinders ambition. At the same time, the sick role in Tanzania is understood to carry certain obligations. People who are sick are expected to search for a way to get better. Those I interviewed made it clear they understood this obligation and took it very seriously. They often spoke of their affiliation with the Pentecostal church as something that helped them to fulfill this obligation.

As you know a drowning person does not give up trying to help himself from drowning. --Havijawa

I am on ARVs currently but I am also attending a Pentecostal church. I do not only want treatment, I want cure. --Mhogo mchungu
It can also be viewed like a club where people socialize. Church members
and leaders come to visit me and encourage me. The church teachings
also give me hope. There is something additional, which is difficulty to put
into words that I gain from that church. --Matokeo

Glasser has suggested that people only turn to religion or faith out of
desperation, when science fails them.

The exception occurs when patients are desperately ill or ill with incurable
ailments such as cancer or AIDS. It is then that science is thrown out and
the remedies composed of concentrates of apricot pits (often resulting in
death by cyanide poisoning) are sought for cancer cures, or pilgrimages to
Mexico are undertaken for medicine for AIDS touted to have cured
thousands. It is when we are desperate that we will rely on authoritative
medicine, assume the dependant role, and trust in magic. (Glasser
1998:383)

I would argue that “trust in magic,” as Glasser calls it, does not only take place
when people are desperately ill. Sometimes it is a matter of pre-existing faith or,
more commonly, faith in God co-existing with hopes for science and biomedicine.
I would concur with O’Conner that there is no sound basis that religious healing
is sought only as a last resort where there is no other solution (O’Connor 1995).
As Ayubu expressed during an interview, “I was a Pentecostal even before I
knew that I had this disease. So when I became ill I knew exactly who to rely
on.”

The church seems to fill a gap in healing not often addressed by medical doctors
in Tanzania. The church offers a space of faith, but also a space to address
emotions such as remorse and fear, which are so common among AIDS
sufferers. As Helman (2000) has suggested, these emotions may not be taken
into account by medical doctors who usually concentrate on diagnosing and
treating physical dysfunctions.
My experiences at the hospital where AIDS patients were treated supported this view. Not only were medical professionals disinterested in patients' psychological and emotional well-being, it seemed to me they were often insensitive, failing to uphold patient-confidentiality, contributing to stigma, and generally adding stress to their lives. Even in contexts where ARV treatment is provided, patients require more. ARVs may address their physical ailments, but they offer little to alleviate emotional and psychological stress.

**AIDS and Biomedicine**

Although section 1.6 (m) of the National AIDS policy states that PLWHA may be required to meet some costs of HAART, currently PLWHA in need of ARV treatment receive it for free. The national HIV/AIDS policy will be amended to reflect the current situation on HIV/AIDS.

> I am thankful that we now receive AIDS medicine for free from the hospital. We were told this will continue for five years. I am worried what will happen after those five years. --Matooke

> We were told it's a five year program. After that I think something else will be introduced; I am not sure what will follow. --Nurse Havintishi

Though PLWHA receive ARV for free in government hospitals they still worry about the future. This could also be one of the reasons why they search for alternative treatment. It could also be the reason why they are searching for a cure: to have a permanent solution.

Due to economic pressures on the entire medical sector, citizens of Tanzania have found it increasingly important to take the initiative to find their own solutions to their medical problems. Though Tanzania once provided free health care to its citizens as part of the socialist state, since economic reforms and
decentralization began in the mid 1980s as part of structural adjustment efforts, patients have found themselves increasingly responsible for paying for health care.

Recent global efforts to guarantee the provision of free ARV treatment of PLWHA in poor countries have made their impact in Tanzania. Those requiring treatment in Dar es Salaam can obtain free ARVs in the government hospital. Despite this, there are many who still go for alternative treatment. The provision of free ARVs is still in its early stages and too little is known about the reasons people choose alternative therapies instead of or along side of ARVs to make convincing arguments about why this might be so. It is clear, however, that O’Connor is on target in his claim that, “the presence of modern facilities does not necessarily reduce the use of these alternative practices” (1995:18).

We have told PLWHA not to combine ARVs with the other types of AIDS medicines that they get from traditional healers. We are not sure whether they do exactly what we tell them or not. But for those who combine ARVs with prayers, that is okay as long as they do not stop taking their medicine. After all, those who are religious, those who hold tight to their faith respond better to the medicine. --Nurse Siyangu

The health system in Tanzania is currently over loaded; the doctor patient ratio is 1:25,000. It has also been observed by WHO that the scaling up of ARVs will mean an even greater workload (2006). Some informants reported that when they go to the clinic they spend the whole day there. This is in part because medical practitioners have to attend to other patients who need their immediate attention first. Though PLWHA mentioned this, they did not frame it as a complaint. Most were grateful because they were receiving HIV/AIDS treatment for free. For the sake of their well-being they were willing to wait.
The problem that we are currently facing is that we medical professionals are few. More medical professionals need to be recruited; it’s real a burden. – Havintishi

As for now ARVs are offered for free only in district government hospitals. I think this should change and ARVs should be available in all government hospitals. This will not only be beneficial to us as it will somehow decrease the workload. It will also be beneficial to patients especially in the villages. Some villages are very far from the district hospital were ARVs are available and for a sick person it is even farther.
-- Siyangu

Below are more statements on the problems prevailing on ARV, Counseling and testing.

On the issue of testing and counseling I really congratulate the good work done by “Angaza” --the professionals in testing and counseling. One thing though I suggest they consider the issue of age. It was not correct culturally for a very young man to tell me about my status and to council me on the same. I would prefer someone older. --Shida

The posters reading “center for counseling and testing” I think are a good idea as from afar one can tell where he can obtain such services. On the other hand those posters aren’t nice because when a person sees you approaching those places they know exactly what you are going to do. Unlike the hospitals where everyone goes for different reasons, if someone sees you entering a hospital they won’t know that you are there for HIV test --Hiyari

It is clear from these statements that there are still many problems with the provision of ARVs, as well as counseling and testing services. Medical personnel are overworked, and patients often have to wait for less then courteous service. Yet these drawbacks do not seem to stop PLWHA from seeking out biomedical treatment. Though I had thought I might find people seeking faith healing as an alternative to ARVs, perhaps because of problems in the biomedical system, my data suggest that people instead seek faith healing as an accompaniment to ARVs. They do not turn their back on biomedicine, but instead see it as one component of their health care.
This study seems to indicate that problems that might exist within the current biomedical model for treating AIDS have little to do with why people search for alternative therapies or use multiple therapies. Having said this, however, it is important to note that people do seek out God and specifically the Pentecostal church in search of a cure. While they recognize that biomedicine and ARVs provides them with a certain amount of hope for a longer, healthier life, they also have faith that God might one day cure them if He so desires.
Conclusion

The aim of this study was gain an understanding as to why PLWHA turn to Pentecostal churches for faith based healing. The focus was on PLWHA and has a Pentecostal faith. I examined how HIV/AIDS status changes a person’s identity; how that change of identity changed the meaning of life; how people struggle to find a way to get their lost identity back; how that struggle of gaining their identity back lead them to faith based treatment. I also discussed how faith based healing is conducted, and how these various factors influence PLWHA to turn to faith based treatment.

In Tanzania people tend to act upon the information they get from trusted others like religious leaders, healers and doctors. Usually the information from different healing model differs even when it is about the same subject. The differences occur because of the variations in interpretations. This situation prevails also in HIV/AIDS treatment. Each health model has its way of treating AIDS. PLWHA in Dar es salaam live in an environment where the truth about AIDS is told and explained from different perspectives. This situation gives room to PLWHA to choose what they deem fit for their situation.

The overall findings of this study suggest that people are not ignorant of the scientific aspects of HIV/AIDS treatment. They are quite aware that from a clinical point of view HIV/AIDS has no cure. When they turn to faith-based treatment they do so not out of ignorance but as a result of a self care management As Trostle et al (1983), Conrad (1985) and Robertson (1983) have argued, people are active agents in the course of their own health care. Therefore the act of PLWHA to turn to Pentecostal churches for faith-based treatment should be understood as a way for them to take personal responsibility for their health and gain control of their lives. And reflects the way
individuals strive to live a better life in the midst of a chronic disease (Thorn et al 2002).
Bibliography

Bernett, T. & Whiteside, A. 
(5 Aug. 2006)

Caldwell, et al. 

Cohen, D. 
(5 Aug. 2006)

Conrad, P. 

Farmer, P. 

Farmer, et al. 
Geetz, C.  

Glasser, M.  

Helman, C. G.  

Hutch, R. A.  

Jonson, et al.  

Johnson, J. L  

Nanda, S. & Warms R.L  

Nyblade, et al.  
2005  Measuring HIV stigma: Results of a field test in Tanzania.  
O’ Connor, B. B.  

Pearce, T. L.  

Robertson, M.  

Smith, et al.  

TACAIDS  
(1 Aug. 2006)

TACAIDS  
2006 National Policy on HIV/AIDS.  

Tanzaniacare.  
(3 June 2006)
Thorne, et al.

Trostle, et al.
1983 The logic of compliance: Management of epilepsy from the patient’s point of view. *Culture, Medicine and Psychiatry* 7: 35-56

USAIDS

Van den Borne, F.

Walcott, H.F

WHO