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In search of a cure: Experiences in alternative medicine in Masvingo Urban, Zimbabwe

by

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Declaration

I, Hardlife Stephen Basure, student number U17313122 hereby declare that this dissertation, "*In search of a cure: Experiences in alternative medicine in Masvingo Urban, Zimbabwe*," is submitted in accordance with the requirements for the Doctor of Philosophy (Anthropology) degree at University of Pretoria, is my own original work and has not previously been submitted to any other institution of higher learning. All sources cited or quoted in this research paper are indicated and acknowledged with a comprehensive list of references.

Dedication

To every patient, navigating the labyrinth of healing.

Acknowledgements

To have achieved this milestone in my life, I would like to express my sincere gratitude to the following people:

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To God be the glory, forever.

Abstract

This thesis examines the consumption patterns of Asian alternative medicines in Masvingo urban. My focus was on understanding the flourishing of the Asian cures in the Zimbabwe's oldest city by focusing on the distributor, the consumer and the environment characterising the discourse on alternative medicine. The major arguments point to a changing landscape of the experience of health and healing due to several factors. I argue that macro politico-economic factors and cultural issues are responsible for structuring the consumption of Asian alternative medicines. The political and economic crisis has had a huge bearing on the health sector hence spurring the emergence of alternatives which seek to fill in the gap and simultaneously offer an opportunity of income to many individuals whose livelihoods cannot be sufficiently met through the formal channels. On the other hand, the political leanings of the country towards the East have brought with it an influx of Eastern products and health remedies. I also argue that local cultural factors are responsible for the patterns in which the medicines have found place in the city since they claim to deal with issues which are of cultural and social significance to the people in the study.

List of Acronyms

AICAM	Asian Inspired Complementary and Alternative Medicine
AIDS	Acquired Immune Deficiency Syndrome
CAM	Complementary and Alternative Medicine
ESAP	Economic Structural Adjustment Programme
HIV	Human Immunodeficiency Virus
KJV	King James Version
LMS	London Missionary Society
MCAZ	Medical Control Authority of Zimbabwe
NCM	Non-Conventional Medicine
NGO	Non-Governmental Organization
PCC	Pentecostal Charismatic Church
QMR	Quantum Magnetic Resonance
RBZ	Reserve Bank of Zimbabwe
RTGS	Real Time Gross Settlement
TCM	Traditional Chinese Medicine
WHO	World Health Organization
ZINATHA	Zimbabwe National Traditional Healers Association
MLM	Multi-Level Marketing

Table of Contents

Contents

Chapter 1

Setting the scene: health healing and the search for a cure

> *We are headed for a wholesale change—a medicine as different from modern, scientific medicine as the modern practice was from its primitive predecessors. We are in the early stages of what can be called the "new medicine," a medicine in which patients will recapture responsibility for their own health choices—including choosing their own therapies based on their own beliefs and values. It will be a world in which patients will, in a very real sense, have to heal themselves.* Veatch (2008:04)

1.0 Introduction

Health and healing are central concerns of humanity in all societies. It has been the source of countless claims and developments as people seek to maintain states of wellbeing. Claims to restore health have come from different segments of society and in contemporary health care systems, pluralism can be seen to characterize the healthcare sector. However, the predominance of western biomedical models has seen them being recognized as the formal and mainstream healing systems, much to the detriment of other medical systems which have assumed the label of alternative medical systems (Estroff, 1988; Holst, 2020; Mohyuddin & Ambreen, 2014). These encompass traditional medicines, herbal, medicines, faith healing among others (Chavhunduka 1997). Healing is an indispensable part of all known human communities. From the consumption of herbs, pain killers, healthy foods, societies have always been health-conscious in a variety of ways. Walking around the streets of Masvingo urban (I use this term as it is used colloquially in the region to refer to the urban areas of Masvingo), one is mesmerized by overzealous salespeople trading their elixirs which have fantastic claims to deal with a variety of ailments. The ordinary busy person simply brushes past these salespeople, whilst occasionally some would grab the fliers shoved in their faces and continue along with their journeys. What I am sure of is that one cannot go into the town's central business district on any day and fail to encounter these medical merchants.

Surprisingly, no significant official (governmental) attention has been directed towards these medical salespersons, whose existence has become part of the urban ecosystem. As Taru (2019) noted, Zimbabwean state institutions are sometimes absent or operate minimally in certain respects. It is in this arena of foreign alternative medicines where the eye of the state has not been adequately directed. Though both biomedicine and indigenous medicine have boards that

regulate their operations, most foreign healing medicines slip through the regulatory loopholes and operate outside the purview of the state and its regulatory agencies. Chapter four further discusses how this lax regulatory environment in Zimbabwe has partially allowed the flourishing of foreign healing remedies. These observations, coupled with my personal experiences, stirred an interest in me to investigate the dynamics of these medicines which have invaded the nooks and crannies of the city. At the onset of my study, I went to the city's Civic Centre to explore a medical exhibition where different specialists advertised their products. My attention was drawn to a stand manned by two well-dressed gentlemen, who had a laptop, a silver machine and different brightly coloured bottles which contained a wide array of pills. That was my first major contact with Asian medicine distributors, and after about thirty minutes of discussion, testing and diagnosis, I walked away with a blue bottle, containing oblong-shaped bright blue tablets, which were supposed to usher me onto a path of recovery from some problems we had discovered during the discussions.

This type of medicine seemed to be a new kid on the block. My observations around town directed me to organisations with similar modus operandi. The only difference seemed to be the ways in which they treated and some of the medicines they sold. The initial research questions which came to my mind were what *are* these medicines? How do they operate? What do people go through to secure wellness and a cure to different ailments? As will become clear throughout this thesis, these questions were also refined during the study, to incorporate other emerging issues which included discourses on the perceived 'authenticity' of medicine, competing medical systems as well as the power of the patient as the locus of healing relationships.

1.1 Thesis standpoints

In relation to the various questions raised, three major arguments emerged from this research. The first major argument is that there is evident exploitation of uncertainty in alternative approaches to healing. The nature of healing itself is inconclusive and gives vague parameters which are open to exploitation by both patients and healers. Issues of power and control are central to understanding the dynamics of this uncertainty. The second argument is that the body is a platform upon which the political, socio-economic, and cultural dynamics of life play themselves out through health-seeking behaviour. To consume Asian inspired medicine, for

instance, is – at least partly – to embrace the political discourses of the East as it is perceived in Zimbabwe. It is also to claim a postcolonial approach that questions and rejects biomedical hegemony and is an expression of the freedom of the patient from the control of the medical specialist. Related to this, the proliferation of Asian alternative medicines would appear to reflect a nation in crisis, riddled with political and economic turmoil. It is also a way of economic empowerment in a nation characterized by a dysfunctional economy, hence the practice of associating health and wealth. It is also a pointer towards economic freedom where one is exhibiting financial ability through the types of foreign medical remedies one can consume. It reflects the cultural through expectations of bodily functions and appearance, which are issues alternative medicines claim the ability to solve. The third argument is that the historical contact of different medical systems has led to hybridization and mimicry, with contemporary alternative healing imitating the biomedical model, such that the way of operation of non-biomedical models are becoming more like biomedicine in presentation and outlook as well as in crafting of philosophical foundations of healing. As opposed to greater repulsion of biomedicine, alternative healing is challenging biomedical hegemony through creating narratives that present a logic of healing that is almost like biomedicine. Significant emphasis is on presenting an image acceptable by science and rationality in a biomedical fashion. However, the distinctive approaches and techniques remain somehow different though the attempts of incorporating a scientific approach are evident. A point to note is that whenever there is evidence of mimicry, attempts are often made to create the distinction between the authentic and the imitation. Hence one cannot escape dealing with arguments on 'fake' medicine which I have also attempted to consider in this thesis.

1.3 Conceptualizing the field: some definitions.

In this section, an attempt is made to explain some key issues relevant to the study. However, the definitions are not exhaustive since the following chapters also contain some sections of literature review (For effective engagement with various literature on healing, alternative medicine, the body and authentic/fake dichotomy, I have chosen to review literature in relevant chapters as opposed to having one large section on literature in the introduction). The first key issue which needs to be understood is the nature of complementary and alternative medicine central to the thesis. This study sought to capture people's experiences in alternative medicines against the backdrop of the proliferation of mostly foreign alternative medicines in Zimbabwe,

all of which claim abilities to deal with a wide range of ailments. Defining alternative medicine has always been problematic and contested with general definitions defining it as encompassing those medical systems outside formal regulation of state authorities (Debas, Laxminarayan, Straus, *et al.*, 2006; Hollenberg & Muzzin, 2010; Pal, 2002). However, even those which are within the statutes have categories, with western biomedical medicine having an oversight of the medical fraternity. Alternative medicine, as the name implies, points to a deviation from a reference point of healing (Ross, 2012). In this case, the reference point can be seen to be constituted mainly by biomedicine, the 'centre of medical gravity', if you like. Biomedicine is often regarded as the conventional or orthodox healing system (Ernst & Fugh-Berman, 2002). Using the yardstick of formality may also fail to capture the nuances of power dynamics even within the formal system. Taking, for example, the relationship between biomedicine and indigenous healing/ traditional medicine, one can note that the latter, despite being recognized at law, is still perceived as an alternative to biomedicine. Though numerous studies have cited the primacy of traditional medicine in Zimbabweans' health-seeking behaviour (Chavhunduka, 1998; Gunda, 2004; Moshabela, Bukenya, Darong, *et al.*, 2017; Shoko, 2007), in my experience the prevalent perception has been to categorise it as informal and as an alternative. A deeper analysis of the politics and dynamics of naming is discussed in the next chapter. The business of bringing the subject matter under discussion to a logical and coherent discourse with clear terminology was challenging. However, certain features of the medicine could be analysed to try and categorize the medicine that this thesis deals with. Firstly, the point of origin of much of the medical interventions discussed in this thesis are important in the attempt to find a suitable nomenclature. Most of the products and procedures which characterize the foreign alternative medicine under study are of Asian origin and most of the products are also manufactured in Asian countries. An identification based on the point of origin, can therefore assist in classifying the medicine.

The ways in which the medicine is incorporated in the existing healing corpus is also important in the classification of this relatively 'new medicine'. I have adopted the idea of Complementary and Alternative Medicine (CAM) due to the ways in which the medical products work. Firstly, they can be seen to be complementary to existing medical systems as most of the products do not seek to supplant existing medical systems. A closer analysis shows that the foreign alternative medicine blends with existing biomedicine, faith healing as well as indigenous medicine. In some instances, the foreign alternative medical products are also

viewed as a better/alternative way to existing medical systems hence the need to classify the medicine as an alternative to what already exists. These two considerations have informed the categorization of the medicine I discuss in this thesis as Asian Inspired Complementary and Alternative Medicine (AICAM). I will discuss in the next chapter what constitutes AICAM.

1.3.1 Mapping the study area: Historical overview of the city

This study was based on Masvingo Urban, which is generally regarded as the oldest city in Zimbabwe since it was one of the first points of settlement during the period of colonisation. The city is also famous for being home to one of the ancient artefacts of African civilization i.e., the Great Zimbabwe Ruins from where the country is supposed to have adopted its name, and the city itself is named after the stone walls (Masvingo) at the ruins (Chigara, Magwaro-Ndiweni, Mudzengerere, *et al.*, 2013; Garlake, 1982). The city was the preferred capital for the colonial Pioneer column before they abandoned the idea after reaching Salisbury (present-day Harare). The colonial settlement grew attaining the municipality status in 1953. The postcolonial town also attained city status in 2002 as the population continued to grow to the current estimates of 88 000 people. The city grew as a major administrative centre for the province; hence its population reflect a circular migration of people within the province. The predominant ethnic group is the Karanga, which is regarded as a subgroup of the Shona ethnic group. This has largely shaped some of the belief systems and perceptions towards health and healing. The religious beliefs of the Karanga are somehow linked to general attitudes towards philosophies of disease causation and the kind of measures which are acceptable when one is dealing with the disease.

The economic system of the city is generally inherited from the colonial outlook of the city, with administrative and commercial jobs constituting much of the labour market. The city houses the provincial government offices, and it is also the provincial hub of trade and commerce. There is relative lack of industrial development in the city, hence most of the working class is absorbed by government and few commercial institutions. There is also a considerable informal economy, which spans trade in different commodities including food, agriculture, clothing, home industries and other trades. The informal economy absorbs much of the unemployed persons and is the most accessible means of livelihoods in a country characterized by high unemployment and limited formal channels of employment. The proximity of the city to the South African border mediates informal economy, with most people engaging in cross-border trading. The trade in alternative medical products also inhabits this

informal economy, since most of the distributors operate informally, whereas those who have a semblance of formality operate backyard clinics or share spaces with other traders operating hair care saloons or small merchandise stalls. The city is the most preferred investment hub of people within the province, with most people working in the province owning residential properties in the city. This has resulted in the growth of residential areas as the city absorbs a ballooning population and occasional residents who view properties as an investment. Place of residence, to some extent, are indicators of lifestyle and economic status. Masvingo urban has plush low density residential areas such as Rhodene, Clipsham and Zimre Park. Eastvale and Target Kopje are middle density suburbs. The bulk of the population in Masvingo urban reside in high density suburbs such as Mucheke, Runyararo West and Rujeko. The expansion of the Great Zimbabwe University has also added a student population which has altered the population dynamics of the city. It has added pressures on accommodation, and added a cultural trait influenced by student cultures.

1.4 Methodology

The study was informed by ethnographic fieldwork to understand the different aspects of foreign alternative medicine and its practice. The ethnography was conducted over a period of fourteen months of fieldwork. The study was based in Masvingo Urban which also happens to be a provincial capital that is the centre of commerce and other services within the province. Pragmatic and practical concerns influenced the choice of Masvingo Urban as the study area. These included issues of proliferation of trade in foreign alternative medical products as well as my own access to the research site. Having lived and worked in the city for more than ten years, I have witnessed changes to the city's landscape and practices. Being a resident researcher also came with the advantage of extended fieldwork and continuous interaction with the research issues even outside formal times of conducting the research. It should be noted from the onset that studying informal and quasi-formal practices has its own challenges. Some of the challenges are related to the vastness of the field. This forces one to take time to categorise the different practices which fall under the areas of interest. The study noted at least ten variations that could be classified under the foreign alternative medicine. However, for practical purposes, I divided the practices into three broad categories, that is, herbal medicines, quasi-scientific medicines/innovations as well as healing techniques. On the healing techniques, there were only three major practitioners who practised massage therapy, one with the assistance of machines whilst the other used their hands and considered themselves to be

reflexologists. The rest of the players in the foreign alternative medicine market were distributors of herbal and related products.

The complex nature of studying alternative methods has been discussed by Ross (2012). She notes that alternative healing is a modern fieldwork site that is dynamic, elusive, and subject to numerous interpretations. I experienced these complexities and spent several months attempting to compartmentalize and make sense of the varieties of alternative healing methods. To deal with the problems posed by the vastness of the field, I engaged in the ethnography of the city considering that most of the foreign alternative medicine practitioners were dotted around. An ethnography of the city can be seen to be a method which not only takes the city to be a social laboratory but also incorporates the urban dynamics in the understanding of social phenomena (Ocejo, 2013). The urban layout, location, politics, and economy are all factors that were important in creating discourses of practice around the issue of health and healing. The city was also important in the distribution matrix of foreign alternative medical products, as it was an integral component in the networks of distributors. Though indigenous medicine was not of my particular interest, I also observed how its practice was influenced by novel herbal methods as well as the interaction with foreign alternative medicine as they shared the same urban spaces. The lines between healing systems increasingly become blurred as there is a lot of interfaces and crisscrossing between the medical systems. The following sections discuss some of the ethnographic methods explored as well as the fieldwork experiences in the usage of those methods.

1.4.0 Participation and observation.

One of the hallmarks of ethnographic research is the data gathering method of participant observation. However, it is also one of the most contentious methods due to the ethical dangers associated with the practice, as well as the emotional attachment which it creates. This has the potential to compromise the quality of data and the objectivity of the researcher. Despite these dangers, I found participation and observation to be useful in generating information about foreign alternative medicine. It enabled the capturing of narratives and descriptive data, since participant observation enables the ‘thick descriptions’ of data from the field, as the researcher immerses themselves in the field of study (Geertz, 1973; Tholen, 2018). My participation and observations were limited to certain parameters.

Firstly, I participated indirectly in the distribution of foreign alternative medical products. Due to the relations which I nurtured with key informants, I escorted them when they visited some of their clients and observed every detail of the consultative encounters. I also spent considerable time in the clinic of one of my key informants, who would treat me as his assistant when attending to his clients. Most of the time the clients would not mind my presence since most of the procedures and consultations were devoid of sensitive issues. I also attended three different training workshops, where I received information on how to sell the foreign alternative medical products as well as the economics of the trade. Though I received the technical knowledge, I felt it inappropriate for me to also join the trade personally. This was due to personal reasons which included my curiosity and questions on the authenticity and effectiveness of most of the foreign alternative medical products. Moreover, due to constant interaction with some consumers, I was afraid of not being able to provide sufficient answers in case things go wrong during the healing relationship. Hence, avoiding direct participation in selling products, helped me to process my reservations and doubts internally, as well as learning from consumers' experiences thereby avoiding passing judgement based on negative personal experiences and misgivings.

The second dimension of my participation including using my body as the subject of the research process. This process enabled me to find inner insights and gain trust with respondents since at times we were 'walking the healing journey together'. I also underwent the whole process of diagnosis and treatment for the different problems which the distributors diagnosed on me. Firstly, I consumed some pills which were meant to supplement some calcium deficiencies which I had been diagnosed with. Secondly, I also paid for and received some massage therapy sessions to deal with some back pain that I was experiencing. These personal experiences were also important in shaping my understanding of the consumption dynamics that characterise foreign alternative medical products. Moreover, they provided me with an opportunity to interview and have discussions with some patients, who narrated their experiences in using the different foreign alternative medical products which they were consuming. The use of the body was also important in attempts to have a first-hand experience of how it felt to consume foreign alternative medical products. Although I am a researcher, I also experience life like anyone else, pain, sickness, and some unresolved illnesses which I felt, there was no harm in trying out the foreign alternative medical products. Although I was somehow sceptical, anxious, and excited about the new medicines, I must admit I found some

of their explanations plausible to my feelings and experiences having used them. It is possible that this was psychosomatic on my part. However, the coincidence sometimes seemed beyond mere happenstance but could point to some knowledge of conditions and solutions to them.

Sometimes I pushed the experiences to the back of my mind, reasoning to myself that maybe it was simple guesswork, where one can generally know that people of this age and sex are often plagued by these illnesses. It is like guessing that a young woman may be suffering from menstrual discomforts, for example. I did not finish the courses of some of the pills and supplements I was given due to several reasons. Sometimes fear after getting some information could make me stop as I also considered the danger, I was exposing my body to. This experimental methodology was thus useful on several fronts, for my own personal garnering of knowledge on the alternative medicines and, perhaps most importantly, in building trust with my research informants.

Personal encounters also included my experiences with some close family members and relatives who would also consume foreign alternative medical products to deal with different health problems they were experiencing. Their experiences provided most of the candid conversations on foreign alternative medicine as I could witness the entire process of consumption. Unlike some other interviewees who had boundaries and where it was difficult for me to be able to observe the whole process, these personal experiences provided verifiable and true information. One could go and use other medicines after we spend the day together, but for personal experiences, most of the time I was also consulted and even contributed to some medical decisions during the healing journey. However, I made it a point to avoid prescribing products and suggesting the usage of foreign alternative medical products to close acquaintances. I could only observe their choices and ask their experiences with the medicine without swaying their opinions to consume any particular brand of foreign alternative medicine. Neither could I carry my personal experiences and testimony from elsewhere to close people as a way of suggesting better ways of dealing with their health issues.

Another method that I employed was the observation of the city and environs under which foreign alternative medicine distribution occurred. The location of the alternative medical clinics, the positions and location of marketers, the kind of people who passed through and came for consultations were also observed. This observation of the urban space revealed some interesting dimensions of stratification according to income levels. It determined the types of

medicines which were sold and the type of clientele who could access such areas. City observations also brought out information like the signage, type of posters, location of posters that people used to advertise their medical business. In the well-established tradition of the Chicago School, the city became the laboratory of research, where observation was crucial to provide insights, without tampering with the way people interacted. Just walking around the city or sitting on the pavement watching people move in and out of the alleyways where they purchased different goods and pausing to read different notices was an important way of gathering insights into the world of foreign alternative medicine as well as people's health-seeking patterns.

1.4.1 In-depth and unstructured Interviews

In-depth and unstructured interviews were held with various groups of people who included the foreign alternative medicine distributors, consumers, biomedical personnel, key informants, and general people who had an interest in foreign alternative medical products. I interviewed a total of forty consumers of foreign alternative medicine. These were mainly acquired through purposive sampling and snowballing. The clinics were important for also making referrals since the distributors were willing to link me up with most of their long-term clients. The consumers provided most of the information around the consumption patterns of foreign alternative medicine. I also managed to interview thirteen distributors/healers/health consultants, who were purposively selected among the numerous practitioners in the city. My selections also attempted to ensure that the various healing methods and techniques under foreign alternative medicine are effectively represented. Some preferred to be called 'doctor' whereas others simply chose to be identified as distributors. I attempted to ensure that the interviews were captured in a formal and orderly manner. However, I found it too cumbersome to rely mostly on formal interviews as people would respond almost in a mechanical and methodical manner. Rich information often came from the conversations held in the clinics, in public spaces, and during healing sessions. The idea of bringing out a voice recorder created uneasiness in interviewees even after they had consented to participate in the study. Only key informants and most distributors were the ones who were more comfortable as they did not mind being recorded or me jotting down notes whilst I asked questions.

1.4.2 Netnography and secondary data

The utility of social media platforms in social research is increasingly becoming appreciated and incorporated by different researchers (Airoldi, 2018; Caliandro, 2018; Horst, Hjorth & Tacchi, 2012). In anthropology, netnography is the term that has been adopted to characterise the harvesting of online data in research (Bowler Jr, 2010; Kozinets, 2015; Langer & Beckman, 2005), whilst others have opted to employ the term online ethnography (Horst *et al.*, 2012). Social media spaces also proved to be important sources of data in my research. Most of the distributors operated WhatsApp groups where they advertised their products and interacted with both current and prospective consumers. Some also heavily marketed their products on local WhatsApp business and citizen groups. Others even conducted online training on distribution and posted testimonies as a way of marketing and proving the authenticity of their products. Information was also acquired from Facebook pages as some distributors had pages in which they advertised products whilst consumers also posted their experiences. Social media pages also provided information, not only on what was happening in my field of study but also experiences in other parts of the country. Such discussions provided important insights, and a window to see experiences in other parts of the country and the world in general. As noted by Caliandro (2018: 1) the role of the ethnographer must not be limited to a particular group, but must involve, "…mapping the practices through which Internet users and digital devices structure social formations around a focal object...", I resorted to centralizing my research around the experiences of foreign alternative medicine. Hence, I collected information from local groups to which I belonged. It can be noted that contemporary communities have online groups for different things. These may include service delivery, advertising, family groups, work, and occupational group as well as groups which may just be focused on a particular topic like football, accommodation searches or even neighbourhood notices. I pursued almost every group link which I came across, which had people from my research area. Interestingly, adverts, experiences and people seeking information on foreign alternative medicine, always popped up in most of the groups. Sometimes where the group administrators were strict, foreign alternative medicine distributors and other medicine vendors were removed from groups for posting information which was irrelevant to the group objectives. The ways foreign alternative medicine adverts were also distributed in the WhatsApp groups almost ended up appearing like spamming. Distributors would flood group chats with their predesigned adverts as they sought to find clients.

The anonymity of social media could be an important factor influencing the bringing out of genuine experiences. These days, most citizens also take social media as a platform to anonymously ask for help or experiences on topics and issues affecting them. Health issues can be seen to be part and parcel of some of the issues which get attention on social media. During the fieldwork, several heated discussions surfaced on Twitter, Facebook and WhatsApp groups addressing the issues of foreign alternative medicines and people's interactions with the medicines. This also provided reference points and experiences of people, not only in the city but also in Zimbabwe at large. Secondary data such as information from print and broadcasting media also proved to be of importance, and I also utilized pamphlets, brochures and manuals used in foreign alternative medicine distribution.

1.4.3 Data Analysis

My data analysis was grounded in the interpretive paradigm. An interpretive framework is a combination of the participants' presentation of reality and the researcher's role as a co-producer of meaning guided by the types of knowledge frameworks that inform the discourses of that society (Henning et al 2004). I also employed a thematic approach where emerging themes formed the backbone of the data analysis. The themes flowed from the data collected through observations, interviews, participation as well as secondary data. Data were coded to create a coherent structure where people's views, perceptions and worldviews could be condensed around various themes in each chapter. Data analysis was done in a progressive manner, with chapters organized around themes evolving from the data collected.

1.5 Positionality and researching at home

In this section, I make an analysis of how my presence in the research field had implications on the flow of the project and might also have influenced the outcome of the research. The researcher has an active role in the construction of meanings and the overall outcome of the project. However, personal conditions and standpoints must be declared as a way of reflexively analysing some subjective factors which are integral in the construction of worldviews in the research (Townsend & Cushion, 2020). As a user of multiple healing systems, my experiences in faith healing, indigenous healing, and biomedical healing also created a bedrock for my understandings of foreign alternative medicine. My choice of the research topic was influenced by personal experiences and accessibility of the city, which allowed me to engage in research

without much difficulty. Personal concerns about the safety of people around me also sparked an interest in understanding this 'new' kind of healing.

Most parallels and similarities across the healing systems were interpreted in terms of my understandings of the different medical systems I have been in touch with. Although the experiences enabled me to appreciate different healing styles, personal experiences of health-seeking behaviour evoked feelings of labelling some healings as fakery due to my personal failure to experience the promised results. Sometimes these experiences also roused feelings of empathy towards patients whom I viewed as victims of bad medicine or charlatans, something which also raised ethical issues which I discuss in the following sections. At the same time, I also felt that some healers are pawns in greater schemes, believing and parroting information that has been passed on to them without even stopping to question the truth in their healing claims. Personal experiences drove me to conclude that there is no certainty in the field of healing. People seek, receive, and offer healing within the parameters of what they have experienced and what they know. Though biomedicine prides itself in verified healing methods, the various subjectivities of healing processes and the experience of negative outcomes from quests for healing may also be seen as factors that will always make monopoly over healing to be impossible and simultaneously leaves the ultimate decision of healing firmly in the hands of the patient. I have revisited this subject in my conclusion where I try to contextualize the journeys of healing.

My multiple experiences in the healing systems also resonated with how I saw people's openness to embrace foreign alternative medicine medications. Medicines and techniques of healing often overlap each other such that people do not experience a lot of shocks when it comes to foreign and new medicines. Even machine massage therapy could easily be linked to biomedicine whilst herbalism resonated well with existing indigenous methods as well as general home remedies. Taking a medical intervention often gives individuals, patients, and families the perception of acting against a condition. This might also have explained much of the optimism in individuals who consumed foreign alternative medical products. From the various medical systems, there was general optimism about getting better, be it from having hands laid on, being given objects and substances to deal with conditions or being subjected to different techniques meant to induce healing. Hence, my prior experiences could be seen to

provide a basis for familiarity, such that I often had to stop and reflect on the taken for granted information that an outsider could easily pick.

The issue of being an insider, though being an important determinant in acquiring consent and having respondents open, at times created numerous ethical issues which I had to be careful to observe. It is easier to get into discussions with people you know of their healing experiences, but it is also easier to forget the crucial element of consent especially towards those respondents with whom I had strong filial ties. Hence, I strived to ensure that I acquire permission to use such information in the research through signed statements of consent. At times, the temptations to remind a respondent of some details of their experiences was always there since as an insider, I shared intimate knowledge of some of the respondents' experiences.

I was present when they struggled with certain illnesses, and I was also there when they sought healing from various sources. Such issues made me notice when individuals deleted some elements of their experiences when it came to interviews. It also unconsciously influenced me to add some details to their stories, especially things which they were not aware may influence their choices. An example is when I linked religion and the consumption of herbal medicine. To the individual respondent, he/she might not be consciously aware such that they draw parallels between their behaviour and other facets of their lives. Hence, I often found some were quite amazed after I showed them my writings about their experiences. This raises questions about whose story a researcher is capturing in the research. The ability of a researcher to connect the dots and create a story out of people's experiences might produce a narrative that shocks the respondents themselves. Sometimes respondents do not think beyond what is manifestly present, though as researchers, we seek to uncover meanings that are hidden. The product is always an outcome of both researcher and respondent perception, where the researcher imposes his baggage onto the experiences of the respondent and help in the creation of meanings that may be alien to both. To interpret is to introduce one's categories of thought and experience to the respondent's narrative.

My locatedness as an anthropologist researching at home also influenced other issues such as trust. Healing relationships are also trust relationships. In the city where I was staying quite several people knew me or knew where I worked. There is some prestige and honour associated with working at a university as well as being known that you are pursuing doctoral studies (see Taru, 2019). That tag was often used by some of my key informants who were distributors and

took prestige in introducing me as a colleague they worked with closely. Hence, people's trust in the distributor would often increase after hearing that someone working at a local university was working with the individual distributor. I struggled hard to keep the lines of neutrality as the researcher so as not to influence the outcome of the healing encounters. However, my mere presence was reason enough to make a difference in raising the credibility of some distributors. As one of my key informants often boasted of assisting and treating high profile figures, working with university staff, and having a doctoral candidate by their side was reason enough to increase the rating of that distributor. Sometimes I also struggled to avoid proffering solutions and information about an illness which I was not convinced about. A sense of guilt would often come in cases where I felt the medicines being offered may not be of much benefit to the patient. How do you give your own opinion in a situation where you feel that your respondents have an unfair relation where one part is benefiting at the expense of the other? These are issues that I also battled with as an insider who sometimes felt compelled to assist in some scenarios. Tilting the scales of power is something that a researcher must be aware of and try to work around in research settings. We occupy different positions of social power in society, where usually knowledge and abilities which one has can influence people's perceptions towards you.

Positionality also entails developing a researcher identity and filling specific roles in the research field (Dilger, Huschke & Mattes, 2015). It is also an emotional process through which the decision to take a specific identity in the research has far-reaching implications for the research environment itself. In this study, I assumed two positions, one of which identified me more with the distributors and healers. As I spent more time with them, observing them in their practice, I felt a sense of belongingness to them. I got to understand them more and got to know their worldviews, though some conflicted with my personal opinions and convictions. At the same time, I also played the role of the patient, also receiving treatment, interacting with other health seekers, and experiencing the hopes and frustrations which anyone on the healing journey often encounters. This created a complex position for me as I developed emotional attachments to both consumers and distributors. I had to understand the phenomena from the perspective of both sides and that was emotionally draining since there was often that desire to bring my personal opinions and judgements about the truth.

My positionality also stoked an internal reflexive debate of ethics over morality. As noted by Keane (2014), morality raises questions of duty and moral obligations of the researcher whereas the ethical side of research may be rigid and influence the assumption of neutrality in the research. In my research, truths are questioned, and at times the views held by the people do not correspond with official truths. My moral obligation to correct perceptions and advocate formal and acceptable standards of healing was antithetical to the non-interference and neutrality expected of the researcher. This was also against a backdrop of individuals placing trust in me as someone they assumed to be knowledgeable and authenticating the healing practices of practitioners I often accompanied. This also created a moral dilemma where my position as a researcher placed me in a complex position during the research.

Moreover, as someone who was studying behaviour on the margins, which was outside the protection of the legal statutes, and bordered on illegality, there was always that hanging feeling of spying on a people's way of life, something which could expose and unsettle the dynamics of their ways of healing.

1.6 Ethical issues

This section looks at some of the ethical issues I encountered during the research. The first ethical issue encountered was getting research permission. In most research, entry into the field is usually regulated and characterized by gatekeepers. However, researching alternative medicine has its own peculiarities considering the independence of most agents involved in it. Fonnebo et al (2007) noted that CAM often exists outside regulatory frameworks and is not of great importance to health insurance. CAM medication does not follow regulatory standards and its practitioners are often independent of each other, operating as sole practitioners. They belong to no regulatory board or association making it difficult to find an entry point into the world of CAM research. Although some of the distributors I worked with were selling almost similar products, they worked independently and did not subscribe to any overall regulating authority. Even those distributors who were selling similar products had different supply lines and did not even work as a consolidated unit. You could find at least five outlets selling the same medicines but getting products from different suppliers and having no clear chain of command.

In Fonnebo et al's words, '*the gatekeepers are not at home'* (Fonnebo et al 2007:1). Hence, in response to the lack of organisational structures, I resorted to getting signed consent forms from all individual foreign alternative medicine practitioners whom I worked with, in my research. I also employed dynamic informed consent which was used to seek consent from individual respondents. Most international research boards accept dynamic informed consent as an ethical practice in conducting ethnographic research. The American Anthropological Association (2012) recognises dynamic informed consent as standard ethical practice in anthropological research. Efforts were made to ensure that in most cases, consent is corroborated by signed forms although some situations called for verbal consent. Sometimes issues relevant to the research could pop up during conversations on my way home using public transport, or just having conversations with colleagues and in other public places. Such situations were tricky and only verbal consent could suffice to alert the people that the information we discussed could be useful for my research purposes. It would be absurd to turn around and produce a consent form to ask permission to use information from an informal chat or public conversations. My experiences pointed to the fact that informed consent is an ongoing or continuous process, requiring constant attention to ensure that one does not violate the rights of the interlocutors.

Such issues also produced ethical dilemmas in relation to information that popped up online in chat groups, Facebook pages or Twitter pages. This was information that anyone can have access to, hence exist in the public domain. Different scholars have also noted the ethical dynamics of online ethnography or what Kozinets calls netnography (Airoldi, 2018; Caliandro, 2018; Kozinets, 2015). Sometimes I could follow conversations that were relevant to my study in different social media chat groups, something which raised issues concerning the usage of information that is generally within the public domain. Confidentiality was always ensured by ensuring that no information which could be traced back to specific individuals was presented in the thesis.

Though several steps were made to ensure that confidentiality and privacy of data were maintained, some situations proved to be tricky. This was in the case where at times mentioning a product could point to a specific brand of foreign alternative medicine and hence it became easier to know the practitioners trading using those specific products. One could know which company sold herbal teas or which company recommended specific healing procedures. Some

of the pointers to specific individuals could not entirely be concealed if one took the detective work of piecing things together, with some luck they can make some intelligent guesses. Issues such as religious affiliation were some of these leading pointers which could not be easily concealed.

1.7 Thesis Outline

This section provides an overview of the structure which my thesis will take. The **first** chapter is the introductory chapter which dealt with an overview of the issues discussed in the project. It further makes an analysis of the methodological experiences in the field whilst simultaneously situating the fieldwork experiences in the broader body of anthropological inquiry. A historical overview of the study area was also done. The chapter also addressed ethical issues and experiences of researching health issues.

Chapter **TWO** starts with an analysis of the controversies surrounding the field of medical systems. It also addresses the developments in the medical sphere, focusing on the dimension of alternative healing in Africa, as well as its linkages with the broader global developments of alternative healing. The chapter also documents the entrance of foreign healing approaches with a special focus on the Asian influences on the field of medical care. The ideological foundations of alternative medical care are also discussed. Philosophies and worldviews behind different healing approaches and techniques will also be discussed in the chapter.

Chapter **Three** focuses on the Zimbabwean health sector. A historical narrative of the developments in healthcare is going to be given, focusing on healthcare policies and delivery systems. The political and economic crises which Zimbabwe has experienced and their toll on healthcare were also looked at as well as its role in giving space to new alternative healing avenues. Generally, the collapse of the biomedical healthcare system has been seen to have coincided with a rise of foreign healing systems. It is also noted however that the biomedical healthcare system did not collapse entirely since there is a concurrent propping up of health by NGOs though focusing only on critical areas and specific diseases.

Chapter **Four** deals with the political economy of alternative medicines. A discussion of the business dimensions and pathways through which medicines are acquired and distributed will also be done. The dual objectives of health and wealth seem to underlie the practice of Asian inspired healing. Discussions also situated the study in broader arguments of healing under the

neoliberal dispensation. Justifications on the relative popularity of alternative healing were also addressed.

Chapter **Five** analyses the gendered dimension of alternative healing. It explores gender-based ailments which drive people to seek alternative healing as well as the gender composition of healers. Structural analysis will be made to establish how gender influences both utilization and taking up roles of healers. The societal expectations from both men and women were analyzed to expose how these influence the consumption dynamics of medicines. It can be noted that the consumption brought out underlying gender dynamics in the area under study.

Chapter **Six** examines the search for authenticity in healing among patients. It explores issues surrounding the acceptance of medical truths and the way through which individuals get to make medical choices. The motivating factors behind medical choices especially in a context of uncertainty are also analyzed. The chapter also addressed the patients' authority over medical decisions exploring how individual decisions of the consumer were an important consideration in healthcare utilization patterns. The chapter also addresses healing relationships and the micro patient healer interactions. Issues of power dynamics and medical decision making are also examined.

Chapter **Seven** analyzes the religious dimension of alternative healing and how the foreign and local religious cosmologies meet to construct realities around alternative healing. Traditional and modern belief systems are instrumental in providing a basis for acceptance of Asian inspired healing. Field notes show an interesting link and participation of new age religions in foreign healing practices hence this chapter examined the religious basis and arguments which practitioners forward to support their participation in alternative medicine. Congruencies between the structure of modern urban religions and the foreign alternative medical practices were also examined as there was evidence of similar patterns between the two.

Chapter **Eight** is the concluding chapter which raises the major points in the thesis and sets the stage for future research. A recap of major arguments opens the chapter and highlights of prominent issues in the thesis are also made. The chapter also addresses emerging theoretical and methodological issues in the study of foreign alternative medicine. The chapter concludes

by raising new directions in the study of alternative medicine, particularly the prominence of Asian medicine in contemporary African societies.

Chapter 2

Discourses on medicine and alternative healing

2.0 INTRODUCTION

This chapter analyses the nature of the medical field and explores the controversies characterizing medical systems. It also addresses the developments in the medical sphere, with a focus on the aspect of alternative healing in Africa and its linkages within the global frameworks of alternative healing. The emergence of Asian influences in medicine is also analysed in the chapter. An emphasis has also been made to explore the ideological and philosophical foundations informing different healing traditions. To achieve these goals, the study starts by exploring some of the controversies of naming and categorization in the medical field. This is important in exposing power dynamics in healing systems since naming and categorization are subject to power and politics. I proceed to link global developments in the medical sector before making an analysis of healing traditions in Asia and Africa. This part is important in directing the focus to present day medical issues in Zimbabwe. Issues of health have undergone a series of evolution characterised by, among other aspects, shifts in power relations, ideological shifts in disease aetiology and intervention as well as medication (Foucault, 2003; Gijswit-Hofstra, Marland & De Waardt, 2013; Magner & Kim, 2017). In this chapter, I go through the different phases of the evolution of medical systems while concluding by providing the current picture of the medical issues in the area under study.

Theoretically, Foucauldian analysis of the evolution of healthcare and the path it has gone through is also crucial in understanding the history of healing. Foucault (1967) notes the situatedness of approaches to healthcare in his exposition on medicalisation and power in society. It should be noted that the evolution of present-day healthcare systems mirrors struggles and contestations between the Western biomedical model and the ‘others’. Throughout the history of the medical establishment, there is evident otherization, where one can see the dominance of one medical system as premised upon its ability to discredit what it terms deceptive medical practices. The non-western societies have been subjected to a colonial gaze upon which their illnesses became dependent upon analysis and interpretations of the colonizing physicians. There are several dualisms that I address in this chapter since they form the backbone of the global development of healthcare systems. The first dualism relates to

tradition versus modernity, while the second deals with authentic versus fake. These dualisms explain the point of interaction between western medicine and African discourses on health and healing. While the entrance of an Asian perspective of healing seems to be a novel approach in African healing systems, its structure still conforms to the existing categories of a binary between Western medicine on one extreme and others which are bunched in the category of non-scientific medicine. However, the interesting position of Asian medicine is that it is neither indigenous nor is it western. Although it occupies such an intercalary position, the ways in which it has adapted to the existing medical system without upsetting the status quo, bring interesting perspectives on the field of complementary medicines.

Some of the discourses on alternative medicines have roped in the concept of globalization as an explanatory framework of understanding the manifestation of alternative medicine in various places, with the rise in alternative medicine being taken to be evidence of the growth of postmodern tendencies of consumption and plural realities (Fadlon, 2005). The character of the current arrangements in the medical space of Zimbabwe, and southern Africa at large, can be noted to be an outcome of different socio-political phases of the practice of medicine. Two major phases stand out, that is the colonial as well as postcolonial phases. The colonial phase is marked by impositions and domination by external powers, something which led to antagonistic relations between the foreign healthcare practitioners and the local people (Abdullahi, 2011; Mapara, 2009; Waite, 2000). In the postcolonial phase, we witness vestiges of colonial subjugation of indigenous medicines and any other form of healing that has not been exposed to the scrutiny of the western biomedical eye. However, there is evidence of a thriving alternative medicine space that needs to be studied to properly expose its structure. In that endeavour, I have also noted that this alternative medical space continuously evolves and is shaped by current socio-political and economic processes.

2.1 The politics of naming

Naming is important and it carries significant communication and symbolism (Gale, 2014; Kleinman, 1973). The very act of classifying different healing approaches has wider ramifications on acceptability in society, funding and inclusion in policymaking and budgeting. There are two important labels that can be identified in the field of medical care i.e., the orthodox formal healing sphere and the informal other. The process of informalization is also explained in this section as I discuss more on the evolution of medical systems. The formal system is not difficult to categorize, and it can be noted that across the

world, it has been dominated mainly by the western biomedical model, which is taken to be the ultimate yardstick of understanding health and illness (Baer, 2004; Csordas, 1988). Although non-biomedical approaches may be incorporated into the formal channel through legislation as seen in various countries, they enter at a lower level to biomedicine and seldom get the same value from authorities and decision-makers, despite their efficacy or popularity among the people (Bodeker & Burford, 2007; Bodeker & Kronenberg, 2002; Filc, 2004).

The field of alternative medicine which this study addresses is replete with a variety of terminology, all of which communicate various aspects of the position of the medical approaches. Some communicate legality issues, whilst others also point to the structure of utilization whereas some may bring out power dynamics characterising the field of medicine. When it comes to western biomedicine, few issues require clarity since it is the formalized, integrated into state public health system and orthodox healing approach. However, the remaining medical approaches present a minefield when trying to apply a label without drawing the ire of the different practitioners and patrons of the medical approaches. Some terms which have been thrown around, which I will try to clarify in this section include *traditional medicine*, *alternative medicine*, *complementary and alternative medicine* (CAM), and *non-conventional medicine* (NCM) as well as *integrative medicine* (Ernst & Fugh-Berman, 2002; O'Connor, Calabrese, Cardeña, *et al.*, 1997; Stein, 2017). Boyle (2011), notes a progressive transition of terminology, signifying shifting attitudes and perceptions towards medical approaches outside biomedicine. He notes a shift from unconventional medicine to alternative medicine, complementary and alternative medicine and more recently, integrative medicine. After explaining these terms, I will also try to put into perspective the kind of medical approach which is studied in this research and the difficulties of such classifications.

The label *alternative medicine* is one of the major terms used to describe medical systems falling outside the western biomedical model, (Zollman & Vickers, 1999). But if one asks: what this kind of medicine is an *alternative* to? The response will project power dynamics and the lenses which are used to analyse such healing systems. Everything falling outside the formalised official healing system usually falls under the label of alternative. Thus, the orthodox healing systems assume all the power and become the plumb line for healing. This can be said of biomedicine in Africa, which assumed the role of the orthodox healing system to such an extent that even the indigenous ways of healing were relegated to the status of alternative. Some definitions have also argued that the issue of power is not important, claiming the term alternative simply point to untested healing approaches, which have not been approved through the scientific method (Ludmerer, 2010). However, the hegemony of science brings us

back to the question of the objectivity of the scientific method which seems to be universally applied regardless of the context.

The term CAM also became fashionable, but it still perpetuates the inferiority status applied to medical practice falling outside the biomedical model. By the terms inherent in the name, one can see that the healing approach is expected to be taken as a supplement and to complement another way of healing. Hence, CAM has usually been treated as a fringe healing approach. Zollman and Vickers (1999), noted that the term complementary evolved after the efforts of the two medical systems to complement each other. So rather than alternative medicine being an option outside of the orthodox approach, it became an integral component where ideally it could also provide solutions alongside biomedicine. However, the term has also been used to refer to that class of therapies outside biomedicine without necessarily insinuating anything concerning the relationships between the therapeutic approaches.

In the area under study, I have adopted a generic acronym of Asian Inspired Complementary and Alternative Medicine (AICAM)[1], to capture the conditions characterizing the medical therapies which are used. As noted in chapter 1, the usage of place of origin has been an important factor in determining the adoption of the nomenclature 'AICAM' to describe the medical system under study. The arena of alternative medicine in Zimbabwe has traditionally been associated only with indigenous traditional healing therapies as well as faith healing. Hence the entrance of foreign alternative medicines presents a challenge of naming. The term AICAM not only reveals the origin of the medical approaches but is also used to classify the operation of the healing approaches. They are complementary in as much as they do not seek to oppose the conventional biomedical model, hence they seek to complement the formal medical systems. This could be seen in referrals which could exist between some AICAM practitioners and biomedical practitioners. On the other hand, some therapies could be regarded as alternatives due to their tendency to forward alternative theories and ideologies of disease

[1] I have used AICAM as an operational acronym to refer to medical approaches with Asian origins. The term has not been used in literature. Although the term 'Asian' is broad, it seeks to summarize medical approaches from Asian countries like China, Japan, India, and Malaysia among others. This does in no way imply that AICAM is a consistent and orderly practice, but it enables me to bring the many disparate practices under one umbrella, whilst the different chapters explore its nature. I briefly discuss AICAM in this section and in chapter 4 where I explored the nature of the practice, products, and personnel. A final word on the topic is done in the conclusion.

causation and ways to deal with these diseases. These ideologies were often contrary to biomedical thinking and provided alternative truths on the nature of illness and health. Some of the practitioners could claim that biomedicine only treats whilst their approaches heal diseases. The nature of alternative medicine in Zimbabwe is discussed in greater detail in the next chapter. The next section examines a brief history of the medical field, showing the different dynamics which shape medicine today.

2.1.1 Healing, medicines, and anthropological discourse.

Issues of healing and medicines have been one area of interest among anthropologists.in understanding healing systems, two important issues must be considered i.e., products and behaviours. Different studies have been undertaken, which examine the sociocultural conditions structuring the production, distribution and consumption of medicinal products as well as the dynamics characterising healing techniques and relationships (Van Der Geest, 1989; Martin, 2006; Whyte & der Geest, 1988). For Whyte and Van der Geest (1988), medicines are so powerful such that they tend to overshadow the whole therapeutic intervention. Hence healing becomes more understood through the lens of medicine. It is the interaction of patients and healers with the medicine at the centre stage. This study focused more on the products in alternative healing. The tangible products which are exchanged during healing encounters. As the thesis shows in the following chapters, healing products are important in shaping the popularity of AICAM in Masvingo Urban. As noted by Whyte and Van der Geest (1989), medicines are powerful because of their concreteness and tangibility as well as their ability to be separated from the social relations of healing. The qualities of AICAM seem to confirm these assertions as shown in the discussions about the medical specialists. In essence, anyone with limited training could become a distributor of the AICAM medicinal products. Studies on medicines have also looked at the characteristics of medical products, with some even bordering on reification of medical products (der Geest & Whyte, 1989; Martin, 2006). Medicines acquire personality traits and characteristics which influence their appeal on the market (Martin, 2006).

One important aspect of anthropological studies on healing has been the attention paid to ritual and symbolism. Healing behaviours have been viewed as symbolic and pregnant with meanings. Turner's extensive focus on Ndembu rituals of affliction, bring out the symbolic value in healing encounters, as healers perform rituals to rid their patients of illness (Douglas, 1970). Apart from medical products exhibiting an appeal of their own, the meaning making

enterprise of alternative medicine can not be escaped. It is part and parcel of webs of significance, to borrow Geertz's terminology (Schneider, 1987). Products and procedures of alternative medicine are part of the sociocultural contexts of their existence. They are shaped and shape the sociocultural contexts in which they are found. Meaning making in healing encounters is something which anthropologists have focused on. It ranges from interpreting and decoding ideas attached to healing paraphernalia, to the observance of the symbolism attached to healing procedures and rituals (Ostenfeld-Rosenthal, 2012).

2.2 Global healthcare space

The subject of healthcare has undergone a series of transformations throughout history. It can be argued that healthcare issues have long been contested due to the difficulties in ascertaining objectivity within the field. My global analysis of healthcare begins in the nineteenth century where we see an evident polarization and mutual disdain between the conventional medical doctor and the alternative healer. For the medical healer, the alternative healer is seen as peddling unsubstantiated claims and fictitious medicines whereas to the alternative healer, the medical doctor is seen as being affected by rigidities and an 'I know it all' culture. At the same time, the medical doctor is seen as only interested in profiteering from a sick patient (Starr, 2008). Hence the history of medicine is a history of struggle over the mastery and authority of medical knowledge. The struggle begins on who qualifies to be the medicine man as well as what passes as medical knowledge.

The documented narratives of healthcare pin some of the earliest known evidence of health beliefs as lying within the domain of belief, superstition, and religion. Badash et al (2017), note that ancient medicine viewed health to be at the mercy and favour of gods as seen even with the present day medical symbol of the rod of Asclepius, which is a perpetual reminder of the historical significance of religious belief in the institution of health. Since religions are different and culture-specific, it can be noted that most healing approaches reflect more the societies in which they are found. Healing traditions mirror existing societal conditions whilst simultaneously cementing the philosophical foundations underlying the healing system.

Another major observation within the evolution of medicine has been the extent to which healing systems mirror the prevailing conditions within society. This can also explain the modernist approach to understanding health and wellness. As Western societies developed, the modernisation way of thinking at one time permeated and informed the worldviews even within the arena of health and healing. The dominant narrative of unilineal human evolution also contributes much to the categorization of medicine within the modernist perspective. As noted by Fadlon (2005), the modernization approach has been responsible for setting a binary between the traditional and the modern, with biomedical hegemony assuming the position of the modern, dismissing other forms of healing to the arena of tradition. Hence consulting non-conventional medical approaches is something which was associated with backwardness, superstition, and a general inability to achieve the accoutrements of modern society. This kind of thinking mirrors how healthcare planning has also evolved in Africa. As will be shown in the following sections, colonial and postcolonial healthcare planning in Africa assumed the skewed lenses of western biomedical perspectives which categorized medicine according to perceived notions of civilization. Modern biomedicine was and still is held in high regard, having assumed the status of being the epitome of objective healing systems.

However, these claims of objectivity and authenticity have been dismissed by other theorists who claim that western medicine is just another medical approach that can never be divorced from the western cultures from which it originates (Lupton, 2012; Trostle, 2005). Some theorists also note how the process of industrialization brought with it a kind of mechanistic thinking concerning disease aetiology and treatment. The human body was likened to a machine and that idea influenced the diagnosis and treatment of diseases in western societies (Lupton, 2012). This served to portray biomedicine as a health system that is reflective of the western cultures under which it developed. It is not immune from the influences of the different environmental influences which inform it. This is contrary to the claims to universality which objective science claims to push.

The twin processes of modernization and globalization have also seen the birth of another crucial aspect of health, i.e., global health. Global health care policies have almost been exclusively built around the supremacy of the biomedical model. This has even cascaded to national healthcare policies in almost all parts of the world, where we witness biomedical

privilege whilst the consideration of alternative and traditional medicines only seems to be part of an afterthought. The disease model can be seen to permeate the global healthcare policy with healthcare interventions focusing on diseases as biological malfunctions which need to be eradicated. This can be seen in numerous global health campaigns which focus on immunization of whole populations as a mechanism of eliminating the disease, the recent COVID-19 pandemic is illustrative. Funds have also been set up to sponsor such global campaigns especially in developing countries that may not be able to afford the expensive medical campaigns. Global health has also developed in phases beginning with the 16th and 17th-century focus on tropical medicine (Anderson, 2014; Palilonis, n.d.). As Europeans sought new places to settle, the diseases they encountered shaped the evolution of tropical medicine. This was later replaced by colonial medicine which took various forms as Europe started to occupy non-western societies. Two major types of medicine were the military medicine, where military personnel and physicians oversaw healthcare mainly as a mechanism of enabling effective occupation of colonies through ensuring the health of armed forces (Arnold, 2017; Lowes & Montero, 2018; Neill, 2012). The other form came from medical missions which were mainly from religious organizations which sought to bring European religion, mainly Christianity, through offering individualized healthcare which could also act as a carrot to lure converts and warm up non-westerners to the civilizing missions of the Europeans (Vaughan, 1991). Apart from these developments in global health, efforts to organize and coordinate healthcare at a global level were also influenced by the global effects of epidemics which were usually spread along trade routes (de Bengy Puyvallée & Kittelsen, 2019; de Wet, Ramulondi & Ngcobo, 2016).

Epidemics like cholera killed thousands of people in Europe, Asia, and the Middle East, prompting physicians to organize a meeting that became the first platform for international health cooperation. The International Sanitary Convention brought together physicians from five European countries and set the stage for international health strategies. Meaningful coordination however was consolidated with the formation of the World Health Organization (WHO), after the second world war. It focused mainly on global public health and embarked on massive vaccination programs aimed at eliminating diseases as well as minimizing mortality rates among children and other populations. Its other mandate was also to manage infectious diseases as well as to direct funds channelled towards healthcare globally. In the contemporary

period, NGOs also joined the field of offering healthcare services in an attempt at covering those individuals who are left out of healthcare service delivery. NGOs sought to bring greater inclusion in healthcare through focusing on neglected populations as well as other areas which affect health care such as the provision of clean water and sanitation. A lot of funds to date have flowed through the NGOs that focus on the provision of healthcare. However, what is notable is that the structure of international healthcare has its roots in western civilization as well as western ways of knowing about disease. This is also evidenced by the formation of WHO in the West and its leadership which has was inclined towards western countries.

This brief historical background points to the ascendancy of biomedicine to become the major reference point of healthcare systems across the world. The development of biomedicine within its European cultural settings presents some of the problematic aspects which are experienced today. Issues of the epistemological grounding of disease causation and healing influence today's clashes between medical systems. It can be noted that from the beginning, the arena of healthcare is fraught with contestations especially on the control of medical knowledge and hegemony over healing approaches. In the early stages of institutionalization of medical care, the fight is between religion and tradition versus the modernizing forces which were presenting new knowledge on the nature of diseases and approaches to deal with them. As the western cultures underwent different phases of development, there are evident shifting dynamics of power on two levels, i.e., the level of physicians as well as the level of physicians and patients. The clash of medical ideologies when it comes to non-western societies is documented in the next section which looks at colonial and postcolonial medicine on the African and Asian continents.

2.3 Healing and medical traditions in Africa and Asia

The marginalization of other medical systems in Africa has been noted to bear a historical imprint. It has been noted that the development of healthcare systems in Africa mainstreamed western allopathic medicine since most African countries inherited healthcare systems from colonial governments (Eisenberg, Davis, Ettner, *et al.*, 1998). Hence an appreciation of the character of the medical space in Africa is also dependent upon a continuous analysis of historical and political trends which the continent has passed through. During the colonial

period, various scholars have noted the racial categorization of African medical spaces on numerous fronts (van Dijk, Reis & Spierenburg, 2000; Janzen, 1992; Singer, 2004). Vaughan (1991) notes the effects of the scientific method applied by western biomedicine to be the alienation of health and illness from the social contexts in which they are produced. This has an effect of masking different contours which structure the experience and patterns of diseases. Issues such as systems of production and social reproduction, exercise of political power as well as poverty and exploitation have been noted to be just as important to explanations of health and illness, such as the germ theory (Vaughan, 1991; White, 1995).

An analysis of former French colonies also presents a good image of western medicine on the African continent. Lorcin (1999) noted experiences in Algeria where western medicine contributed to the creation of hierarchical paradigms of culture and ethnicity which necessitated the growth and entrenchment of the French politico socio-cultural system. Lorcin noted that the French conquest of Algeria influenced the extension of French medical services to the indigenous populations and since the medical missions were meant to create conducive conditions for the foreigners, it became imperative to study disease patterns and cultures among the indigenous groups. From this perspective, it can be noted that colonialism was one of the major drivers of the onset of biomedicine on the African continent, hence ultimately biomedicine was an indispensable part of the colonizing nations. Due to this colonial legacy, colonial medicine set itself on a collision path with local healing systems due to its superiority complex perpetuated through colonial state. It has also been noted, concerning French medicine, that it overlooked and despised healing systems already present in the Algerian society (Lorcin, 1999).

Another notable aspect of the relationship between colonialism and western medicine is biomedicine's participation in the colonial governance systems. Different theorists have noted medicine's crucial role in creating a conducive environment for colonialism as well as its ability to exploit the benefits of medicine to gain trust and dominance over the colonized (Keller, 2006; Lorcin, 1999; Sutphen & Andrews, 2003; Vaughan, 1991). This issue of colonial links of western medicine has ultimately shaped the nature of postcolonial encounters in health and healing since it presents an attitude of mutual suspicion and mistrust. According to Keller (2006), the historical encounter of Africans with western medicine can be seen to culminate in

an uneasy relationship with one part viewing the western medicine with suspicion whereas the physician appears to have a condescending attitude towards the patient whom he regards as incapable and lacking desire to adhere to the dictates of the physician. Hence postcolonial clashes in health and healing can be traced back to the colonial encounters with biomedicine which created an uneasy relationship between western medicine and local understandings of health and healing. The flourishing of conspiracy theories around various aspects of health and illness can, perhaps, be linked to colonial encounters of indigenous populations with western medicine. One of the statements often thrown around brings out the idea that westerners and everything white cannot be trusted with promoting the African good.

One contentious point in the history of medicine in Africa since the entrance of biomedicine has been the issue of aetiology. The flawed scientific beliefs of the 19th century cascaded to medicine and produced some unpalatable views in terms of disease causation and patterns. The aetiology of African illness was directly explained in terms of race. In British East and Central Africa, western medicine regarded Africans as naturally disposed towards certain ailments (Lowes & Montero, 2018; Vaughan, 1991). At the same time, African healers were also dismissed as invoking illogical and useless measures in dealing with illness. This points to a medical history tainted with power struggles and the imposition of foreign medical traditions which were regarded as scientific and hence were to be used as standard practice. This culminated in the relegation of indigenous forms of healing into the informal and often overlooked category of alternative medicine. The colonial project had the effect of dismantling everything non-western since one major goal of colonialism was to extend the benefits of modernity to the uncivilized world. Hence the medical practices of non-western communities were just another area of illogical mystic healing which could not be subjected to the rigours of western science. This also feeds into the dualisms of authenticity and false healing. The importation of the scientific method in healing resulted in the erroneous bungling and dismissal of indigenous methods of healing as false and based on unsubstantiated belief systems. An aura of superiority surrounded biomedicine as it prided itself in being an evidence-based approach to healing.

A recurring observation on the history of medicine, is the fact that healing approaches are a mirror image of the societal conditions in which they are found. Although claims to objectivity

have been put forward especially from a biomedical perspective, historical trends have exposed how the errors in Western medicine can lead us to conclude that it is just another way of approaching healthcare rather than an infallible framework of dealing with health issues (Gaines & Davis-Floyd, 2004; Ibeneme, Eni, Ezuma, *et al.*, 2017). Janzen's (1992) work on suffering and healing exposed the link between suffering and illness with other wider social arrangements such as human relationships and socio-economic institutions. Janzen exposed the fact that issues of healing can never be viewed with a disinterested eye since they have broader social and political ramifications.

The historical approach to healthcare in Africa can thus be analysed from different angles. In the first instance there is notable disdain of everything indigenous due to the uncivilized label stuck onto the African continent. This resulted in the demonization and negative perceptions on everything indigenous (Chirwa, 2016; Mkandawire, 2009). However, this did not succeed in wiping away the hold which African people had on their belief systems including approaches to healing. Hence, the colonial enterprise of demonizing African medicine was met with equal disdain and resistance bent on protecting what the indigenous people considered a way of life (Bierlich, 2000). An attack on the healing system could not be viewed as simply an attack on one aspect, but an onslaught on the totality of the people's culture. On the other hand, resistance to biomedicine also signified an anticolonial movement since colonial medicine was directly linked to colonial administration as noted in the crucial roles which medical personnel played in the ordering of colonial space as well as in the reinforcement of certain prejudices against the colonized.

Clashes of medical discourses cannot be limited to African experiences alone. One interesting area of medical dynamics has been the European experiences in Asia. Biomedical encounters in Asia are almost similar to those of Africa in the sense that Asia was also designated as another backward area requiring civilization within European thought. However, some of the compelling advances and innovations in Asia could not be simply ignored, hence we witness a certain degree of tolerance and incorporation of Asian medicines and healing techniques even in the west. Colonial medicine experiences in the East bear an uncanny resemblance to African experiences. The condescending attitude of western biomedical approaches subjugated and silenced much of the indigenous medicines on the Asian continent. In countries like India and

China, coming in of biomedicine resulted in the relegation of age-old healing approaches due to biomedicine's resentment of heterodoxy in healing. The biomedical way was the only acceptable standard of healing with other methods being relegated to quackery. In India the British side-lined healing approaches such as Ayurveda and Unani through designating biomedicine as the orthodox healing approach (Ernst, 2007). Although some parts of Asia experienced a violent introduction of biomedicine through colonial legislation, the Chinese experience was a bit more complex and different due to its encounters with the age of colonialism. Western medicine in China mainly came in through missionaries. The entrenchment of local Traditional Chinese Medicine (TCM) resulted in resistance to the new medical knowledge due to non-use by local elites. Hence western medicine was patronized by the poor, who could not afford the indigenous TCM doctors (Leung, 2015). However, success in dealing with infectious diseases using vaccines as well as improved public health conditions, strengthened the position of western biomedicine in China. Leung (2015), noted that the around 1912, the Chinese government embraced advances in science hence unlocking funding towards training of biomedical doctors and scientific discoveries. So obsessed with science was the government that it even attempted to eliminate TCM in 1929 albeit without success (Leung, 2015). The mainstreaming of western biomedicine by the government was however altered with the coming in of a communist government to power which emphasized the need for greater inclusion of different healthcare approaches to ensure that the great Chinese population receives healthcare. Leung (2015) notes that this resulted in a dual system where the modern biomedical physicians became concentrated in the big city hospitals whereas the hard-to-reach rural populace was mainly attended to by the TCM physicians. The Mao Zedong communist government actively encouraged the revival and development of TCM arguing that it was supposed to serve side by side with western medicine (Howson, Ullmann & Porkert, 1982; Leung, 2015).

The government in China has placed TCM and western biomedicine on an equal footing even in legislation and policymaking, hence making it an integral component of the healthcare system (Hesketh & Zhu, 1997). The popularity of TCM at home has led to the exportation of its approaches in various forms but mainly through the herbal approaches which could be easily packaged and exported. The dual use of western medicine and Chinese medicine, at home and abroad, has also resulted in a notable medical syncretism where both sides may borrow

diagnostic approaches and medication from either side. This can be said of the transformation of Chinese herbal medicines into the conventional biomedical pills, something which numerous pharmaceutical companies are continuously attempting to do. There have been notable congruencies on mechanisms which are important to health and dealing with illness among TCM and biomedical practitioners though the ideological basis remain the differentiating factor.

The foregoing background points to important aspects of the historical development as well as phases through which medical practice has gone through in both Africa and Asia. It can be noted that there are many similarities in the experiences of medicines on the two continents. The violent hegemonic entrance of biomedicine has been well noted in both Africa and Asia (Lorcin, 1999; Lowes & Montero, 2018; Sutphen & Andrews, 2003). One overarching aspect is the attempt at establishing biomedicine as the orthodox value neutral healing approach regardless of space (Sutphen & Andrews, 2003). This effectively silenced and subjugated alternative knowledge and healing approaches. Without downplaying the successes of biomedicine in dealing with illness, it has been noted that its spread has also been facilitated by its ability to command instruments of force more than by an innocent and objective display of its superiority over alternative medical approaches. The power dynamics have been experienced at various levels which include the colonizer and the colonized as seen in experiences of colonial medicine. Science versus religion and tradition is another platform where power dynamics of health and healing play themselves out. The biomedical model claimed superiority through its claims to objectivity and arguments that it could treat illnesses in a verifiable manner whereas traditional medicine in both Asia and Africa seemed to rest more on beliefs, culture and religion.

2.4 Politics and Medicine in Africa

This section analyzes how politics have played an important role in shaping the terrain of health and illness in Africa. Firstly, the political dynamics can be interpreted by looking at the dynamics of colonialism, struggles against it and the subsequent postcolonial period. The politics of control and the tentacles of the state extended to the medical sphere, where regulation of discourses of health was dependent upon the ideological inclinations of the colonial state.

Issues of force, racial and ethnic profiling are well documented as the colonial state created unfettered space for biomedical medicine to operate (Harrington, 2018; Sutphen & Andrews, 2003).

The political tussle for control within medicine in Africa can also be understood from the dynamics of colonialism and postcoloniality. As noted previously, colonialism shaped the nature and character of medicine in Africa today. However, in as much as colonialism is an influential dynamic, struggles against it have also produced a medical discourse characterised by multivocality within the medical fraternity. Regardless of the undeniable hegemonic influence of biomedicine in most African countries' healthcare policies and planning, it can be noted that the postcolonial period has given a voice to some subjugated knowledge hence paving way for the accommodation of alternative ways of healing. The rise in alternative medicines may thus be a manifestation of the opening of the political space with the diminishing importance of colonialism. The important role of African medical specialists in the provision of sound ideological and epistemological basis for health and illness can also be seen as important in shaping the nature and character of alternative medicine in Africa. Scholars have noted that the usage of traditional medicine did not diminish due to the entrance of foreign medical approaches (Mokgobi, 2014), but rather these became an added option which simply broadened the patient's medical choices (Chavhunduka, 1998; Fadlon, 2005). Hence the changes in the political governance sphere should be regarded as also influencing the political structure of healing approaches. Whilst previously suppressed under the influence of colonial authority, complementary and alternative medicines found better expression and space in postcolonial Africa. This has been noted even from the global platforms of healthcare, as bodies such as WHO acknowledged medical knowledge from the periphery and ultimately encouraged the recognition of complementary and alternative medicines (James, Wardle, Steel, *et al.*, 2018; World Health Organization, 2005). In essence, we witness the creeping out of alternative ways of healing in the postcolonial era from the crevices and the underworld of medicine. This follows a relative relaxation of policing and stamping out of these ways of healing within the postcolonial state. Hence the entrance of AICAM should also be understood as coming in at a time when there is greater tolerance and a willingness to incorporate other ways of healing rather than solely depending upon the biomedical model.

Marxian perspectives have documented the importance of power in shaping ideologies and this can be seen to be a truism in the medical sphere (Navarro, 2020). Whereas physicians were important in ordering colonial space, traditional medical specialists were important in organising cultural and ideological resistance and orchestrating movements to overthrow the colonial regimes. Hence, the postcolonial period is characterised by attempts to recognise the contribution of these medical specialists through liberalising the healthcare space. This can be seen to ultimately increase the visibility of alternative ways of healing within African states.

The second important dynamic in world politics is the current shifts in power among the global politically dominant nations. In the current dispensation, the world is experiencing a dynamic shift in world politics, characterised by a diminished influence of the West, coupled with a simultaneous emergence of Asia as an influential force on the international scene. The major Asian giant, China, has been welcomed as an alternative to the West by most African countries. China has recently launched an official belt and road campaign which is aimed at improving its visibility in international trade. Globalization has also undoubtedly influenced the international travel of people thus leading to cultural exchange and borrowing of foreign practices. The political dynamics in contemporary world politics has seen the increasing presence of China in Africa and this presence has economic, political, and social dynamics dating back to the period of liberation movement struggle. With Zimbabwe being currently isolated politically, the Chinese have gained a welcome foothold in the country. This has meant an emergence of different accoutrements of Chinese cultures as the country adopted the Look East Policy. Both the formal as well as informal entrapments of Asian cultures are being experienced across Africa. Elizabeth Hsu (2007) noted that the increase of Chinese medicine in East Africa was a direct outcome of increased diplomatic, economic and political ties between East African countries and the Asian giant. Van Dijk also notes several motives and patterns of Chinese involvement in Africa(Van Dijk, 2009).

Out of van Dijk's eight-point objectives, I have noted that there is a possible link between a desire to secure a market for Chinese products, and the sprouting of Asian Influenced Complementary Medicine (AICM). Apart from state-initiated synergy with African countries, Van Dijk also notes that private companies and individuals have also rushed to Africa mainly for economic motives. This presents a platform upon which possible links between Asian

presence on the continent and the sudden visibility of AICAM. Although China presents itself as the major force wearing the face of Asian presence on the African continent, numerous other countries such as India and Japan have also influenced the continent. This is also reflected in the continental character which AICAM has taken. Practices from such countries as Japan and India are part of the sources of the versions of AICAM prevalent in Zimbabwe.

2.5 Of medicine and quackery: AICAM and pseudo medicine

The debate on authenticity in the medical field cannot be easily swept under the carpet. Medical fields have survived through their attempts at distinguishing the true medical field against imposters. Hence, the history of medical systems is a history of accusations and counteraccusations on who is delivering the authentic medicine. The usage of the term quackery, came into place to describe nonconventional medical approaches which often did not have scientific basis, would contain substances with no proven medical efficacy or would have substances and chemicals potentially harmful to the body. Some of the medical approaches also included specific diets, exercise regimes, abstinence from foods and these were forwarded as important in the maintenance and restoration of health. The authenticity debate has also witnessed some scholars advocating a singular truth in medicine through claiming for a one-sided view of medicine. They even rejected the usefulness of the term ‘alternative medicine’, claiming that medicine is medicine, and anything useful can be included under the category of ordinary medicine (Hemilä & others, 2017; Louhiala, 2010).

The rise of evidence-based medicine relegated most medical approaches which could not be scientifically proven to the categories of quackery. Novel measures also had difficulties breaking into the mainstream since the scientific gatekeepers could simply dismiss what they did not know or perceive to be proper evidence-based medicine. The issue of evidence is not prominent on the African healing landscape. Traditional healers seldom had the burden to build verifiable portfolios of their ability to deal with ailments. Rather, what has always been important was to see the results of one’s diagnosis and interventions, since resolving the problem was adequate to legitimize a medicine man. Abdul et al (2018), raise important concerns on the safety of using herbal therapy. Even some herbal products whose efficacy has

been established may also have naturally occurring metals and chemicals which may harm the health of the consumer.

Most of practices falling under what I term AICAM in this research, have been subjected to scrutiny and have often been dismissed as pseudo medicine by some scholars (Lamm, 2016). Some of the characteristics which have been forwarded as representing modern pseudo medicines include lack of verifiability of medical claims, claims to deal with chronic conditions such as cancer as well as tendency to have a one size fits all criterion when prescribing remedies for different ailments. Most of these practices have been seen to function as placebos rather than being medical interventions with real intrinsic potency to deal with ailments. Offit (2013) looks at four yardsticks which show that alternative medicine is sliding into quackery. These included recommendations which are contrary to conventional medicines whose efficacy has been established, promotion of harmful therapies, consuming patients' monies and promoting magical thinking (Offit, 2013).

However, Lamm (2016), raises important reservations on the effect of scholars trying to label and expose medicine as fake or pseudo medicine. Lamm (2016) avers that this might not be beneficial and may bring harm to patients who have limited avenues for getting treatments for their ailments. Since most ailments do not have sufficient scientific cures, calling out pseudo medicine has been seen as robbing patients of the only alternative which gives them something to deal with their ailments. As will be shown in the following chapters, numerous patients positively testified of the beneficial aspects of AICAM albeit its inability to pass the formal scientific medicine test. The fact that AICAM has a significant followership and consumers who feel its beneficial aspects were crucial determinants in considering its importance within the general medical landscape of Masvingo urban. AICAM's position brings various ethical quandaries as well as implications for public health. On the one hand, the medical approaches under AICAM may be beneficial whilst at the same time some may be dangerous and pose significant public health threats. Hence, there is a need to effectively understand dynamics involving contemporary practices within the alternative medicines.

AICAM practiced documented in this study may fail to pass the authenticity test imposed by biomedicine. Some of the claims they make include claims to deal with chronic illnesses and

philosophical explanations of disease and illness which may be difficult to accept in conventional circles. However, some of these approaches have managed to attain the legal status through registering with the Medicines Control Authority of Zimbabwe (MCAZ), which is the body regulating usage and consumption of medicines in Zimbabwe. The registration of health supplements seems to be laxer as compared to medicines. Although, in practice distributors claim that their products are medicine, on registration, most are classified as health supplements.

2.6 Situating the patient in medical discourse

The preceding sections have focused on a brief history of medical care approaches as well as historical dynamics informing contemporary patterns in healthcare. The factors which have shaped medical history are broad but most of them can be narrowed down to issues of power and control of the medical process. There are aspects of power in conceptualizing the disease as well as providing remedies to redress an illness situation. The closeness of any medical discourse to decision making apparatus can be seen to be important in influencing the level of power it acquires. The rivalry between orthodox medicine and CAM stem also from the ability to be in control of political authority as well as ability to define what passes as knowledge. The relationship between biomedicine and colonialism has demonstrated the dynamics of biomedical power especially in non-western societies where biomedical hegemony was enforced upon the colonized.

However, this macro analysis may leave out the important dynamics sustaining the various medical models. The ability to be relevant to patients/clients should be seen to be at the centre of any medical enterprise since the mere existence point to the ability to service a group of clienteles. Hence an analysis of the patient healer relationship within medical discourse is an important component of medical history. The medical choices of patients remain the biggest factor sustaining a medical practice, hence rather than being fixated on the macro institutions a microanalysis of medical relationships is important. Studies have long tried to establish the justifications towards people's preference of medical choices, something which points to the importance of health-seeking behaviour in the perpetuation of medical discourse. Robert Veatch aptly captures the importance of the patient when he advocates the centring of medical

choices firmly into the hands of the patient (Guyer, 2010; Veatch, 2008). Veatch advocates a situation where the patient is the decisionmaker whilst the medical practitioner occupies an advisory role through diagnosis and informing the patient of possible alternatives (Guyer, 2010). Whereas the colonial patient was a subject, devoid of rights and sometimes subjected to unwarranted clinical trials, the postcolonial era, in a sense restores the leeway for patients to make critical decisions concerning medical choices. Hence the current manifestation of alternative medicine should also be understood in terms of a political shift towards greater democratization in medical choices as well as the respect for patients' individuality. Regardless of issues of medicinal efficacy, the structure of medical discourse reflects patient power in determining health and illness encounters. However, the patient is still faced with a huge task of sifting through various medical claims before he/she can decide on which medical approach to follow.

2.7 Conclusion

This chapter has focused on the broader aspects of the medical discourse exposing the different aspects that underlie the evident parallel existence between alternative medicine and the dominant biomedicine. The major aspects regarding the rise of biomedicine to becoming the yardstick of medical practice are historical and may be traced from both the transition from tradition to modernity as well as to the European colonial expansion which helped to extend the influence of biomedicine beyond the confines of Europe. That expansion process has not been innocent and is characterized by some unethical ways of healthcare and crimes committed in the name of science and enhancing medical knowledge.

The process has also been described by Foucault as medicalization, a process through which medicine became an important tool of exerting power and control over people. The dualistic and parallel medical system should also be understood in terms of how biomedicine has viewed healing approaches differing from its philosophy and approach to health and illness. Complementary and alternative medicine should be seen first and foremost to be an outcome of the resistance of different medical systems to the domination of biomedicine. The resistance of CAM has also seen a proliferation of different healings systems hence enhancing consumer choices in terms of seeking recourse to illness. The globalization discourse should also be seen

to be an important prism carving the character of CAM since it has seen the internationalization of previously indigenous remedies which have been added to the numerous alternative healing approaches in Africa. The next chapter brings the discussion home, by focusing on the dynamics of the Zimbabwean health care system to date. This lays an important foundation for the understanding of the medical space in Zimbabwe.

CHAPTER 3

HEALTH AND HEALING IN ZIMBABWE

3.0 Introduction

This chapter provides a historical narrative of the development in healthcare with emphasis on healthcare policies and delivery system in Zimbabwe. There are several major landmarks which have informed the outlook of the healthcare sector in Zimbabwe, beginning with the missionary expeditions and the subsequent colonial administration, and moving on to the postcolonial melting pot of healthcare policies up to the contemporary conditions. The postcolonial healthcare has also seen a continued propping up of foreign biomedical healthcare through the role of INGOs, which play a prominent role in public health care service. The chapter covers different aspects which informed the character and evolution of healthcare approaches up to its present character. These include general issues of governance and law enforcement, the state of the economy as well as the reception of healthcare among the general populace.

Whilst it is attractive to argue that the rise of alternative medicine is a direct outcome of the failures of the formal biomedical model, this chapter shows the historical roots which may even question such a generalized assumption. Although it is undeniable that the hand of the economic crisis in Zimbabwe, somehow reconfigures the character of healthcare, the factors influencing present conditions are a result of a myriad of issues. Hence, this chapter also explains the onset of the Zimbabwean economic crisis as well as how this has reshaped approaches of healthcare. Apart from addressing the historical aspects of healthcare in the country, the chapter addresses questions relating to how the relative collapse of the biomedical healthcare system has influenced the visibility of foreign healing systems within the Zimbabwean context. The chapter also notes the political dimension of healthcare systems in Africa and how perceptions from a political perspective are crucial in the understanding of healthcare patterns in Zimbabwe.

The major observations in this chapter are that biomedicine, apart from being the official medical system, has never totally succeeded in filling the power vacuum within healing systems (Chavhunduka, 1998; Machinga, 2011). Whilst it is a fact that many people have utilised biomedicine, it is also undeniable that alternative therapies have been an indispensable part of the health and healing in Zimbabwe. Hence, we can see issues of hybridization and

mimicry within medical systems as biomedicine became customized alongside other medical systems. There has always been a vacuum when it comes to addressing health and illness, and this vacuum often attracts other medical systems which attempt to bring solutions to the disease burden in society. The void is influenced by different issues which include political, religious as well as socioeconomic aspects of health and healing.

3.1 Colonialism and traditional medicine in Zimbabwe

Like elsewhere in Africa, Zimbabwe's first encounter with biomedicine dates to missionary work. It is the work of early missionaries and later colonial healthcare departments which influenced colonial medicine in the country (Lowes & Montero, 2018; Tilley, 2016). Good (1991) noted that Catholic and Protestant missions formed the bulk of biomedical care provisioning in colonial Africa. Waite (2000) noted that the work of the London Missionary Society (LMS) was instrumental not only in achieving colonial dominance through evangelism, but also through the offering of medical services. Medical services were the important carrot which enabled settlers to gain a trust and acceptance among the indigenous people through exploiting the vulnerabilities associated with illness. Ultimately, healing someone became the easier way of winning the hearts of Africans than evangelism alone. Apart from being an important facet of the colonizing endeavours, colonial medicine was largely skewed along racial lines in a system akin to apartheid. Biomedical hospitals were mainly supposed to serve whites especially in urban areas. The priority of colonial medicine was a healthy white population, and the secondary goal was to ensure that black labour was sufficient for the colonial enterprise (Packard, Cooter & Pickstone, 2003).

To facilitate easy acceptance of foreign biomedical care, colonial regimes castigated African medicines and healing approaches. Therefore traditional medicine was viewed as a pagan form of healing and was regarded as a controversial form of healing when compared to modern medicine (Waite, 2000). Missionaries who brought Christianity to Zimbabwe were at the forefront of denouncing traditional medicine and the missionaries were joined in denouncing traditional medicine by white officials, doctors and nurses who championed western forms of medicine in Africa. Colonial doctors regarded medicine from herbs as non-scientific and as such there was not much interest from their side. Due to a neglect and non-scientific nature of traditional medicine, there were several diverse restrictions which were taken against

traditional medicine. Some of the measures which were taken against traditional medicine were that its legitimacy was undermined through the creation of missionary schools, organisation of white professional bodies which were used to denounce fellow white men who would refer patients to traditional healers. Patients who were in the habit of using traditional medicine were insulted and criticised. The formulation of the Witchcraft Suppression Act of 1899 worsened the undermining of traditional medicine as its practice was now regarded as a criminal and illegitimate (Waite, 2000). From the repressive act, there was a blanket undermining of traditional forms of medicine based on the materials and charms used which were not related in any way to witchcraft. However, regardless of the tireless attacks on traditional medicine, it co-existed with western medicine for a very long time and most Zimbabweans used both traditional and western medicine. Hence colonialism affected the development of traditional medicine in Zimbabwe whilst simultaneously there was preferential channelling of modern medicine towards the few white minority and urban population. This created a vacuum which resulted in alternative therapies remaining relevant to the discourse on health and healing.

Colonial medicine in Zimbabwe was also about the control of bodies not only of the blacks but also of the white settlers. Principles on separationist policies and legislation should not be simply viewed as springing up from a white disdain of the black indigenous people but should also be interpreted in light of perceptions on disease causation and biological functioning of black and white bodies (Anderson, 2014). Blackness was equated to dirt and was also seen as an avenue through which disease and contagion come upon people. Ncube (2012a) noted that Africans were simultaneously loathed and feared as they and their environments were believed to be the major drivers of diseases and epidemics. Africans were considered to be carriers or vectors of diseases, who could pass on diseases such as malaria, dysentery, syphilis and even sleeping sickness to the Europeans (Ncube, 2018). Hence, eradicating diseases among Africans was synonymous with purging the source of diseases. This sentiment was also evident in the nature of racial approaches to urban planning in colonial South Africa in the aftermath of the bubonic plague of the 1900s (Swanson, 1977).

The control of bodies was seen in forceful immunisation programmes, quarantining and control of movement as an attempt to control epidemics which were perceived to emanate from the Africans (Ncube, 2012a). This control and treatment towards Africans shaped even the postcolonial patient-healer relationships in Zimbabwe. Fewer patients feel comfortable in the

presence of the unlimited power of the biomedical healthcare practitioner. This lop-sidedness of power relations often led to resentment and attempts to avoid public hospital whenever possible. The hospital was a symbol of everything colonial, thus avoiding it was an important form of defiance towards colonialism. Hence, the presence of alternative measures which claim to deal with ailments is a welcome diversion which aids the postponement of the hospital visit.

Colonial power could be seen in the order of the hospital. The white, clean uniforms were a symbol of power, and most often than not, the hospital staff exercised considerable power over their patients. A trait which can still be found in the present-day postcolonial hospital, nurses are sometimes known to be mean, rough and to make patients jump, especially in the public health system. Jokes are often made that when one becomes a nurse, they become experts at insulting people and bellowing instructions. It is a characteristic which has made people to fear biomedical practitioners even in present day Zimbabwe.

3.2 Postcolonial Zimbabwe and healthcare

The term 'postcolonial' has evolved to become an analytic framework representing not only an epochal shift, but also a departure from colonial ways of doing things. In a way it has often been associated with the decolonial project. Decolonizing medicine can be seen to include dismantling colonial structures as well as embracing diversity and alternative methods of healing. In terms of medicine and healing, postcolonialism in Zimbabwe could only be interpreted in terms of an epochal shift, characterized by changes in office bearers, whilst there was little movement in changing the mindsets and ideas informing healthcare in the country. The greatest question in studies of postcoloniality is to what extent can the present conditions signify a break away from colonial traditions and ways of doing things (Packard *et al.*, 2003)? To answer this question, this section explores the transition from colonial to postcolonial medicine. However, it is my observation that the current medical sphere reflects colonial medicine and responses to it. The discourses on medical systems in Zimbabwe are an outcome of colonialism as well as responses to it.

Upon attaining independence in 1980, there was increased responsibility on the part of the government towards making sure that the black Zimbabweans who were the majority had access to social services. The government needed to repeal provision of social and health services which was heavily biased towards the white minority in colonial times (Dodzo & Mhloyi, 2017). The independent Zimbabwean administration inherited a health system which

had a racial and regional bias. Segregationist policies left the newly born nation with a divisive healthcare scenario which privileged whites and urbanites, whereas the majority rural populace did not have good access to healthcare facilities. Therefore, upon attaining independence the Zimbabwean government reduced the colonial imbalances by improving access to social services through increases in health infrastructure. The challenge for the health sector during colonial times was also through limited funding and colonial neglect (Mhike & Makombe, 2018). As noted earlier, this neglect stemmed from the character of colonial medicine which was geared more towards being an instrument which will serve colonial interests, than a health system which could cover the whole nation.

Although the newly born state embarked on an ambitious project of expanding access to healthcare, the mindset remained the same. The colonial and Western framework of healthcare was the basis upon which all national healthcare planning took place. This was seen through the modelling of healthcare along a largely biomedical path. Training and infrastructure development followed western healthcare models without adequate inclusion of indigenous medicines (Airhihenbuwa, 1995; Gaidzanwa, 1999). Moreover, donor funds and international healthcare partners worked under the framework of western biomedicine, hence the continuation of the neglect of local medical solutions. Therefore, the postcolonial label in healthcare was simply in the replacement of foreign by local political actors, whereas decision making, and ideologies firmly remained within the framework of the erstwhile colonizers.

Apart from funding and external influence, the ideologies informing education and training of healthcare practitioners did not do much to orient personnel towards an inclusive and locally based health approaches. If anything, the education, and training treated culture and religion as obstacles to the efforts of achieving better healthcare. Hence, the education system carried on colonial mentalities of emulating the colonialists at the expense of designing home grown and context specific solutions to healthcare within Zimbabwe. According to Mlambo (2005) most professionals often chose to abandon the crisis ridden postcolonial state in search for greener pastures in the west. This shows the interconnections of the educational system with that of the former colonialists since it was easy for individuals to simply switch and be absorbed in western societies. Moreover, the attempts to professionalise and teach traditional medical courses in higher education only served to reinforce inequalities and exploit traditional

medicine. Davey (2013) observed how traditional medical courses taught traditional medicine using biomedical lenses. A student could make a diagnosis using the biomedical lens but administer a traditional medical remedy. Some biomedical specialists continued the colonial tendency of not paying attention to any remedies which were not endorsed by biomedicine even though proven efficacy might have been seen in different communities. Little formal effort has been directed towards incorporating non-biomedical knowledge into the mainstream medical system.

One undeniable aspect of colonial medicine in Zimbabwe is that it introduced another way of healing which the local people added to their repertoire of healing ways. It should be noted that the compelling aspects of the western medicine in dealing with some ailments persuaded the local people to also incorporate this novel healing into their ways of seeking relief from diseases. Hence, one can note the genesis of medical syncretism which has continued up to contemporary periods. Though colonial medicine had its flaws, it left an indelible mark on healthcare approaches in Zimbabwe. The postcolonial medical approach utilizes biomedicine as its springboard. At the level of ideology, biomedicine also influences the thinking patterns, explanations and understandings of diseases and healing.

3.2.1 Traditional medicine in post independent Zimbabwe

An understanding of medical systems in Zimbabwe also depends upon the appreciation of traditional medicine; especially, its development and influences upon health and healing today. The postcolonial Zimbabwean administration has been often blamed for continuing a colonial legacy of neglecting the institution of traditional medicine (Waite, 2000). The government focused more on a biomedical model of healthcare and sought inclusivity of previously marginalized and inaccessible areas through training and deploying village health workers, who became the mainstay of the National Health Service. However, traditional medicine itself could not be entirely ignored though it played second fiddle to the biomedical approach. Two interlinked issues drove the agenda on postcolonial traditional medicine. The first related to the decolonial character of the postcolonial state, where embracing everything indigenous was equated to decolonialism. Hence, traditional medicine, which is an integral part of indigenous cultures represented a positive attempt in restoring the values of the local people. The second, aspect relates the indelible contribution of the institution of traditional religion to the liberation struggle. That critical role which people like spirit mediums and traditional medical specialists played also called for their recognition in the newly birthed state. Hence through lobbying and

organization, there was the formation of an association meant to regularize and formalize the practice of traditional medical care. The major organization, Zimbabwe National Traditional Healers Association (ZINATHA), became the regulating organization regulating and overseeing the operations of traditional medicine. The formation of ZINATHA introduced an all-inclusive framework towards the integration and use of traditional medicine alongside modern medicine. Members of ZINATHA were supposed to be registered such that they could be called by the title of Registered Traditional Medical Practitioner. The operations of ZINATHA were guided by the Traditional Medical Practitioners Act, which was subsequently publicised in 1981, with the major aim of integrating traditional medicine into the Zimbabwean health system. The new organization also harboured the following objectives: facilitating research and development in traditional medicine, fostering the use of spiritual healing, preventing malpractices and dishonesty, developing working relations with modern medicine doctors and lastly training and educating people on traditional medicine (Cavender, 1988; Winston, Patel, Musonza, *et al.*, 1995). In that vein, the organization established a school as well as research centre for research in traditional medicine. It is from the college that hygienic practices were inculcated, diverse uses of traditional medicine and bookkeeping and there was no room for the use of spirit possession. To provide services in urban areas, there were traditional clinics which were opened in Bulawayo and Harare were people underwent treatment (Waite, 2000). To market their products and services, ZINATHA created adverts which indicated the different diseases which were treated under ZINATHA Pharmacy Styles. ZINATHA in turn led to the development of drug supplements for deadly diseases such as, HIV and AIDS, different forms of cancer, malaria, blood pressure, sexually transmitted diseases (STDs) (Shoko, 2018). Due to the diverse services that they offered, more facilities were opened in Gweru, Mutare and Masvingo.

To be able to practice as traditional health practitioners, the then Ministry of Health made it a rule that one had to be registered and be of good character and in possession of the requisite knowledge and abilities. With specialities being noted there was room for the nomination of honorary traditional health practitioner and such appointments would be placed under registered spirit medium. Operating without registration attracted punitive measures with the extreme punishment being a two-year jail term (Waite, 2000). Hence, the law protected the integrity of registered traditional healers and those who were not competent were suspended

Although ZINATHA was formed in 1980, the institutionalization of traditional medicine and its practices did not easily affect both whites and blacks who were then in government and this was partly because of the Christian beliefs which the people held (Waite, 2000). Resistance to traditional medicine came from its alleged lack of scientific rationalism. Healing approaches of traditional medicine were not based on science but on *'pseudoscientific'* forms or folktales which could not be proven in the realm of science. The attack on the objectivity and reliability of traditional medicine, using the biomedical and science goggles was a direct attack on the dominant health institution of the majority. However, this did not culminate in decreased usage of traditional medicine, but in essence spurred a realignment of traditional medicine to fit into the form and structure of biomedicine. The criticism of traditional medicine dissipated with the formal registration of ZINATHA. The objective of integration was, however, an uphill task for the traditional medical practitioners. They had limited funding and organisational support, and their formalization was only acceptable in as much as they did not disturb and challenge the mainstream biomedical approach (Ngarivhume, van't Klooster, de Jong, *et al.*, 2015).

The other major setback about the mainstreaming of traditional medicine in Zimbabwe was that the operations of traditional medical practitioners under ZINATHA did not have written down operational procedures as well as a framework guiding the process. Therefore the integration process was poorly done and another prejudicial perception towards traditional medicine was that it was mainly for the rural folks (Ngarivhume *et al.*, 2015). Moreover, the rationalization and formalization of traditional medicine had an effect of transforming the face and character of the practice. It could be noted that the transformation sought to hold the practice to the standards of biomedicine, something which resulted in the side-lining of some integral parts of traditional medicine, such as spiritual healing (Davey, 2013). Spiritual healing was viewed as bordering on witchcraft and could also not be subjected to scientific rigours and objectivity set by the biomedical standards. Hence, the postcolonial Zimbabwean government also had a shortcoming of failing to adequately empower alternative therapies, something which worked to prop up the biomedical hegemony which is evident even today.

Although the efforts made by ZINATHA cannot be ignored, another challenge which was faced was mainly from employers who failed to recognise sickness certificates from traditional doctors nor did the medical aid societies accept bills from traditional healers. Shoko (2018) is

of the view that although traditional medicine can have impact in Zimbabwe currently especially with regards to physical disorders there is need for better organisation and recognition. It has been noted that the postcolonial Zimbabwean state failed to act decisively in ensuring recognition and mainstreaming of traditional medicine, despite efforts from several fronts to put the healing approach on the limelight. Different dynamics including, power, funding, general attitudes negatively impaired any chances of traditional medicine from gaining any prominent role within the new state. The affinity of the younger generation of leaders towards foreign systems coupled with the general populace' fascination with all things foreign, should be seen to work against the success of traditional medicine in the postcolonial state. Colonialism has been seen to lead to an attitude of resentment towards local cultural products while at the same time instilling a reverence to foreign products (Rocha, 2017). Though traditional medicine was relegated to an insignificant trade, scholars noted its continued use and importance in the healthcare system of Zimbabwe (Chavhunduka, 1998).

Experiences in traditional medicine gives a bedrock for understanding dynamics of healing approaches outside the formalized systems. The scepticism and perceptions towards traditional medicine are a pointer towards the general perceptions towards all unregulated medicines. One aspect of note is that the coming in of the postcolonial state renewed the debate over conventional and nonconventional medicine, something which even led to the enactment of legislation which gave recognition and officialised traditional medicine. A closer analysis of the way traditional medicine was officialised also point to a desire to twist the trade to fit European constructions of healing systems. Checks, and balances, formalised schools and clinics as well as attempts at establishing standard operational procedures shows an active desire to model traditional medicine along the same manner as biomedicine. The whole enterprise brings out several viewpoints in terms of power relations within medical systems. Firstly, there is an evident otherization of non-biomedical systems, a practice which has given birth to the present day multi healing system scenario in Zimbabwe. Secondly, a desire by marginalised healing systems to fit into the template of the biomedical model to get affirmation and acceptance concerning the authenticity of these alternative therapies. Hence, one can note the attempts at modernizing indigenous medicine as attempts to fit into the official standards of what constitutes a proper medical system. In the end many alternative therapies engaged in what Homi Bhabha terms mimicry, where the objective was to model healing along the ways of the biomedical model (Bhabha, 1997).

However, to sell, most alternative therapies also had to show that they have an edge and are better than biomedicine. Their trump card became a presentation of their medicines as not only like biomedicine but also better since this was natural and posed no significant side effects as compared to biomedical therapies. This augurs well with Bhabha's (1997) observations of mimicry where the foreign is both enviable but looked at with disdain. Biomedicine's ways are enviable such that traditional and alternative therapies began to mimic them in form and presentation though the philosophies and medicines used differed. At the same time, biomedicine's condescending view towards traditional and alternative therapies exhibit the view of superiority which informs the attitude of the coloniser, whilst attempts at incorporating some elements of traditional medicine show how the colonised is also viewed as exotic and fascinating. Hence Bhabha's concept of ambivalence aptly captures the relations between biomedicine and traditional medicine.

3.2.2 Health and policymaking in Zimbabwe

The healthcare system in Zimbabwe is one of the complex systems due to the heterogeneous nature of medical systems which coexist within the nation. It should be noted that upon attaining independence policymaking in relation to healthcare was complex and driven by different political and pragmatic considerations. Some of the earliest considerations include endeavours to redress the colonial imbalances in healthcare through the inclusion of the black majority into the mainstream healthcare system. A confusion over which ideological path to take also saw a melting pot of capitalist and socialist approaches to healthcare, depending upon the leanings and desires of the foreign funders. It should also be noted that the premise upon which health care policies were crafted utilized biomedical thinking, whilst side-lining other medical approaches which were existent in the country. Healthcare systems in developing countries have become more complex as compared to experiences in the developed world (Gale, 2014). According to Kidia, (2018) Zimbabwe upon independence had a well-polished health network albeit, being skewed towards certain regions like urban centres.

Zimbabwe's health policy was informed by two main factors. Firstly, the health sector was characterised by inadequate health infrastructure, and provision of such consumed a considerable part of the available resources to the extent that government, by the mid to late 80s, was financially hamstrung to effect a paradigm shift from curative to preventive health (Mhike & Makombe, 2018). Secondly, the rhetoric of socialism and the euphoria of independence had a bearing on health policy. Government considered health care provision as

one avenue through which it could alleviate poverty and, therefore, decisions on health became entangled in the political cycle (Mhike & Makombe, 2018). The socialist ideology led to wide ranging policy decisions which were meant to be inclusive as well as to create an egalitarian system envisioned by socialist ideologies. It is against this backdrop that we witness the introduction of decisions like free primary health for all and the removal of user fees for healthcare to certain populations. The flagship policy of post-independence Zimbabwe, "Growth with Equity," was a framework which entailed, inter alia, the improvement and expansion of social services and consumption levels in the local economy (Government of Zimbabwe 1981). Equity in health—as enunciated in health policy—entailed improved distribution of and access to health services. Hence, this major post independent policy adopted the socialist rhetoric and set the stage for a health care approach designed to be affordable, accessible and available to every person in the country. Equity in healthcare was also sought through the drive towards universal; primary healthcare as noted in the Planning for Equity in Health, which was part of the Transitional National Development Plan 1982 (Sanders & others, 1990).

Apart from the pro-people and socialist tendencies of the first decade of Zimbabwean policymaking, the second decade witnessed economic crisis which saw the country succumbing to the effects of the Economic Structural Adjustment Programmes (ESAP), in the 1990s (Gaidzanwa, 1999). These IMF and World Bank sponsored policies adopted a capitalist market-based approach to the running of state affairs. In healthcare policy, this was felt through removal of health subsidies and introduction of user fees which transferred the costs to the patient. This made healthcare unaffordable for many citizens due to the removal of subsidies as well as the drive towards privatization as the state was being rolled back to conform to the dictates of capitalist market-based economics. The 1996 review of the Economic Structural Adjustment Programme revealed that the envisaged equity in healthcare was eroded by market capitalism hence an attempt to introduce some safety nets to cushion the poor and vulnerable. The National Health Strategy (1997-2007) was launched in a bid to restore equity and improve on the quality of healthcare available in the country. The successes of the policy were however short lived and successive economic crisis stifled the development of better healthcare facilities. However, the policy opened healthcare for a multisectoral approach which saw collaboration between the ministry, communities and NGOs in the provision of healthcare services. NGOs were particularly important in the fight against HIV/AIDS and related

illnesses, since most public healthcare facilities did not have capacity to deal with the scourge. The multisectoral approach was also seen in efforts towards reduction of maternal deaths and improvement of health delivery which were enshrined in the National Reproductive Health Policy, the National Health Strategy 2009–2013, and the Zimbabwe National Maternal and Neonatal Health Road Map 2007–2015 (Choguya, 2015).

3.2.3 Neoliberal reforms and the privatization of public expectation

Perhaps the far-reaching implication of the neoliberal capitalist reforms was not the removal of the subsidies per se, but the privatization of public expectation. Neoliberal capitalism brought a new mindset which was contrary to the popular socialist ideology, where people often looked up to the state for provisioning in areas such as health, employment, and other social services. Individuals were left to deal with their issues on their own with limited state assistance. This created a climate conducive for the flourishing of alternative medicines as the state reneged on its duties of ensuring that the health of its citizens is catered for. This may also even explain the lukewarm approach towards dealing with unregulated medicines in the postcolonial nation (Kachambwa, Naravage, James, *et al.*, 2019). Limited resources and energies have been channelled towards fighting and regulating medical practices falling outside the formal healthcare systems. Citizens have also been conditioned by such an attitude such that the responsibility of health seeking lie in the hands of the patient and their immediate family. Neoliberalism has carried on the discourse of mistrust of biomedical healthcare systems which were birthed in the nature of colonial medicine (Richardson, 2019). The patients are left to navigate on their own and find remedies for their own health, hence neoliberal capitalism introduced and reinforced a sense of individuality in health seeking behaviour. Health institutions are perceived as only seeking to reap profits from the patients thus fuelling discourses of mistrust of biomedical health systems.

The Zimbabwean public health system should also be seen to exist along a binary of the public and private sector. The public sector tends to dominate the Zimbabwean health system the accounting for 65% of the services in terms of health in the country. Since Zimbabwean health system was under the dominance of missionaries during colonial times, mission hospital play a pivotal role in the provision of health services in the rural areas, while the private sector was mainly concentrated in urban areas (Dodzo & Mhloyi, 2017). Specifically, for urban areas,

health care facilities were under the jurisdiction of local authorities who receive grants from central government. In terms of ratios of access to health facilities, most members of society are located within 5 km from their next biomedical health centre although about 23% are in the range of 5-10 km and about 10% of the community live about more than 10 km from the nearest health service centre. Zimbabwean health care can still be regarded as pluralistic due to the existence modern medicine, faith based healing, patent medicine shops, and traditional medicine (Choguya, 2015; Dodzo & Mhloyi, 2017). With the pluralistic nature of the Zimbabwean health care system, people choose amongst the wide range of services such that they get medical assistance. The Zimbabwean health care system was mainly focused on provision of basic primary health care emphasising on community-based interventions which was heavily supported by strong referral systems and services.

At hospital level, government improved inward efficiency through staff deployment, drug consumption and vehicle usage, among other things. The Zimbabwean government supported policy changes with capital investment, human resources, and infrastructural development. The improvement of health service delivery was largely financed through an expansion of government spending. Between 1980 and 1990 the Zimbabwe government consistently provided an average of four to six per cent of its total expenditure to health provision. The base for the delivery of comprehensive primary health care was the provision of health care centres and 273 were constructed between 1980 and 1989, giving a total of about 927, including local government, mission, and industry-owned facilities. This improvement in infrastructure fed into government health policy and strategy for the period 1980–1990, aimed at building and upgrading district level hospitals and clinics. These health care centres were largely located in rural areas for the benefit of some of the poorest and vulnerable sections of Zimbabwean society. However besides the steady progress after independence, the year 2000, saw a gravitation towards a decline of the once well organised health delivery system and the real crumbling of the system was in 2008 (Choguya, 2015). According to Meldrum, (2008), the collapse of the Zimbabwean health system was characterised by critical shortage of trained personnel especially doctors and medication for the financially crippled patients (Meldrum, 2008).

In 2009 under the Government of National Unity (GNU), the Zimbabwean government with the help from World Health Organisation (WHO) formulated the National Health Strategy for Zimbabwe running from 2009-2013 (Mafuva & Marima-Matarira, 2014). It is under this framework that traditional medicine is covered in detail and there was a call to incorporate the perspective of WHO towards traditional medicine. Therefore, there was a change in policy stance towards traditional medicine as there was need to follow WHO guidelines which called for the recognition of traditional medicine. The national health policy also indicated that there is need to enhance close monitoring on the extent to which herbal medicine can be regarded as safe and as such there were attempts to document practices in traditional medicine. According to Mafuva and Marima-Matarira (2014), the policy calls for the differentiation between the diverse roles which exist between Traditional Medical Practitioners Council, the traditional healers and the Health Professions Council. From this policy perspective it is worth noting that there was a change in government position as there was a call to make traditional medicine professional. Due to a number of factors such as resource availability, socio-economic uncertainty and poor capacity building there is a low pace at which the integration of the two forms of medicine within the Zimbabwean context (Mafuva & Marima-Matarira, 2014).

3.3 Legislation on Zimbabwean medicine

Another crucial aspect of the exercise of health and healing, as noted in previous sections, medicine has always been a site of struggles for control over what constitute a legitimate approach to healing. The colonial period had its own fair share of legal cocktails meant to standardize and legitimize the operation of healthcare officials. In the same vein the independent Zimbabwean government established structure which were also meant to create guidelines for the operation of health care providers as well as distribution and consumption of medical products. In Zimbabwe, all forms of medicine are under the auspices of the Medicines Control Authority of Zimbabwe (MCAZ) which was created through an Act of Parliament. MCAZ has the mandate to ensure the safety of both animals and people through the medicine that they access. MCAZ is also governed by the Medicines And Allied Substances Control Act (MASCA) (Gwatidzo, Murambinda & Makoni, 2017). Thus, there are benchmarks which need to be met for medicine to be registered and these organisations are there to regulate poor quality and counterfeit medicines into the Zimbabwean market. Among some of the conditions which need to be met when registering medicine include public interest; (ii) safety, quality, and therapeutic efficacy attributes; (iii) satisfactory good manufacturing practice (GMP), and (iv)

in the case of a medicine manufactured outside Zimbabwe, valid certification issued by appropriate National Medicines Regulatory Authority (NMRA) in the country of origin or other stringent regulatory authority (SRA). If there is breach in any of the stipulations made above, there are several penalties which are imposed which are in the form of warnings, fines or imprisonment. More so, MCAZ also controls the breaches in terms of the provisions such as keeping unregistered products, and this can lead to revocation of licenses and or heavy fines which can be imposed.

There are several legislations which deal with medicine in Zimbabwe. Already discussed is Traditional Medical Practitioners Act (TMA) of 1981 which was the basis upon which the Traditional Medical Practitioners Council was created. The Traditional Medical Practitioners Council has the mandate to register and discipline all members of their association. Research which is done under the banner of traditional medicine is regulated by the Traditional Medical Practitioners Act (TMA). Therefore, quantity and quality of traditional medicine from ZINATHA is regulated by the act.

Although the act is old, the Drugs and Allied Substances Control (DAS) of 1969 is an act which is to provide control on the registering, buying, selling, dispensing of drugs and similar substances s. Under DAS of 1969 there was the establishment of the Drugs Control Council (DCC), which was of late transformed to Medicines Control Authority (MCA), which makes sure that there is implementation of the legal provisions towards drugs in Zimbabwe (Hongoro & Kumaranayake, 2000). MCA is in charge of inspecting and providing licenses towards people, buildings for the purposes of selling drugs. Activities and services done by people or organisations in terms of their quantity and quality and, which are publicly significant are regulated by the Public Health Act (PHA) of 1925/1996. This is so specifically for notifiable ailments such as tuberculosis (TB), sexually transmitted infections (STIs) and hygiene. The PHA creates room for the formation of the Public Health Advisory Board which is mandated to advising the health minister and municipal local authorities on public health issues.

MCAZ repeatedly provides warning on the usage of traditional medicine which is promoted with the belief that they provide cure to all diseases such as HIV and AIDS. MCAZ warned that members of the public are put at risk in terms of their health for those who have replaced conventional medicine (Shoko, 2018). According to Gwatidzo, Murambinda and Makoni

(2017), there are vendors of medicine without licences who trade their wares to commuters and these wares include skin-lightening creams, steroidal products, sex-enhancing products, oral contraceptives, pain killers, various herbals remedies which are available cheaply. The challenge being faced is that medicine which should have been sold in regulated places such as pharmacies, hospitals and clinics are finding their way to the street without any prescription being demanded. At the end of the day there are a number of questions which are being asked on the medical supply chain with regards to its integrity (Gwatidzo *et al.*, 2017). The compliance to all the acts and statutory instruments is questioned and their source remains a story for another day.

3.4 Health, alternative medicine, and the socio-economic context

The post-2000 phase which witnessed the collapse of the Zimbabwean health delivery system saw an increase in the rate at which mission hospitals provided increased medical care than public facilities (Mhike & Makombe, 2018). Moreover, the hyperinflation period also made medical aid and even local currency useless and as such this was an opportune time for the rise in use of herbal medicine. It should be underscored that several factors underpinned the decline of the health system in the country. The major factor could be seen as the political inefficiencies characterizing the nation. Issues of health are dependent upon resources, and it is the responsibility of the political system of the day to allocate resources in a way which ensures that the health system functions well. The era beginning the year 1999 saw a marked rise in the decline of the economy and the related sectors of governance. Years of mismanagement, misappropriation of funds and governance blunders had created a time bomb since the attainment of independence. That time bomb evidently exploded around the year 1999, hence the evident decline in people's incomes and failure by government to execute its mandate (Asuelime & Simura, 2014). The centre could no longer hold, and up to the contemporary time, the nation is in the middle of experiencing the downside of bad governance politically and economically. As Chigudu (2019) observes, the post-2000 era saw a multifaceted crisis in Zimbabwe which was detrimental to the country's healthcare system. The political crisis also saw the birth of discontent and emergence of the first real attempt at unseating the long serving rule of Robert Mugabe and ZANU PF (Asuelime & Simura, 2014). In the political, economic, and social crisis of the period, the Mugabe regime attempted to cover for internal problems, and problems on the international scene by adopting a look East Policy. The traditional Western support was no longer coming since the government was blamed for political and economic

crisis in the country. Asia became the non-judgemental all-weather friend; hence the ruling regime chose to re-ignite ties with the Eastern nations.

Writing about the cholera pandemic, Chigudu, (2019) makes an important observation that diseases and their handling cannot be confined to the medical field but exhibit important political dimensions. Likewise, the nature in which medical systems are structured in Zimbabwe, can be understood from the political lens. As will be shown in the following chapters, the consumption of AICAM can be situated in the political framework of the nation. On the one hand, the political aspects inform the collapse of the formal healthcare system, giving prominence to multiple alternative therapies which seek to stand in the gap. On the other, the political leanings of the government in power have given directionality to foreign engagement, hence the Look East policy is responsible for greater links with Asian products.

Since independence Zimbabwe has been dogged by various socioeconomic crisis which should also be analysed to see their effect on healthcare service delivery (Rotberg, 2010). As indicated earlier on, there was social, political, and economic chaos in Zimbabwe at the beginning of the new century. At the end of the day, the socio-economic and political crisis affected all sectors of the economy with health included. Individuals and households were not spared either as government revenue collection declined, unemployment rose and monetary policies failed (Dodzo & Mhloyi, 2017). According to Kidia (2018), corruption and debt were the major drivers for decay in infrastructure and supply of basic health services and public spending on health fell by 3% from 2000 to 2007. By the year 2008, hyperinflation set in rates of inflation were pegged at 231 million percent which led to the demise of the Zimbabwean dollar and there was stagnation in trade and economic activities. From this stage, government was incapacitated in the provision of services public hospitals and there was worsening of health indicators. The 2008 economic crisis led to hospitals and clinics not able to provide basic services due to shortage of trained personnel and shortage of basic necessities (Meldrum, 2008).

Due to its pro-poor health policies, this level of health care, the Primary Health Care, has been given much priority and attention and had been called to be revitalised following the decade of economic collapse between 1998 and 2008. However, challenges continue to plunge the effective provision of health services at this level as more resources tend to be channelled towards higher levels in the public health system. The government remained constrained in

financing health in the post-crisis era. In 2010, MoHCW, (2010) stated that lack of resources; financial, human, and material resources are the major challenge facing the Zimbabwean health sector under the prevailing economic conditions. According to Shoko (2018), during this period, there were Indian shops who made remedies for flue using hot spice and some flour-type powder, mixed with hot lemon juice. As people sought after cheaper medical solutions, there was increase in fake medicine on the market capitalising on the economic chaos which was in the country.

There was adoption of the multi-currency regime which was under the GNU and a number of currencies were adopted and these included the US dollar, Euro, UK Sterling pound, South African Rand and Botswana Pula (Buigut, 2015). The year 2014 saw a number of currencies being added to the already existing currencies and these include the Australian Dollar, Chinese Yuan, Indian Rupee, and Japanese Yen (Southall, 2018). People were sceptical on the timelines as to when the government will drop the multi-currency system and the options at hand thereafter and this was further increased by lack of trust in government and monetary institutions. Under the GNU phase the economy stabilised and there was access to health services at a reasonable fee. The post GNU after 2013 elections, there was sharp change in terms of foreign direct investment (FDI), and the growth of the economy was stalled, and cash crisis set in. The Reserve Bank of Zimbabwe (RBZ) failed and is failing to provide money through formal channels and thereafter, there has been imposition of cash withdrawal limits (Dube & Gumbo, 2017). The failure to provide money through formal means meant that the public further lost confidence in the monetary authorities. Due to the lack of cash availability, the health sector was not spared as companies and individuals failed to have access to medicine.

According to Ray and Masuka, (2017), about 8% of the households in 2015 were faced with huge health bill and 13 % of the poorest households were faced with footing their medical bills and only 3% of the rich had challenges in terms of health care facilities. Taking 2015 as an example it can be noted that public expenditure towards health was pegged at $103.80 per capita which can be equated to 10.3% of the Gross Domestic Product (GDP). The financing of health within the Zimbabwean context is structured in this way, 21% being from government and another 25% is from contributions by individuals towards medical aid societies, 28% comes from employers and 25% is from donors. Therefore, with the socio-economic crisis

setting in Zimbabwe, this implies that government can fail to fund the health delivery system and there will be over-reliance on the donor community. The availability of the private health insurance schemes in Zimbabwe are mainly concentrated in the urban areas catering for only 10% of the working population. This becomes like colonial times under which health provision was for the urban minority. Currently there are high unemployment rates and there is reliance on informal jobs which do not cover medical costs and most of the people must cater for the own medical needs. Thus, from the economic front it can be noted that the bulk of the Zimbabwean population cannot afford access to health care due to lack of employment and the high medical costs. Thus, with such a situation at hand, there is no alternative left for the bulk of the population but to resort to alternative medicine which is in the form of foreign healing systems.

Due to limited availability of cash, the RBZ towards the end of 2016 introduced "bond notes" a currency which was initially given a false equivalence with the US dollar which in a way was trying to ease the acute cash shortage which were being experienced. Due to lack of trust in the monetary authorities, there was resistance towards the bond notes as people remembered the loss of savings during the hyperinflation period. There was no trust in the monetary authorities which was heavily manifested in the policy inconsistencies (Maziva, 2016). All these financial woes did not spare the health care system in Zimbabwe and the affordability and access to conventional medicine, and this provides a precursor for the rise in alternative medicine which are available on flexible payment terms. As indicated earlier on, due to high levels of unemployment it can then be indicated that the majority of the people do not have access to medical aid cover and as a result people resort to medicine which is channelled through the informal markets or go for traditional medicine as a way to run away from the high out-of-pocket costs in designated places (Gwatidzo *et al.*, 2017). Due to the acute shortage of foreign currency in the country, there is a lack of basic medical services in government hospitals and whenever and wherever these are available, they are found at exorbitant prices forcing people to resort to find alternatives in the streets where they are at risk of coming across substandard and falsified medicines. Therefore, from the above it can be noted that there is limited compliance with the Universal Health Coverage principle as there is no equal access to quality medicine which is affordable to the general populace.

Limitations in the availability of foreign currency meant that the RBZ had to limit again the forex to priority areas and luckily health was covered under the priority areas. However, preference was given to companies rather than individuals and even for the companies not all which submitted their applications got their allocations. With such a scenario, companies resorted to the purchasing of foreign currency on the black market which offered exorbitant rates. Thus, with reference to the health sector the patient will be the one who will bear the exorbitant rates of the medical services rendered in private hospitals and pharmacies were medicine was procured. This brought back again memories of the hyperinflation period whereby access to medical facilities was for the rich (Mugwagwa, Chinyadza & Banda, 2017).

With modern medicine being a shelf beyond the reach of many, indigenous herbal medicines provide an effective and affordable alternative for economically underprivileged countries like Zimbabwe (Chipungu, Mamimine & Chitindingu, 2019). In Zimbabwe, about 80% of the population is still dependent on traditional medicine. Herbal medicines are preferred because they are considered to be safer, cheap, easily accessible and as people think that their physicians not treat them properly, so they prefer self-medication through natural medicines (Kanwal & Sherazi, 2017). Yuan et al (2016) stated that about 1.5 billion people make use of Chinese herbal medicine global and Zimbabwe is included due to increase in costs of accessing conventional medicine (Yuan, Ma, Ye, *et al.*, 2016). Reasons advanced towards the use of herbal medicine are that they are found locally, they have a cultural importance, known history of efficacy and cheaper compared to western medicine (Thomford, Dzobo, Chopera, *et al.*, 2015).

Recently, there was a promulgation of the Statutory Instrument 142 of 2019 which brought about the death of the multi-currency regime in Zimbabwe. This implied that in Zimbabwe the RTGS$ was now official trading currency. This had huge implications on the private care health system especially pharmacies which were applying for foreign currency from the Reserve Bank of Zimbabwe. Even though people can be treated in government hospitals at a lower cost, the pharmacies at the government hospitals are not well stocked in terms of drugs. This means that patients are referred to private pharmacies which have been stocked with drugs bought with foreign currency bought at the parallel market at exorbitant rates. At the end of the day the patients are charged either in the banned foreign currency or the RTGS$ equivalent which will be ten times more than the value of foreign currency. With unemployment rate

pegged between 80-90% this implies that most of the Zimbabweans do not afford the prices of drugs charged in pharmacies. At the end of the day with all these financial woes, Zimbabweans are increasingly resorting to alternative medicine which is being peddled in the streets of most urban areas (Mushinga, 2016). Hence, alternative health care has the potential to make a valuable contribution towards improving the health of all people in Zimbabwe.

However, it should be noted that the use of herbal medicine did not start in Zimbabwe and Africa because of the collapse of the economy but co-existed together with western medicine. The different forms of traditional medicine include the following although the list is not exhaustive: acupuncture, chiropractic manipulation, meditation, homeopathy, and other approaches (Erah, 2002).Though the collapse of the health sector was evident, the entire system has been saved from total implosion by the periodical assistance from the humanitarian organizations and NGOs. NGOs, dependent on foreign funding have focused on different aspects such as the HIV/AIDS pandemic and sexual and reproductive health, children and vulnerable people's health as well as maternal health (Nyazema, 2010). However, it should be noted that these NGO's usually work within the framework of western biomedicine. An observation of their operations will show that there is little regard for any medical approaches which have not been subjected to the scrutiny and approval of biomedical authorities.

3.5 Collapse of the Zimbabwean biomedical healthcare system and the rise of foreign healing systems.

Many people cannot access basic drugs and vaccines and as such these people resort to the use of traditional medicines which are cheaper, readily available, and closer to their cultural and spiritual connections. Although in this modern era, there are a much more advancements in modern medical treatments, traditional medicine, especially herbal medicines, has always been practiced (Kanwal & Sherazi, 2017). Sound health systems make sure that members of the society are well taken care of and have diverse options to choose from (Opara & Osayi, 2016). Herbal medicine has, in the face of systemic challenges, presented a viable alternative in a largely pluralizing health system. Some of the systemic challenges have been noted in terms of the major consumers of alternative medicine products. Although the study was situated in Masvingo urban, the webs of distribution covered the whole province. Some of the major

consumers, who purchased the products from the urban came from areas that did not have adequate health infrastructure. Of particular note is the fact that some consumers were affected by displacement induced by the Tugwi-Mukosi Dam and they were resettled in areas without proper healthcare infrastructure (Nhodo, 2020). Through their networks, they were able to buy low-cost herbal products that were considered handy for various common illnesses. The linkages of the urbanites and the rural folk created a network for the distribution and consumption of alternative care products.

Since the year 2000, the dominant setbacks in the Zimbabwean health system are the exodus of trained personnel, obsolete equipment and shortage of drugs and related consumables. Currently due to shortages of foreign currency and near hyperinflation, medical aid societies are rendered useless and most of the people have their contributions eroded just like in 2008. The current economic conditions have affected accessibility of health care services of most Zimbabweans. Traditional healing becomes a better alternative which is cheaper, reduces the inequality gap, preserves local livelihoods and is for the poor (Singh & Madhavan, 2015). However, it can be argued that at face value, economic factors tend to pre-dominate the choice of traditional medicine, yet one cannot predict with certainty the reasons for choosing traditional medicine. According to Debas, Laxminarayan and Straus (2004), there is a common misnomer that traditional medicine is chosen over western medicine due to lower costs. Although there are cases under which traditional medicine is cheaper than western medicine there are studies which found out that traditional medicine can have the same costs or more than western medicine when dealing with the same conditions (Debas, Laxminarayan and Straus, 2004). According to Debas et al (2004), to a traditional healer for example, financial costs are not the main reason for choosing them but other factors such as ease access and the level of convenience and confidence when treated. However, it still needs to be established what other driving forces are behind the increase in the usage of alternative medicine in Zimbabwe other than the rising costs in conventional medicine especially with reference to the purchasing of basic and essential drugs.

Maroyi (2013) argues that within the Zimbabwean context, traditional medicine is chosen by most of the people due to affordability and accessibility for the financially constrained communities. For a very long time, the extent and scale of using traditional medicine can be regarded as high. The economic challenges which are being faced by the health delivery system

force people to resort to herbal medicine. Generally, people are now considering herbal medicines as they are regarded as a natural remedy, less toxic and safe when compared to contemporary medicine There is a surge in the use of herbal medicine which are mainly originating from China, Tanzania and India for the treatment of a number of diseases (Shoko, 2018). Correspondingly the demand in herbal medicine has led to the cropping up of herbal clinics and pharmacies in and around the country in both rural and urban areas (Maroyi, 2013). In Harare for example, due to the demand in herbal medicine, there are herbalist and conservationists who are making herbal gardens such that there have sources of plants to use for treating different medical conditions (Shoko, 2018). To that effect there has been the establishment of nurseries for several local tree and grass species which have medicinal value which are sponsored by the Medicinal Plant protection group.

The Zimbabwean people seem to be aware of the challenges that can be associated with both traditional and modern doctors who will be offering help to them (Mafuva & Marima-Matarira, 2014). However, it should be noted that with formation of hospitals and pharmacies dealing specifically with traditional medicines in both formal and informal markets bring with it challenges on the sustainability of harvesting the medicinal plants. The different types of alternative medicine available in Zimbabwe include traditional Chinese medicine incorporates acupuncture, herbal medicines, special diets, and meditative exercises (Choguya, 2015). In addition to the Chinese remedies, there are also Indian mediation which comes with exercises such as yoga, purifying diets, and natural products. These forms of medicine have been under increased usage after their promotion by WHO such that they can be integrated into modern medicine. What is then needed is to have policies and regulations at national level such that there is swift integration with country health systems (Debas, Laxminarayan & Straus, 2004; Mugwagwa *et al.*, 2017).

Although within the Zimbabwean context, there has been a rise in alternative medicine especially from the Asian sub-continent, there is no constant check on the products and at the same time there is no compelling data pertaining the safety and efficacy of the medicine thus hampering any efforts towards the distribution of the medicine. However, establishing the efficacy of medicine by only scientific methods completely misses indigenous traditions of healing. Although there have been a lot of challenges from the colonial to post-colonial times,

still traditional medicine is considered an option in Zimbabwean health care systems. The evidence can be noted through the establishment of pharmacies, surgeries, marketplaces, community centres and herbal and nursery gardens. Thus, where bio-medical practices have failed, traditional medicine has come in as a cover for the bulk of the poor communities in Zimbabwe.

3.6 Conclusion

The foregoing discussion has shown the context in which foreign medical practices have found a foothold on the Zimbabwean medical space. Various issues which include the colonial experiences, postcolonial policies and ideologies, politico-socioeconomic factors as well as belief systems and experiences converge to set the stage for the consumption of alternative therapies. It can be noted that the colonial medical experience has shaped a pattern where medical knowledge is dominated by and is viewed through the Western eyes. However, this type of medicine is seldom in touch with local realities, setting the stage for resistance and multiple medical systems. Medical syncretism best describes the conditions through which AICAM is flourishing within the Zimbabwean context. As people continue to use biomedicine, they also explore various healing methods since the formal system often neglects the contours shaping health seeking behaviours among the local people.

Though, biomedicine has emerged as the formal medical system and the preferred as well as trusted healing approach, it should also be noted that no singular discourse can claim mastery over disease and illness. Local realities and experiences shape people's interaction with medicine and subjugated knowledge can find an ear in the field characterised by medical syncretism. Hence, every claim which can rise can surely be guaranteed of faithful disciples. The nature of the medical field has been such that claims are not easily refuted, and medicine is deeply entrenched in a people's sociocultural values such that logic and rationality may not best explain how individuals make medical decisions. Though many scholars predicted the inescapability of rationality in modern industrial society, the medical sphere presents a picture of the persistence of what others may view as irrational. It might seem obvious that when one gets sick, they will go to a hospital and take the 'proven' medicine. However, the persistence of alternative medicine and the way in which people consume the medicine show that people hold different views when it comes to medicine. Biomedicine is looked at as just but one type of medicine which cannot hold all answers in relation to the amelioration of diseases and illnesses.

The chapter ultimately recognizes the role of political conditions in the country and how these influence the consumption and character of medical products. Whereas the colonial and early postcolonial periods give shape to medical experience, it should be noted that the political conditions of the postcolonial state equally contribute to the character of health in the country. The fragility of the postcolonial state significantly contributes to the way in which individuals consume medical products. The apparent collapse of political and economic institutions of the state should be held responsible for the situation obtaining in health. The following chapters explore the role of the political in influencing consumption patterns of AICAM. Having discussed the conditions characterising the emergence of AICAM, I proceed to explore the experiences of individuals as they navigate their way through the medical maze.

CHAPTER FOUR

The Political economy of Alternative medicines

It is six o'clock in the evening and Nathan is still in town at the bus terminus waiting for a consignment of goods from Harare. I sat with him in my car making small talk about everything from business to politics. After about an hour he rushes to the bus which had just arrived, and he beckoned me to follow to help him carry four medium sized card boxes to the car. Upon asking he tells me that his contact in Harare has sent him the order which should ordinarily take him to the following month. Each month he receives four boxes of different medicines which he resells to the public. He simply breaks down the boxes and sells them to his customers. 'So where are all these medicines coming from?' I asked him as we left the terminus. He answers, 'my brother, I do not even know many details. My contact in Harare does all the sourcing and we order from him. He is the one who does the running around and I am simply a distributor taking a smaller profit from the sales. Upon getting to his 'clinic', we offloaded the boxes into a small back room. The front room serves as the consultation room and does not have a lot of things apart from a desk, a bench, a laptop, and something which looked much like an old-fashioned aluminium briefcase. On the extreme left in a corner there is another machine which looks like a treadmill. As we sit down, I posed the question concerning the machines. 'Ooh those are some machines I use in diagnosis. That machine on the table is a scanner and it can give me an approximation of what is missing in your body. You should know that we only get sick because of some deficiencies in our bodies and to correct that we need supplements which we take from the plant resources. Let me show you how we do it,' he said as he opened the scanner, connected a cable to the laptop and connected a cable to the scanner. He gave me the end of the cable and asked me to hold it for about ten minutes. 'We will make an analysis and print a report for you. The deficiencies in your body will tell me what types of problems and diseases you might be experiencing. Then we will give you supplementary tablets, test you again until your values are within the normal ranges.' The tablets are just processed herbs, as you can see from the batches we received, some are from ginseng which is a popular herb in China. At the end of 10 minutes the report was printed, and he told me that I need more zinc, potassium, and calcium. He also told me I may be experiencing skeletal pains and pains in the groin area. I bade him goodnight and promised to come back to pursue the matter further.

The next day I had an appointment with the nurse. She took me in her car, and we talked as we drove to see some of her clients around time. She intimated some of the high-profile people she had attended to and spoke confidently of how satisfied they were with her services. We made a stop and gave one client a refill of his pills then proceeded to see two elderly women who were 'scanned' first and given some tablets packaged in the same packets used in clinics. The back of her car worked well as her clinic as she simply opened her laptop and scanner and started doing her consultations. As we drove back to where I was supposed to drop off, I asked, 'does the machine really work,' to which she replied, it never goes far from what one is suffering from so I think it is useful. We can compare different reports and you will see people have different diagnosis. Anyway, you have seen the clients and heard testimonies that they are being healed.

4.0 Introduction

Having discussed the Zimbabwean health system, this chapter examines the practice of alternative healing and answers multiple questions concerning the distribution and consumption of alternative medicines in the area under study. The questions include how do people acquire medical paraphernalia and knowledge which they distribute? What are the benefits which people also acquire from such medical enterprising? What are the reasons behind the relative success of AICAM? In addressing these questions, the chapter interrogates neoliberal arguments on health and illness and Foucauldian concept of governmentality as analytical tools to understand the dynamics of AICAM. I will attempt to contextualize the ways in which neoliberalism shapes the experiential dynamics of health-seeking behavior as well as the provision of alternative therapies. The concept of governmentality is also important in as much as it reveals state-people relations as well as the ways in which citizens unknowingly participate in the production of medical discourse. The actions of the state are important in shaping the way the consumption of AICAM is structured

As highlighted in previous chapters, the medical paraphernalia of alternative medicine is diverse and exists in several forms which range from healing techniques, exercise regimes as well as herbal remedies. Most of the alternative medicines found in the area under study exists in the form of herbal remedies, which constitute almost ninety percent of Asian forms. Among the respondents, one practitioner practiced AICAM whilst one medical doctor practiced TCM, having received formal training from China. Another contentious issue also relates to genuineness as it should be noted that there has been a very thin line between the formal Asian TCM and pirated versions which find their way to Zimbabwe. The search for authenticity in medicine is always problematic, and some authorities have gone to the extent of labelling unregistered and unproven medicines as fake medicines (Klantschnig & Huang, 2019). The online campaign by the Medicines Control Authority of Zimbabwe (MCAZ) warned the consumers with a catchy phrase which read;

They may look, feel, or taste okay, but how do you know they are real medicines?

Hence it becomes a bit difficult for the ordinary person to decipher and separate genuine TCM from opportunists who just order informal medical paraphernalia from Asia. The issue of

authenticity is important in as much as it influences the distribution dynamics, especially how the products find themselves onto the shelves of the distributors. This chapter gives a broader perspective on the nature and character as well as distribution of AICAM therapies. The observations will be limited mainly to the city of Masvingo although the chapter attempts to contextualize the city into the global economy of the distribution of alternative therapies.

4.1 Experiencing AICAM in Masvingo: Distribution and consumption dynamics.

> '*As objects, medicines are produced, distributed and appropriated through institutions and interactions of various kinds. They are socially transacted from the time they are gathered in the bush or produced in a factory until they are rubbed on by a concerned mother or injected by a helpful neighbour*' (Whyte & der Geest, 1988: 3).

This section discusses the journeys through which AICAM products travel as they are harvested, packaged, distributed, repackaged, and consumed in Masvingo urban. As noted by Whyte and van der Geest (1988), the sociocultural contexts of production and consumption of medicine is important in shaping the interaction between individuals and the medicines. Therefore, through tracing how distributors, patients and their wider social networks interacted, the study brings out nuances of the consumption of AICAM.

AICAM experiences in this study were drawn from three major groupings of people. I interviewed people from the medical fraternity and one of my key informants was a medical doctor trained in TCM. The second group interviewed were the traders/ distributors of AICAM as well as their patients. Another important group of people were third parties who may have not directly consumed the medicines but came into conduct indirectly. These included relatives who had family members or acquaintances who consumed AICAM. These usually corroborated the experiences of some of the patients who had consumed AICAM products. Personal experience was also important since I personally tried out some of the products to alleviate personal problems. As someone who also experienced some bodily discomforts, I used some of the products in which I perceived to have limited or no risk in trying out, such as the massage machines, as well as some herbal supplements and this also added to my experiences of AICAM. Admittedly, explanations given by some of the healers were not only persuasive, but also convincing such that one could feel compelled to try out the medicines. Moreover, spending time in the company of distributors and healers, whilst observing their

practice, had that effect of bringing out an alternative reality which one could not resist being part of.

4.1.1 The herbalists /doctors

In any trade, there are usually distinctive mechanisms which set apart roles of individuals who are the specialists. My research carried me to various specialists, who preferred a diverse range of professional titles. My first time walking into one of my research centres, I was ushered by the usual street touts, soliciting for customers for a commission, whilst shoving fliers into your hand. After a brief chat with one of them, he then said to me,

> *Chiremba varimo vanogona kukutsanangurirai zvizhinji nekukuvhenekai pamuchina*
>
> [the doctor is in; he can explain more to you and examine you on the machine].

From that brief chat, I encountered the first categories of professional titles in AICAM trade. Some preferred to be called doctors, like the man I had to encounter inside the backroom office which I was led to by the outside personnel. First impressions showed a simple man clad in the everyday ordinary clothes, attending to his clients in a calm and composed manner. The man, who chose to be identified as Dr Simba, welcomed me, and showed me the way he operated. He was a middle-aged man in his late thirties and had a family with three children. I also managed to dig deeper into his background, which revealed a man frustrated with lack of opportunity in the country. He had commercial qualifications at degree level but had experienced frustrations in the world of work, such that he saw the AICAM trade as better off than spending his time under someone's employ. Simba bemoaned the shrinking salaries which were almost meaningless, hence he decided to devote his full attention to the healing business. Like any other healer, the name *chiremba* (doctor), stuck more both as his preferred title, as well as how the general people chose to address people dealing with healing. It was simply one of the various titles which were prevalent in the AICAM trade. Most of the practitioners whom I interacted with were all identified using the common term of *chiremba* which is an equivalent of the modern doctors in hospitals. The usual vernacular and indigenous titles of *sekuru* (uncle/grandfather) or *mbuya* (grandmother), were rarely used in the patient client relationships, although these can be found to be prevalent when referring to biomedical doctors and nurses.

However, during the study I encountered three major categories which included herbalism, massage therapy as well as TCM. Though these approaches seemed a bit different, their general

philosophies converged since they shared similar perceptions on how illness comes about. Of note, is the presence of numerous products, which are passed on to consumers as elixirs of health. The vignette at the beginning of the chapter presented only one dimension of the melting pot of medical interventions subsumed under the term AICAM. It encompassed herbal medicines, mysterious machines and sometimes simple techniques which were all expected to bring about relief. One interesting thing was the escape of these medicines from formal regulation through the presentation of different perspectives to authorities and to the clients. When one walks around the metropole area, you would find labels written 'herbal clinic', but on asking the majority were registered as providers of luxury rather than medical facilities although their claims to the consuming public were contrary. One such practitioner was registered under a health and beauty spa; another was registered as a saloon whilst others presented their businesses as involving supplements which could fall under food or nutritional supplements. Such representations are crucial in understanding the legal obscurity of AICAM whilst at the same time it explains the relative informality of the practice. Many other service providers I interacted with did not even possess an office, exploiting social media platforms such as WhatsApp to get clients and arranging fluid meeting places in and around the city. As one interlocutor noted;

> *Mukoma ndinoenda kwaita mari than kugara pano ndakamirira varwere. Vamwe havatofambe kana kudzimba tinosvika.* [My brother, I go wherever the money is than sitting here waiting for patients. Some can't even walk so even in homes we can visit].

Some of the service providers were informal to such an extent that they did not possess a venue, nor fixed spot for operating from. These operated like hawkers, carrying their healing paraphernalia in cars or even in satchels. They were popular in the informal sector where they interacted mostly with vendors and informal sector traders. I observed some healing sessions among vegetable vendors outside one popular supermarket in the city. My interlocutor Dr Ben was wearing a white lab coat and carrying the signature body scanner. He initially offered a free sample consultation to one volunteer, whilst other vendors looked on. After finishing with the initial volunteer, most of the vendors also requested that he passed through their stalls. At the end, he ended up with five individuals who bought his products and over the next months, three of them became his regular clients.

The lack of formal operational spaces at times compounded difficulties in categorizing the practitioners because their activities exist outside the parameters of any regulatory body, and they owe allegiance to know one. They are neither answerable to the state nor to any professional body. It is a medicine devoid of operational regulations which will require the individual to exercise her thoughts when considering believing in the different medical claims made. This aspect of lack of professional ethics and regulating body has often been a sticking point on the authenticity and legitimacy of AICAM. Some authors have used it as a parameter of labelling AICAM a pseudo medicine which is more aligned to reaping profits from unsuspecting individuals (Hornberger, 2019). Most of the distributors, could fall under what I term *healthprenuership*, which was characterized by individuals who lacked significant knowledge about health and healing, but who engaged in the sale of medicinal products for reasons of reaping profits. It could be noted that some distributors lacked basic understanding of human anatomy but could see an opportunity to get an income through selling AICAM products and growing a follower base. When patients seek health, they often do not have sufficient time to scrutinize every claim but will often go to any lengths to ensure that they get healed.

Apart from the pills and machines some of the healers I encountered simply chose to address the things which people could feel and experience. They depended more on how the person requiring medical attention would explain as the problem then use some kind of manual to make sense of the symptoms and offer what they felt to be best approaches of resolving the illness. As one respondent noted;

> *Hazvinetse kupa mishonga. Ukangondiudza panorwadza ndongotarisa mubook then ndotokunyorera mapiritsi anoenderana nezvawareva. Plus, edu mapiritsi haakuvadzi nekuti ari natural*. [It's easy to prescribe medicines. I just look up in my book to see the pills which can address whatever you tell me].

The diagnosis was simplistic and lacked rigor since one could simply get any medication for things which they claim to be experiencing. The patient was in a greater position to influence and define their problem, hence controlling the consultation process. Virtually all practitioners of AICAM claimed to use natural noninvasive methods of healing. Their approach did not require surgery as they believed that different supplements and techniques which they used were adequate for an individual to attain wellness. The claim to the naturalness of the products

made people cast off caution since natural herbal products are often seen as having no side effects on the body. So, whether the products work or fails, it was considered as posing no significant danger to the consuming public.

Another interesting thing was the ways in which AICAM also medicalized some conditions such that they could prescribe medication for conditions which ordinarily would not be regarded as medical issues. Remedies were given even for conditions such as appearance, with numerous body-altering pills, herbs and creams which were meant to augment the looks and appearance of individuals. Due to the etiological systems some wanted to heal even the source of food as they looked to the environment and food as some of the major culprits exposing individuals to diseases in the contemporary societies. The doctrine of toxins was forwarded as underlying the disease manifestations found in society. Most diseases were traced back to harmful toxins invading the body through polluted water, food, and air. Hence some of the medical practitioners were also claiming to have products which can ensure clean living, thus aiding a disease-free life.

Those who added a dimension of sophistication used some machines, like the body scanners, vibrating machines and heat massagers infused with rocks with mythical stories behind them. Most of those who used body scanners employed the use of a quantum resonance magnetic analyzer which some scholars have labelled as bordering on fake/pseudo medicine. For Hornberger (2019), the Chinese made Quantum Magnetic Resonance (QMR) was simply sophistication added to bring an element of complexity and bring about legitimacy of a medical approach which applies modern technology. Among those who employed the use of QMR technologies included Herbal Sphere International, which claimed to treat challenges using herbal products from Malaysia, Green World, whose products were manufactured in China, Sunony whose products were also from China and Herbal World. Another long serving Chinese herbal company was also Tiens, which seemed to have quite a broader coverage although its presence was slowly receding. The usage of the magnetic analyzers has been marred by controversies the world over, due to the lack of a verifiable scientific approach to the usage of the machines. However, most AICAM has relied on the usage these machines in diagnosing people.

Even where the different technologies were utilized, they complemented the philosophical orientations and understandings of disease etiology by the different AICAM providers. For

some the source was the spinal cord and stimulating different parts of the spinal cord was expected to trigger healing. Others also viewed disease as emanating from imbalances within the composition of body nutrients and minerals, hence the need for herbal supplements which were expected to restore 'balance'. Hence although different kinds of machinery were employed, it only served to reinforce long held views and perceptions of the functioning of the body. It fell into existing philosophies on how one becomes ill and the pathways to restoration of health. Some medicines such as alleged stem cell therapy - based treatment named STC30 had generic claims about the nature of disease, hence the way through which the problem could be rectified. For them, no matter what the condition was, stem cell therapy could fix it since it could stimulate the body's regenerative capacity and cause the body to start a process of self-restoration and healing

Most of the urban based purveyors of AICAM try to maintain a professional deportment and hygienic appearance synonymous with healthcare providers. Just walking around town, you will encounter smartly dressed men and women, some donning black and white, some blue suits and neckties whilst some even go to the extent of wearing the white lab coats traditionally associated with doctors. Around seven o'clock they will already be in town waiting and soliciting for clients, passing fliers, and standing closer to their clinics. They mean business, and their deportment gives you the seriousness with which they treat the work which they do. Unlike the culture of informal trade which usually lacks any standards and maintaining appearances, most distributors take themselves and their work with some air of professionalism. Hornberger (2019)'s observations in Bushbuckridge, South Africa, commended Green World for providing distributors with branded apparel and logos which instill a sense of professionalism and legitimacy.

4.1.2 The Patients

Walking into my wife's doctor's office one day for a routine checkup, I was greeted by a sweet and sour scent which enveloped the whole room. Whilst I was trying to still process the surroundings, the doctor, with a smile explained what I was smelling; *You might have had something smelling in here, it's just this tea which one of my patients sold to me,* he said pointing to a cup which he was drinking from. She said it will improve digestion and has got many health benefits so I just thought I could try it out. The consumers of AICAM were mostly determined by the needs which they needed to fulfill. These needs included preventive measures, such as immune boosting and specific concerns such as terminal illness, chronic

conditions, and lifestyle issues. Consumers of AICAM have been as diverse as its distributors. From the simple village folk who visit the provincial capital occasionally to the urban residents. From the learned people employed in various parts of the city down to the relatively uneducated individuals making a living on the fringes of the city economy, AICAM has cut across the various strata of class, age, sex, education, and any other category you might think of. It is a phenomenon which led me even to rethink the kind of rationality underlying medical decisions. How does a patient come to make the decision to pursue a specific healing system? The pursuit of health seemed more to be a product of personal and experiential dynamics rather than the scientifically proven efficacy of a disease. It is not only the sick, desperate, and terminally ill individuals who frequented complementary medicines offered in AICAM, but people from various classes and even those without problematic health conditions. Monopoly over medical knowledge can never exist with any one medical systems and individuals have always exercised greater autonomy in choosing the medical system to use. AICAM has managed to create a stable clientele base based on various benefits such as flexibility and social networks. As will be shown later in the chapters, AICAM has managed to pierce the various layers of society drawing clients from both great and small alike.

Let me consider some of the patients I interacted with during my fieldwork, from the people I interviewed and followed up, there were two women who had reproductive issues. Four other elderly ladies had different ailments stemming from old age, such as bone pain problems, arthritis, and blood pressure problems. Some of the men I interviewed had blood pressure, prostate, and weight problems. However, most other cases composed of people without identifiable concerns, but simply bought products as immune boosters and preventative medicine. Another huge chunk of consumers was also characterized by people who desired to enhance their appearance thus bought skincare and beauty products. The distribution of the patients was diverse as it included both urban and rural people who visited the provincial capital once or twice monthly.

Some of the customers also included guardians of minors and relatives of sick people, whose desire was to see an improvement in the conditions of people under their care. One mother had a daughter who often had fits and sometimes would faint. She claimed that the problem subsided after using some Green World herbal pills which were purported to improve blood and cardiovascular health. Another case also included a family which had to pool together

resources to buy two boxes of STC30 powders which claimed to help the body regain health by repairing the stem cells. The woman, who is identified by the pseudonym Sihle, had been diagnosed of esophageal cancer and she was undergoing chemotherapy. Some of the side effects of the cancer treatment included weight loss and difficulties in eating foods. She would often vomit whenever she consumed food, but she claimed to feel much better and able to take in food after taking the STC30 stem cell therapy. The two boxes required to finish a course costed USD140, a fee beyond the reach of many ordinary Zimbabweans. It could be noted that from some of these patients, people care much about getting well such that they do not consider the source of healing. They do not spend precious time employing due diligence, but the search of a cure takes them anywhere where help is promised. Sihle's case is further discussed in greater detail in chapter 6.

4.2 The Pathways of AICAM

The vignette at the beginning of the chapter summarizes the experiences of some of the distributors of medicines in the area under study. It can be noted that the distribution of medicines in Masvingo Urban is part of a broader network of relations through which the goods flow from different Asian sources up to the point of distribution. As noted from the vignette, most distributors in Masvingo received their medicines from the capital city, Harare. Since the town is located at a strategic location in terms of the transportation network, it is easier for people to exploit the public transport system when sending goods. Hence many of the distributors send payments and receive their goods through the public transport. Most have never even bothered to go to Harare to meet the people who supply them, but the system works based on trust that they will not be defrauded. I managed to glean several insights from conversations with different people who traded the medicines on how they managed to acquire the goods. One distributor had this to say:

> *I was contacted by someone from Uganda in a WhatsApp group who wanted to expand her distribution of Asian medicines and explained to me the business plan which she wanted me to adopt. I was taught through online platforms how to do everything from knowing which pills to sell and for what kind of problems. To show that the business was genuine, she sent me the first consignment free of charge as I started to settle and get acquainted to the business.*

The conversations revealed that the distribution of Asian medical paraphernalia is part of a greater international network of individuals who do everything from procurement to the distribution of medicines to the end users. Most of the distributed products came in the form of packaged pills and capsules, herbal powders, creams for topical application, teabags, and coffees. One of my key informants, who happened to be a state registered nurse, also noted that most of her supplies were acquired from contacts in the capital city. She noted that what she simply did was to call her trusted suppliers from Harare who in turn could post the required drugs via the buses which ply the Harare-Masvingo route. Most of the distributors had never bothered to explore the world outside their own location, leaving the greater bulk of the work of sourcing medicines to different runners who could order from outside of the country. However, this could in part be a result of gatekeeping since knowledge enabled some individuals to reap more profits. The local agents got less than what agents in the capital, Harare got, and in turn those outside the country could reap more profits than those down the supply chain.

However, several other distributors who were well established managed to cut the value chain of middlemen, opting to source their products directly from different Asian sources. One respondent noted that when he started trading larger volumes, he managed to take a trip to Tianjin in China to see how the herbal remedies are processed and packaged as well as to learn more about the products which he was selling. Another respondent who also setup a massage technique-based healing business also noted that he had to go to South Africa where he underwent training and went to Japan to learn more about the technique which he used in healing patients. These individuals managed to establish links which enabled them to ship the products without relying on middlemen from Harare.

4.3 Counting the cost

Another interesting question, which I looked at, involved the issue of the business dimension of the herbal remedies. For most of the distributors, the issue of selling the Asian medicines was also informed by its profitability since it became the sole income earner for the traders. With the shrinking of the Zimbabwean economy, the employment market shrank so much that many people have been driven into the informal market (Jones, 2010). Hence, trading in medicines is one area where people have rushed to such that in almost every street of the town,

you find an outlet or corner where these medicines are sold. The philosophical drive permeating most of the informal trade in AICAM also notes a concurrent process of wealth accumulation and the pursuit of health. One of the most often used motto is '*health and wealth'*, hence, the assumption that these two processes are inseparable. As one respondent noted:

> *This kind of medicine is a medicine which empowers. Apart from you getting helped from consuming the natural medicines which you are given, there is also a chance for you to make money and earn a living from selling the medicine to your community. It can become a very good source of income especially to you who is already employed. I was sick when I was first introduced to this kind of medicine, I tell you apart from getting better, selling the medicines has improved my disposable income.*

The drive towards financial emancipation through entrepreneurship can also be seen to be at the heart of the success of AICAM in the area under study. When I attended one workshop from another distributor who was seeking to grow his business base, I noted that the traders had a well-polished distribution network of their products, and there was a heavy drive towards selling the medicines as a proper way to climb out of poverty and unemployment. Some of the herbal companies either employed multilevel marketing strategies or gave an incentive in the form of reduced wholesale prices to individuals who joined their organizations to purchase their products. The aggressiveness of the multilevel marketing even manifested in how some of the distributors and companies had more information on the profits and benefits of recruiting members to their organizations than they had on the diseases they purported to cure. This substantiates Hornberger, (2019)'s observations that the ability to earn higher and gain profits was often used by distributors as evidence of the authenticity of their products. Legitimacy was drawn from the evidence of sales which the distributor was making rather than on the evidence of ability to bring desired results (Hornberger, 2019).

The idea of coupling health and wealth also resonated well with local attitudes and importance placed upon health. An analysis of some fliers also brought out the symbolic and symbiotic relationship between wealth and health. One of the statements given read:

> *'the greatest wealth you can ever get is your health. Health is wealth.'*

Another common idiom which comes in idiomatic form makes the claim that poverty can be measured through your health. The locals ask a rhetoric question, '*chikuru chii upfumi kana*

utano?'[2] [what is the greatest having health or having wealth?]. Hence, it is important to note that the promise of achieving the double goals of health and wealth which most traders of AICAM stress on, is one of the greatest lures towards pursuit of AICAM.

Due to the declining economy and a series of economic downturns in the country, most people have become so business minded such that they can sell anything which can give them a little bit of profit. As one respondent noted,

> *we are now a nation of vendors, everyone is seeking to sell something, and I won't be surprised even if my wife tries to sell me some stuff even in our own home. Yes, it may be about health, but most people may simply be chasing an easy quick buck since we are going through tough times.*

The nature of trade in AICAM exhibit elements of both opportunity based and necessity driven entrepreneurship (Jones, 2010; Nyoni, 2018). For some it is an opportunity to boost their income whereas for others, it is the sole income earner. The reason why some individuals have remained selling these medicines is because it is something which has been profitable for them. Various sellers had different years of selling experience ranging from one year to twelve. It is a business which has kept those who have decided to be loyal to it. Taking the case of Nathan mentioned in the vignette at the beginning of the chapter, a peep into his life revealed a pattern of how the dysfunctional state institutions led him to his current position. Nathan, a 27-year-old man had failed to achieve much in schooling before he joined the trade in AICAM. He had achieved a respectable six subjects at ordinary level, something which could earn him a chance to proceed with his education. However, the situation at home made it difficult for him to proceed, since his parents had lost their income at the height of the economic crisis. They devised a strategy for at least ensuring that Nathan's four siblings also acquire the General Certificate Ordinary Level qualification. Hence, Nathan was left to look for a source of livelihood. As he noted,

> *I could not just sit around at home, so I decided to try finding employment. However, as you know these days we compete with unemployed graduates, I failed to get even temporary teaching. I ended up trying a lot of things to find some income until finally settling for these healing products*.

[2] There is popular song by Oliver Mtukudzi that poses the same question.

Nathan's story showed the intersection of political and economic factors and the distribution of AICAM. The trade was partly driven by the individual attempts to deal with the effects of state failure. The failure to provide employment opportunities, as well as avenues for individual empowerment through formal channels can be seen to be responsible for driving some individuals into the informal trade of medicinal products. This could also be seen in the case of Dr Simba who had a university degree, got employed, but ended up quitting due to the erosion of salaries in the volatile Zimbabwean economic environment.

Some professionals have also been found taking the selling of medicines as a side hustle to complement what they earn from the formal job. One of my key informants was a state registered nurse but she had to supplement the income which she got from the formal job by engaging in the trade of AICAM products. She actually showed that she earned more from AICAM than what she got at work. However, she could not leave her employment due to the benefit which flowed from backing her AICAM trade on the biomedical clout. At various workplaces you could find individuals also selling various AICAM medicinal products, ranging from skin enhancement products to remedies of common ailments such as colds, diarrhoea, ringworm, and other infections.

Like any other medical specialists, some also pushed more the idea that they are more concerned about the welfare of their patients, rather than focusing on the profits accruing from the AICAM trade. One interlocutor argued that he decided to join the trade after a relative he had gone with for assistance had been helped. He says:

> *Kwandiri haisi nyaya yemari. Even though chero kurarama ndogona kuchengeta mhuri asi inyaya yekuti ndakaona kuti ndogona kubatsira hama dzangu nevamwe since ndichikwanisa kushandisa mishonga iyoyi.* [For me money is not the issue though my livelihood is tied to this medicine. I saw how my relative was treated and saw it as an opportunity to assist my relatives and community].

Another aspect of the cost of AICAM relates to its pricing structure. There is a generalized belief that complementary and alternative medicine is often cheaper than conventional medical approaches (Agyei-Baffour, Kudolo, Quansah, *et al.*, 2017; Duru, Nduka & Obikeze, 2019). In relation to healthcare, cost is sometimes calculated in terms of the costs of the treatment process as well as in terms of its efficacy in dealing with the problem under consideration. At times it is impossible to assign monetary values to health issues since it is a qualitative endeavour which

can only be interpreted subjectively. Let us consider the experience of one patient whom we will call Sophia. Sophia is a 34-year-old married woman, with two children. She was diagnosed with uterine fibroids and after failure to access free surgery, one of the surgeons referred her to some people who sold AICAM which they claimed to be able to naturally shrink the fibroids. The cost of a single bottle of the herbal pills she was given was USD40 and she was supposed to take these pills until the fibroids disappear. Though she claimed to feel better after taking the first bottle she still needed more to be able to reach the stage where she could claim to be completely healed. However, due to worsening economic conditions and the change in monetary currency of usage in Zimbabwe, she could no longer afford to continue with the treatment regime. The scenario above puts a dent on the claim that complementary and alternative medicines are cheap since affordability is relative and sometimes the monetary fees charged on medication may also be high even within AICAM. Though, she could no longer afford to continue treatment, she lamented the positive relief from pain which she was experiencing whilst taking the medication. The failure of the state in the provision of affordable hospital services can also be seen to influence a drive towards adoption of alternative therapies. Moreover, most individuals are also not gainfully employed to be able to afford even simple surgical procedures. Sophia's case is further discussed in Chapter five since it also brings other important dynamics of the consumption of AICAM.

Another case is about a 30-year-old patient who allowed me to identify him as Tino. Tino was suffering from back pain and after failing to get better and afford the various tests and scans required at the hospital, he opted to for AICAM. He received massage therapy coupled with heat inducing therapy. The session was forty-five minutes per day costing USD2 or you could opt for a ten-day program going for USD20. However, considering the costs associated, Tino would simply attend the sessions erratically as and when he could afford. The better thing was that the therapist there could accept flexible payment plans for trusted regular customers. The overall pricing regimes were not very different for simple cases of common illnesses, but the conventional side became more expensive when it came to chronic and complex illnesses which required elaborate diagnostic processes. As Tino argued:

> *At least here I am paying for the actual treatment rather than spending my money on numerous tests which do not show where the problem is*.

To him, tests were not treatment since they did not tangibly contribute anything to the relief of pain he was going through. Hence, AICAM was seen as more economical since he paid for services directly associated with redressing the problem which he was going through. This showed the power of medicines as objects that represent transference of healing through something that is tangible (Whyte & der Geest, 1988).

The issue of consultation services was also another factor which made AICAM more popular and easily accessible. The rates of consultation which people paid was almost equivalent to what patients pay at local clinics, hence being considerably cheaper to initiate the treatment process. Some healers would also waiver consultation fees and make patients pay for the actual products which they received. Due to the growing usage of online platforms, people could post their symptoms on WhatsApp groups and receive initial advice which could guide their planning for the treatment process. Hence, the ways in which the healing process occurred allowed flexibility and responsive to patient needs, something which would appear to be cheaper than the hospital encounter. This augurs well with the global neoliberal agenda which is characterised by flexibility and increasing new ways of extraction of profits from the market. Neoliberalism's effect on AICAM was seen in several ways which included cutting down the complexities and supposed costs of the formal healthcare systems (Reubi, 2016). Hence, at face value AICAM appeared less cumbersome and cheaper than the hospital processes. At the same time AICAM can be seen to be an outgrowth of a dysfunctional formal healthcare system which has been killed partly by capitalist ideologies of privatisation. The privatisation of healthcare has meant that individuals are left on their own to choose what may seem more advantageous and best alternatives for themselves (Navarro, 2020).

4.4 Distribution networks and economies of affection

An analysis of the ways through which AICAM found a place within the existing medical systems has been through the exploitation of personal links and social relations within the local community. Health and illness are usually issues shrouded in privacy and can only find a foothold in circles of familiarity. Although practitioners also found a clientele base from strangers, most relied on the people they had closer social relations for regular customers. Friendship, family, work as well as other sources of contact could be seen to be the most regular sources of clients for AICAM. The caption below gives a picture of how some also managed to find clients:

> *I was sick and diagnosed with diabetes. I was always sweating and having headaches. The doctor instructed me to take diabetes medication and to reduce intake of foods which can make me susceptible to diabetes attacks. As you know those pills are taken for life, my cousin sister, who works at a hospital convinced me to try out some of the Chinese pills she was selling. Of course, I could believe her since she is also my sister and may not expose me to danger. After seeing that the pills work, I also recommended my friends to try out her medicines since as for me, I have been totally entirely healed and even stopped taking the diabetes tablets. If it were not for her, I would not have walked into any of those shops to consider try out the medicines, they offer.*

The issue of trust and authority worked in influencing some people's choices of taking up AICAM. The comfort of knowing that it was a relative who was recommending gave some people the boldness to trust and use the new medicine. Another lady also noted that a medical doctor recommended and gave her contacts of individuals who sold AICAM and recommended that their products could help heal her. The findings reflect that people are also ready to believe people in authority as well as within their social relations, hence AICAM exploits people's social networks and rides on economies of affection to find clients. People's social relations are a powerful tool which influence constructions of health and illness as well as health-seeking behaviour. People are more likely to accept the testimony of an acquaintance than that of a stranger, hence apart from reading online reports, most people's likelihood of using AICAM was influenced by referrals from colleagues, friends, and relatives. This fluidity of power can aptly be captured by Foucault's concept of governmentality which also brings about a sense of how power is fluid and ubiquitous in society. An individual's decision is not an independent aspect but is tied to influences of the person's culture, society and social group (Petersen, 2003). Friends, relatives, and acquaintances, all appear to be part of the elements of the social group which influence individual medical decisions. Through the concept of governmentality, one can also note that power is not something which is always characterised by coercion and imposition, but one also has to look at the various technologies of power masked in the idea of individuality (Foucault 1994; Petersen, 2003). Technologies of power give a semblance of objective and independent thinking without exposing the façade of how one's decision making is influenced by different power dynamics. Health decisions may appear to be neutral and individualistic but a look at the economies of affection exhibits that familiarity creates power which is important in referrals within the distribution of AICAM products. Most of the life

stories discussed in this chapter which include, Nathan, Sophia and Tino's stories show a subtle way in which greater national political failures are responsible for the health choices of ordinary individuals. However, these processes are often masked and clothed in mundane social processes such that one cannot easily link the practice of AICAM to state failure. The medicines come through familiar individuals and forms such that it becomes difficult to see through the different layers of political factors which influence their uptake.

If one considers the encounter which I had with my wife's doctor mentioned earlier, it can be noted that economies of affection are highly influential in determining the uptake of AICAM. The person who sold herbal tea to the medical doctor and convinced him of the health benefits of the product was his long-time patient thus creating bonds of trust and making it easier for the patient to sell her products to the doctor. Upon enquiring whether the doctor believed the claims which were being made in relation to the herbal tea, he responded that there was no harm in trying out new things since one can never be so sure when it comes to what can give relief.

Apart from consumption, recruitment of distributors also rested upon the networks which people had. These included, family, friendship, work as well as religion. Though some individually sought out to be in the business of distributing the AICAM products, some were influenced by the circle surrounding them in taking up the job of distribution. Religious acquaintances, friends and other social relations were seen to be important in influencing the desire to join the trade. Some of the distributors whom I interacted with would come together as members of a single religious group to rent out space from which to operate and most even shared some machinery such as scanning machines and would help each other out if a member's stock ran out. As my key informant notes:

> *Isu pano we are mostly from UFI. Ukaenda kudowntown vazhinji vaunowana maSavadha. Inyaya yekuti takatanga this as project yekuzviempower semachurchmates kuti upenyu huvewo nani. Ini capital yangu ndakakwanisa kutenga mishonga yekutanga but for now ndoshandisa machine yamother vatonamata navo plus ndovakati mokwanisa kuuya tongobatsirana rent umwe neumwe achitsvaga maclients ake.* [Here most of us are mainly from UFIC. If you go to the downtown, you will find that many are Adventists. It is just that this is a project we started as churchmates for us to get some income. As for me, I did not have adequate capital, so I just bought medicines for

sale with the capital I had. I use the machines belonging to a lady whom we fellowship with, and she is the one who invited us to this place].

This also shows the importance of social networks in the trading of AICAM. Most clusters were organized around such things as religion and acquaintanceship. Relations were important in two ways in the distribution of AICAM products. They informed cooperation at the level of distributors, and they also influenced one's ability to grow a clientele base. One of my key informants attended to six consumers who were part of family relations and their webs of friendship. Thus, the ability to have connections with different individuals was important in negotiating access to the business as well as access to the consumers. Inasmuch as some consumers could be total strangers, it was easier to have patrons who were within one's own circle of familiarity. Family networks and mutualism influenced the consumption of AICAM beyond the confines of the city as various individuals sought to address health concerns of their relatives using the newly found medicine. From some of the respondents I interviewed, I managed to trace networks extending to above 200km from the city.

4.5 Choice, Freedom, and the popularity of AICAM

The study also noted that widening of options and seeming freedom to make decisions is one of the factors propping up the institution of AICAM. Individuals feel a sense of being in control of their choices in making medical decisions. Plurality of medical systems present individuals with the prerogative of making a conscious decision concerning their health. the history of biomedicine in Zimbabwe has been characterised by coercion, since colonial medicine was not based on negotiation, but on violent enforcement (Good, 1991; Lowes & Montero, 2018; Ncube, 2012a). As noted in previous chapters, a resentment to the ways in which colonial medicine was instituted, could be a push factor influencing individuals to look for alternatives. As a postcolonial standpoint, individuals feel free to patronize the medical system of their choices. Postcolonial governments have also been seen to influence the broadening of choice in healthcare through reviving and formalizing the institution of traditional medicine (Dekker & van Dijk, 2010, n.d.; Murray & Chavunduka, 1986). The element of choice has also been necessitated by the increase of a market approach to healthcare. Some scholars have noted the existence of a market of healing, which is characterized by multiplicity of medical interventions whose utilization is dependent upon belief systems of individuals (Thornton, 2010). Thornton

(2010) further notes that the issue of cost is of little relevance to the healing market as individuals price the cost basing on the efficacy of a medicine. That efficacy is also regarded as the domain of belief and may not really be subjected to objective standards as beliefs vary.

AICAM was seen to empower the consumer by bringing yet another option to the existing medical options. One of the consumers I interviewed spoke of a general dislike of both the biomedical and traditional healing approaches which dominated the market. He said:

> *I generally dislike the hospitals and clinics because of the many side effects which their drugs often have. At the same time, I do not want to go to many of these local herbalists and traditional healers since they have a certain link to witchcraft and spiritual things. I rather use these foreign herbal medicines as they are properly packaged and do not have side effects.*

For him, the proliferation of AICAM was empowering since it enabled him to have an alternative to the existing binary of biomedical and traditional healing systems which dominated the scene. The coming in of AICAM presented the best of both worlds, which closed the chasm between traditional and modern medicine. In a way it seemed to be a modernized version of traditional medicine hence finding appreciation from both sides. On another note, the entrance of AICAM represents a widening of alternative therapies available to the people. The ideas of AICAM resonated with the ideals of modernity, where modernity is conceptualized as having the capability to enhance people's individuality, freedoms, and choices. The idea that you could choose your own health path whilst simultaneously being able to reach the same goal of a healthy life, gave a picture of enhanced freedoms and choices. The fact that most AICAM products did not seek to replace the existing biomedical traditions, point to their attempt at bringing multiple options to the field of healthcare. The communication which I got was that you can choose a different healing system and still be able to lead a healthy lifestyle and even get better results from AICAM products. Moreover, the fact that AICAM seems not to upset the existing structures in the healthcare sector may even account for the general lack of scrutiny and policing of the practice.

4.6 Social media, technology, and healing.

> *Sometimes its cumbersome to go to the clinic and it is embarrassing to spend time narrating your ailment before the doctor. If you look at this group, people just*

> *anonymously post their problems, the specialists here will read and recommend which medicines to buy so you just rush to their premises to buy and you leave.*

The coming of social media is an important facet in the globalisation of the distribution and consumption of AICAM. Some of the distributors also operated WhatsApp groups where they not only address illness concerns, but also proselytize individuals who are willing to join the trade. Social media platforms were important in advertising and growing client base. Most distributors attested that they got more clients from social media adverts and people who first consult on social media platforms could gain confidence to visit and purchase medications. Social media was also important in sharing reviews which gave prospective clients confidence in trying out these novel healing methods. One respondent noted that:

> *Ini ndakangoona vamwe vachipupura kuti these medicines can help. Ndakabva ndazama pamwana wangu aimboita problem yekupera simba, but ever since pandakaashandisa haana kuzmboita dambudziko*. [I just came across testimonies on WhatsApp and decided to try the medication on my daughter who was suffering from loss of strength, but ever since using the medicines, the problem has since stopped].

Hence testimonials and reviews could be seen to be important avenues for popularising AICAM. They gave credibility and served to convince those in doubt to try out the new medicines. However, negative reviews could also be found from the clients due to different experiences in consuming the medications. Social media was also important in providing anonymity, where consumers could share their problems without first divulging their identities. Some also benefitted from reading the experiences of people with similar problems as theirs. Therefore, rather than having to summon courage to approach a health practitioner, social media provided a perfect cover for some individuals to simply learn about ailments and remedies. Social media also acted as a referee, since medical claims could be challenged within social media groups. Though distributors possessed significant powers, where they could make ambitious claims about the potency of their drugs, social media became a platform where people with experience of using drugs could come into the open and challenge the information provided by the service providers.

Another dimension which brought out the alternative healing-technology nexus, was the diagnostic processes which were employed by different distributors. It could be noted that the majority of AICAM practitioners subscribed to the usage of a Quantum Magnetic Resonance

machine which brought an element of sophistication and complexity to diagnosis as well as bringing a flair of modernity (Hornberger, 2019). The other practitioners also used vibrating massagers as weight loss and therapy machines, something which also confirmed the technological turn of AICAM. This level of mimicry could be meant to situate AICAM in the general discourse of embracing science and modernity, rather than relegating it to some level of folk or pseudo medicine. However, AICAM could be seen to retain the flair of traditional healing philosophies which were woven into the modernity discourse[3].

4.7 Neoliberalism, health, and healing

Undeniably, one of the forces structuring our societies today has been the neoliberal culture. Its tentacles stretch to all facets of life in subtle but salient ways. From the street corner guy selling cigarettes and sweets to the big corporates with global influence, the presence of neoliberal capitalism has reconfigured social relations across societies. It is within this context that even writings on complementary and alternative medicines have sought to understand the profit dimension of the phenomenon (Attwell, Ward, Meyer, *et al.*, 2018; Ernst, 2000; Hornberger, 2019). Are people driven by a profit motive? Is engaging in AICAM a way of simply trying to reap a profit from the trade rather than a genuine desire to solve humanity's disease burden? These are some analytical questions which one can ponder at when observing the field of AICAM in Zimbabwe. As noted in previous chapters, the increasing interconnectedness of the world has also been seen more on the economic front to such an extent that different countries are exporting their products and seeking to increase their volumes of trade. One interesting thing about products in Zimbabwe is that you can walk into a shop and find a can of soda manufactured in Kenya, priced cheaper than a locally produced product. The trade and externalization of products extend even from very little and mundane things, like a box of matches, toothpicks, tissue paper. It seems there is an insatiable demand of foreign products such that anything you can pick from a remote village somewhere can find a ready market elsewhere. The neoliberal capitalism's influence can therefore be seen on two fronts i.e., the increase in volumes of trade including in medicines found in different Asian countries and the mindset of the people who do the trading locally. Many people are driven by the desire

[3] Due to word count limit the subject has not been fully explored. However, a follow up article can explore the intersection of traditional healing philosophies and modernity. There are several ways in which traditional philosophies have been enmeshed into the discourse of modernity. Disease aetiology and treatment remains firmly rooted in traditional philosophy whilst elements of modernity and science are appropriated in a way that makes the traditional fit into the modern. This include diagnosis, processing and packaging of the medicines.

to find something to sell, to put a mark-up and to reap a profit and the medical field has not been spared. The neoliberal perspective also structures the relations between the formal biomedical sphere and complementary and alternative medicines. If service providers are driven by the profit motive, then the customers are expected to exercise due diligence and choose the healing path which is most beneficial and least expensive. Profit and survival form the foundations of the trade in medical paraphernalia. Many would thus compare the cost of using the formal biomedical route or to pick the shortcut promised in AICAM, which appears to have the magic formula of getting a cure for most of humanity's ailments.

The usage of neoliberalism as an analytical concept has been subject to controversy with some scholars warning that its over-usage may render the term a cliché. Hence it is also imperative to categorize and contextualize the usage of the concept of neoliberalism. Four strands of understanding neoliberalism have been noted and they include, neoliberalism as policy or programme, as an ideological and hegemonic project, as a form of the state, as well as neoliberalism as governmentality (Bell & Green, 2016). The first form looks at neoliberalism in terms of the implementation of the neoliberal policies of a market-based society. As noted in previous chapters, Zimbabwe reluctantly implemented the neoliberal policies which were foisted upon the nation as conditionalities for accessing Western aid. From the early 1990s, Zimbabwe implemented the Economic Structural Adjustment Programmes (ESAP), which kickstarted the processes of privatization, liberalization, and deregulation, though the programme was never fully implemented, hence denying analysts a full opportunity of whether to attribute the failure of the reforms to either ESAP or the failure of implementing neoliberal policies to the letter. Zimbabwe also experienced some forms of 'rolling back' of the state through the removal of state influence in favour of market forces in certain spheres of the economy and society. Perhaps, one of the fruitful analytical lenses has been to link neoliberalism with the Foucaldian concept of governmentality. According to Foucault, governmentality points to the processes through which relations among people and things are reconfigured to effect governance from a distance. These different ways of understanding neoliberalism apply at different stages in the understanding of issues occurring in AICAM. In a way, the praxis around the implementation of neoliberal policies whether by design or by default, has affected and reconfigured the health sector in several ways.

The privatization and simultaneous deregulation of the economy opened the space for several players in the economy as well as in the health sector. Removal of the healthcare burden on the state has silently meant that the individual has been left with greater autonomy and choice even in making health decisions. It may seem to be a jungle of some sort where citizens are left to navigate health affairs with little influence from the state. Hence, one can note the flourishing of quasi-health facilities which one would wonder how they escape the regulatory eye of the state. Rather than being a hidden underworld, AICAM is overt as seen through the adverts flooding, the town, numerous shops with signs which advertise medical claims. It is up to the citizen to make the choice of which medical dimension to take in pursuit of restoring one's health. The line between the formal and the informal has increasingly been closed especially on the backdrop of a dysfunctional economy. As Jeremy Jones argues, the Zimbabwean economy has been long fallen on a culture of informality characterised by *kukiya kiya*[4] (Jones, 2010). Jones further notes a culture of evasion where individuals evade state institutions, bureaucracy, the law as well as cultural norms and hierarchies.

4.8 Is neoliberalism dead or the only alternative?

Whilst several scholars are exhibiting a fatigue of being inundated with scholarship which rely upon neoliberalism as an analytical concept (Bell & Green, 2016; Reubi, 2016), I strongly feel it is a useful category of understanding the contemporary society in my field of study. In Zimbabwe and perhaps elsewhere, there has not been another organizing principle which has surpassed neoliberal capitalism in terms of influence and impact on communities. Though the nation dabbled with different ideological instruments ranging from socialistic command economies to quasi-liberalism, the presence of capitalism as a major organizing principle can never be ignored (Zhou & Zvoushe, 2012). Hence the hand of neoliberal capitalism should also be critically analysed to uncover its effects on local cultures. The neoliberal culture is part of the local community such that the imprint of capitalism on the community is visible. The unreliability of the state and its stance of leaving citizens to their own devices has created a culture of individualistic entrepreneurship and self-provisioning especially in the face of erratic public service delivery (Kanyenze & Kondo, 2011). People are so used to covering up the gap left by the state, and perhaps this might be another justification why local people do not demand services from government, opting for self-innovations which can cover their needs. The presence of AICAM may also be interpreted as such. It is asymptomatic of the limitations and

[4] Making do. See (Jones 2010).

gaps which the state has left such that we have individuals who step up to provide services outside the existing government structures, outside government scrutiny and regulation. The rolling back of the state has opened the space for greater citizen participation in the market such that there has been multiplicity of players in the health sector with minimal regulation. Neoliberal culture has given birth to a culture of competition and profit seeking even in the health sector. The neoliberal culture is evident in health choices and in the informal marketing and consumption of AICAM.

The good and the bad of neoliberal principles are operational in determining patterns of health seeking behaviour in the area under study. Both its intended desires and the unintended consequences have inadvertently set the structure informing health care behaviour in Masvingo and the nation at large. Neoliberalism managed to achieve a limited state and user pays policy in the health sector and this also created patterns of public health where people seek alternatives (Zhou & Zvoushe, 2012). Since the introduction of the neoliberal structural adjustment policies, fewer resources from the central government have been allocated towards the health sector. Rather than being a service, healthcare became a commodity with a market value. The issues raised in the previous sections explored some cases which reflect some of the influences of neoliberal capitalism on healthcare choices. The myth of choice is one which has been peddled by the internationalization of neoliberalism. It gives a feeling that the consumer can always make a choice which is most beneficial and rational[5].

4.9 Conclusion

This chapter has looked at the dynamics of the distribution and the general political economy of AICAM. The chapter noted the different structures which determine the practice and consumption of AICAM. It can be noted that the distribution dynamics of AICAM cannot escape the linkage with globalization, which has made alternative medical practices found in Asia present in a country far away from the source. It is this elaborate web of networks which has ensured that AICAM products find their way to Masvingo. The distribution dynamics can be seen to be simplified to an extent that much of the diagnosis and sale of AICAM products is done by actors I call *healthprenuers*, who have little appreciation of the aetiology of diseases, but rather parrot what they are taught and is written in simplified modules. It is also tempting

[5] Anthropologists have explored the interaction of neoliberalism, modernity and African societies (Comaroff & Comaroff, 2001; Comaroff, Comaroff & others, 1993; Rutherford, 1999). The idea that neoliberalism structures healing relationship can be explored further outside the limitations of the thesis.

to see the evident global neoliberal hand behind the manifestation and structure AICAM. It is seen in the distribution patterns, it is evident in the semblance of choice, where consumers of health products are supposedly given options from a wide range of health possibilities. It is manifest in the profit motive hidden under the banner of health, the flip side of the health and wealth motto, where *healthprenuers* profiteer through aggressive marketing gimmicks. Where the yardstick of success is not how many people have been healed, but how many people have been recruited into the business of selling AICAM products.

However, beyond the *healthprenuership* arguments lie experiential dynamics of individuals, testimonies, referrals, and other dynamics influencing the uptake of AICAM products by people in Masvingo urban. The trusted biomedical perspective is brought into light by some members of the medical fraternity, doctors and nurses who endorse and sometimes are directly involved in the selling of AICAM products. The political dynamic is also evident, with some practitioners under Sunony directly thanking the government for allowing them to setup shop in the country. The sociocultural dimensions of consumption are also important in understanding how consumption of AICAM blends into the local dynamics of health and culture. Therefore, the next chapter explores the ways in which gender dynamics structure the distribution and consumption of AICAM products. This chapter has also presented the cost dynamics of AICAM to see how its manifestation at various levels including those of patients and healers structure the character of AICAM. The following chapter looks at the sociocultural dynamic by examining the gender dynamics of AICAM consumption.

CHAPTER FIVE:

HEALING GENDER, HEALING SOCIETY: THE GENDERED DIMENSIONS OF AICAM

In the first month of my fieldwork, one crucial aspect which I noted was the overbearing presence of women in AICAM. Though I first befriended a man who became an important guide in understanding AICAM, one could notice that most outlets operated more with women. Women were both the sellers and consumers. One morning when I went into the massage clinic, I could not help to see that I was the only men among female patients and practitioners. Most of them had one problem, back pain, some of it so painful that they could not walk. As I lay on the bed, I made some conversation with the attendant nurse who was equally amused by my curiosity to know about how their clinic functioned. She noted that mostly it was women who had problems of the back. She noted, 'can't you see that it is your sisters who do all the strenuous work at home. The household chores, sweeping the yard all put pressure on the back and worse still when they get married and give birth'. We are assisting a lot of women to go back and live normally again. As I observed, most of the women surrounding me were women who had gone through childbirth as well as a few elderly women. One woman had been accompanied by a young girl who was carrying her child, but soon after the massage, she took her baby and strapped him on her back, a sign that she was now feeling much better.

5.0 Introduction

This chapter examines one of the important aspects of the usage and distribution of AICAM. It addresses such questions like how does gender influence consumption of AICAM? What are the gender issues influencing the different roles which those who sell the AICAM take? The ways in which men and women experience disease and healing are diverse in society. Societal expectations of what it means to be a man, or a woman can also be found to be crucial even in the disease patterns and health seeking behavior. One of the major factors driving the success of AICAM is that it has found relevance in the gender discourses which characterize the Zimbabwean society. Hence apart from addressing disease and illness, AICAM can also be seen as healing gender. People's bodies are gendered and hence the issues which they suffer

from also stem from their gendered spaces in society. The human anatomy is interpreted along different constructions of the sexual differentiation of the body between male and female. Diseases, also, are treated following these sex-based differences.

The medicalization thesis also rings true for AICAM (Illich, 1975). Even things which may seem to be outside the scope of health and healing can be given attention from the medical perspective (Bell & Figert, 2012; Riska, 2010; Roso, 2019). Issues such as beauty and appearance have been given a medical dimension (Kaczmarek, 2019), hence one can witness AICAM also treating problems which hamper people's attainment of the expected standards of beauty. In this chapter, I also note two major arguments which stem from the fieldwork. The first argument raised relates to the role in which the new medicine interacts with the cultural aspects of urban Zimbabwe. In the consumption of AICAM, there is an evidence of how medicine shapes and is reshaped by local cultures. Hence the gender presentations of AICAM lay bare the cultural dynamics of the area under study. The second argument raised, is in relation to the utility of mimicry in reshaping current manifestations illness and healing in the area under study. It is my observation that the field of health and illness has been adulterated by different healing approaches which have mutated such that it becomes difficult to decipher the difference between the mainstream and alternative therapies. AICAM also sets the gender agenda through reaffirming existing gender perceptions as well as bringing to light new gender identities. This can be seen through a system of combining western and local ideals of man/womanhood which is evident in most complementary healing therapies.

5.1 Gender and alternative medicine: Some conceptual issues.

Gender is one of the most talked about subject in the contemporary society. It is viewed as a key structural determinant of the dynamics of peoples' lives in modern society. Simply put, gender encompasses the socially constructed sex-based obligations, perceptions, and expectations which society places on individual (Lips, 2020; Mascia-Lees, 2010). Though we can try to explain gender in simple terms, its practicalities are somehow problematic to pin down owing to the fluidity of the concept. That is why some scholars feel the need to conceptualize gender on a sliding scale which incorporates concepts of sex and sexualities (Milam & Nye, 2015). The sexual identification of individuals is often directly followed by various expectations on how you live, what you eat, how you feel and even how you get sick

and get treatment. For Judith Butler, gender is performative (Butler, 2003). It is a repetition of stylized acts through time (Butler, 2019). Gender is expressed through the appropriation of cultural norms and values of masculinity and femininity.

The totality of an individual's life experiences may be hinged upon how society interprets sex differences among individuals. Expressions of masculinity and femininity cut across people's lived experiences such that even in health, understanding the gendered nature of medical consumption is crucial. The societal interpretation of people's life experiences has a much greater history, which is marked by power and domination in attempts to control people. Some scholars have bemoaned the misrepresentations of Africans in media and scholarship since time immemorial (Lewis, 2005; Tamale, 2011). The gender discourses on the African continent are replete with incidences of how patriarchy, colonialism, medicalization, and even modern emancipatory movements have essentialized discourses on gender and sexuality to gain vantage points of power and control. Though patriarchy is often portrayed in the negative especially its treatment of women, it should be noted that patriarchy has been responsible for construction of both masculine and feminine discourses in society. Even what is termed toxic masculinity should also be traced to how patriarchal dominance conditioned expectations of masculinities.

The other influence shaping gender discourses on the African continent was the colonial practice. In colonialism, we witness a clash of different civilizations, with the alien civilization assuming the position of superiority. This gave the colonizers the power of naming and categorizing everything concerning the colonized (Vaughan, 1991). Gender relations, sexualities and other things concerning the African body were viewed from the standpoint of the colonizers, and some of the effects of these viewpoints still inform present day discourses on gender and sexualities (da Costa Santos & Waites, 2019). With colonization, there was also the accompanying western biomedical models which were responsible for setting the tone of the medicalization of gender and sexuality. As noted by different researchers, public health endeavors in colonial Africa was responsible for setting the agenda for the health issues affecting Africans (Tamale, 2011; Vaughan, 1991). One effect of colonization was the biomedical medicalization of social life (Busfield, 2017; Dube, 2019). With medicalization, even gender and sexuality became medicalized in interesting ways. The roles and focus of men and women were clearly explained in the public health discourse. As noted by Tamale (2011),

public health discourses focused on disease, birth control and control of sexual perversions, this had repercussions on the gender dimensions of health and illness. Illness experience could thus be divided into male and female, and it also served to feed into the dominant gender ideologies and prejudices. In the current dispensation, much of the herbal remedies in AICAM focused more on the reproductive capacities of both men and women such that one could be forgiven to think that these were only herbal sexual remedies. Some of the remedies served colonial constructions of maleness and femaleness where the true African man is a sexual king, well-endowed and never tiring out. The female side is projected as oozing with sexual presentations of the body, something akin to colonial mentalities of the African woman as a symbol of primitive sexual lusts and desires, devoid of any restraint (Ponzanesi, 2017). Hence, some medicines were meant to present and fulfill the ultimate femininities which are seen projected in colonial accounts of African women.

Lastly the emancipatory movements which sought to 'correct' Africa's gender problems, were also responsible for establishing other narrations about African gender relations and sexualities. Movements for gender equality had a lasting imprint on how gender is structured in Africa and how we understand the link between gender and illness. As noted by Tamale (2005) most approaches ignored the intricacies of the African gender dynamics. Rather, we see a recreation and sustenance of Eurocentric views of gender, with both North and Southern scholars being complicit in such a phenomenon (Fourshey, Marie Gonzales, Saidi, *et al.*, 2016; Oyěwùm\'\i, 1997; Tamale, 2011). The experiences which Africa as a continent and Zimbabwe as a nation have gone through have conditioned and created ways of thinking about being male and about being female. These have been made manifest in the focus of AICAM as it attempts to be relevant to curing the problems which people face in the area under study. Hence, the argument in this chapter also follows the claim that in healing gender AICAM provides solutions which are at the heart of the community under study. The diseases they claim to heal, and which are the crux of their advertising expose the gender agenda of the community under study. People can give anything to attain health especially if these are conditions which have a bearing upon how they fulfill their social roles and expectations.

As noted earlier on, the theoretical perspectives of knowledge and subjugation which Foucault enlightens us to are important in analyzing the gender discourses of patterns of consumption. The diagnosis of an illness and how it must be addressed are also influenced by gendered

notions which reflect societal power dynamics. The Foucauldian concept of power is important in various ways as we seek to understand how gender becomes a contour structuring consumptive patterns of AICAM. The first perspective of power comes from setting a gender agenda. It looks at how societal constructions of gender are perpetuated even through health and healing. So pervasive is the influence of the society's gender agenda such that the things we seek to cure represent an idealized perfect world in the eyes of society. What is idolized as perfect health cannot be divorced from how society itself defines the ideal man and woman. Although some theorists point to an overbearing presence of global capitalism as fueling global consumerism (Comaroff & Comaroff, 2000, 2001), it should be noted that how the foreign ideas are internalized and customized to local settings is dependent upon the agenda of that particular society (Fadlon, 2005). That is why we may experience differential experiences to the same phenomena across different societies. The consumerist argument also evokes people of being willing participants to the global consumeristic impulses whilst in essence, a search for something else, in this case health and wholesomeness, may be interpreted in other circles as attempts at attaining the accoutrements of modernity (Hornberger, 2019). Consumerism may take us away from understanding the genuine desire by individuals to have something intrinsically satisfying within themselves. Being in good health, fulfilling expected roles in society and even the desire of belongingness are all part and parcel of why people seek AICAM products. The cost of the products is overshadowed by the price of achieving the promised results. Krige (2011: 115) also advises researchers to go beyond the idea of conspicuous consumption which he argues that the use of 'conspicuous' is accusatory and unproductive. Studies on consumption must aim to explore how consumption is discursively framed by participating individuals and categories as well as situating it with the local context. Consumption is presented as a powerful force that people cannot resist, whilst in essence, individuals are seeking well-being and flourishing marked by local indicators.

In terms of health seeking behaviour, I argue that there is an inherent gender gaze within consumption dynamics of alternative medicine. Writing on biomedicine, Foucault explained the way the medical gaze work through giving acceptable lens to look at illness in society (Fadlon, 2005; Foucault, 1967). A gender gaze, therefore, works in much a similar way by giving a better way at looking at the underlying gender dynamics of disease construction and health-seeking behaviour. As shall be shown in the following sections, gender is also responsible for shaping how people think about diseases as well as how AICAM purveyors

target their products which they claim to heal various illnesses. The gender gaze is used both as a tool to dissect the ways local understandings of disease distribution as well as showing that illness can better be understood within the framework of local cultural settings. It reveals broader sociocultural arrangements and beliefs which may structure the experience of disease as well as the response to it.

5.1.1 Healing gender healing society

During my fieldwork, one of my respondents who was a healer also gave me some words which resonated with the social life of health and healing. He stressed that:

> Sometimes it's not just the disease we heal. It is the mindset. It is the desire to belong, the desire to be normal and be part of society. In essence, when we are addressing problems which people bring, we are restoring bonds in society. Imagine, a husband who cannot do his manly duties. Or that wife incapable of fulfilling her duties in the home. These are things which society frowns upon, and it is our responsibility to restore the wholesomeness and peace which diseases disrupt.

The important position of gender in ordering society is expressly seen in health and illness. Most respondents showed an extreme anxiety to live up to their expectations of what it means to be either male or female. The areas of representation presented, in this chapter show three areas where gender considerations and fulfillment were sought, managed, and presented in AICAM. These included the internal functions of reproductive health, the outward functions of household economies as well as general expectations of deportment. Butler argues that gender often involves assuming the roles which are scripted in the society (Jagger, 2008). Rather than the inward biological aspects influencing the outward aspects of representation, we see gender performance influencing even internal biological processes as individuals consume medicines which are meant to enhance their bodily functions. Being male or female was also presented from those three perspectives and AICAM sought to present remedies to these issues. Therefore, gender should be taken as an important consideration in the explanation of consumption patterns of AICAM. Unlike modern institutionalized medical care, it seemed a bit easier to bring out health problems which are gender specific within the setting of AICAM. One point to note also, was the symbiotic relationship and unitary nature of Zimbabwean gender concepts. Rather than having opposing binaries, some of the gender representations

which came from the field, showed the congruencies of symbolisms which were attached to certain gender representations. One example which brought out these gender representations was the idea of backpain which is presented below under the various depictions and significance of the back. The phenomenon of backpain represents a convergence zone for experiences and ideals of both the feminine and masculine ideals in society.

5.2 Musana (the back)

One of the most important gendered representations of AICAM was best explained by the local Shona concept of *musana.* [the back] The back acted as the body part which condenses most of the masculinities and femininities which are found in the Shona culture. For the woman, the back represented power which is associated with womanhood and motherhood. This encompassed ability to bear children, sexual abilities within the home as well as ability to perform housework. For the men, the back was mainly associated with ability to satisfy a woman sexually, hence traders could be seen advertising *mushonga wekusimbisa musana.* [Medicine for strengthening the back]. It was associated with a man's virility and the ability to perform tasks such as hoeing and cutting firewood, hence an object of both pride and shame. AICAM provided an avenue also for the fulfillment of both masculine and feminine expectations among men and women in the area under study.

Backache is one disease I noted to constitute an interesting cultural dimension in the area under study. Often, it was a disease associated with married people and was thought of to be a result of sexual activities such that it was unthinkable for a young unmarried person to complain of backache. As one of the respondents noted, the elders will simply say,

'*Wakaonei mwana mudoko kunzwa musana.* [What have you experienced a young child like you, to complain of backache?].

It was considered a shameful occurrence for a young man or woman to experience backache especially if they are not married. If we look at the vignette above, it could be noted that the sex which complained of backache the most were women. As the attendant at the clinic noted, the broader sociocultural expectations and duties which women performed could be seen to be the source of most experiences of backache. The unending household chores can be seen to put a stress upon women's health whilst at the same time they define what it means to be the woman in the home. Hence, inability to fulfill the feminized duties in the home could be seen to be a

major driving force for women to seek out quick fix remedies which could enable them to continue exercising their roles in the home.

Apart from the issues of socially allocated roles, *musana* also represented the reproductive capacities of women and their abilities to perform sexual functions. Local talk had phrases such as '*musana wakasimba'*, [strong back] pointing to a woman's strength in childbirth. Anything which could interfere with these reproductive capacities of women also represented a threat to womanhood. Local religious cosmologies even added spiritual dimensions to reproductive health, creating discourses of how the spiritual realm can affect the reproductive processes of both men and women. This explained why AICAM managed to get a sizeable share of followers since it also promised to deal with those issues which compromised a woman's reproductive capacity. Most distributors in town had herbal remedies meant to address problems associated with women's reproductive capacities. These included herbs meant for cleansing the womb, eradicating uterine fibroids as well as improve general fertility. One respondent explained the logic she was given on consuming some herbal teas. She noted that she had been told that the family planning tablets which she had been consuming deposited toxins into her body, hence the herbal tea was supposed to help her detoxify and naturally flush out toxins from her reproductive system. In a way, this was supposed to restore the reproductive system to its optimal functioning state. Hence, AICAM's promise and remedies for ailments associated with the back gave it an important selling point and popularity among some consumers.

Dealing with backache is also an avenue for addressing not only the sexual and reproductive roles, but also the political and economic issues of the society. It should be noted that the back often represented the working of both men and women, especially in relation to unpaid work and low paying manual labour. Women's work in the home is often unquantified and unrewarded whilst simultaneously being arduous hence placing stress on the back. The blue-collar work of lifting heavy weights could also be seen to be affecting most of the men I bumped into at the massage clinic. A closer analysis, hence, produces more than just a mere consumption of AICAM products. It reflects the existential conditions of the consumers themselves, bringing out everyday struggles which people face.

5.3 Women, gender, and illness

As noted in the discussion above, AICAM dealt with a variety of health issues which are gender specific. A quick scan of some of the fliers which merchants of AICAM flood the town with usually exposes the common problems which women encounter. Fibroids, menstrual problems, backaches, conception as well as skin and weight issues are some of the problems topping the list of health problems. Some of these problems usually cannot be simply treated by conventional medicine hence people seek remedies from various quarters and wherever help is promised. Women's health problems could thus be divided into two, i.e., those related to reproductive health and those which are linked to societal expectations on a woman, although these were often intricately linked. A problem which could seem a reproductive problem often had ramifications on the social standing of an individual in the community. Through health, one can see another prism for the control of human bodies by societies as they seek to compartmentalize individuals and create acceptable parameters of understanding people. Both sex and gender are important in understanding women's health and their experiences of disease and illness. Sex and gender also determined an individual's access and utilization of healthcare services.

Some of the consumers I interviewed and traced narrated the journeys in attempting to deal with uterine fibroids. The first story narrates the experiences of Sophia, whose issue is also discussed in the previous chapter. Sophia was a married woman and was having troubles with uterine fibroids which had cost her a baby. She wanted to go for operation to remove the fibroids but due to the high costs involved in the operation she could not afford. After hearing about a free campaign by some doctors she also went to Chitungwiza and attempted to get the free medical services organized by a church. However, due to the overwhelming response, she could not be operated on and the doctor who attended to her advised her of a natural way of dealing with her problems through consuming herbal products. She was given contacts of some people in Harare, who in turn assisted her in joining the programme and linking her up with their colleagues in Masvingo since she was coming back to her hometown. She also showed me a book which she had been given upon registering, which contained information on symptoms and the remedies meant to deal with those ailments. As a member, she was entitled to purchase medicines at wholesale price and if she wanted, she could order and become a distributor too. Sophia managed to buy some herbal pills which she used to take daily inorder to deal with the ailment. She testified that ever since taking the medications, she experienced

relief from the pain induced by the fibroids. For her, the medicine was working as it took away the pain which she usually experienced during menstruation. During the fieldwork, she managed to conceive and gave birth to a son without complications, hence strengthening her belief in the power of AICAM in dealing with her reproductive ailments. However, Sophia did not venture into the reselling of the products which she had been trained to sell due to limited access to capital required to order the products.

Sophia's story was a direct contrast of another 33-year-old unmarried woman whom I also interviewed. The woman experienced the same problem of uterine fibroids which were also affecting her daily routine and her ability to enjoy life. Her belly was getting bigger as the mass of fibroids in her womb kept on expanding. She remarked '*I am even ashamed of how I look because now people think that I am pregnant or something*.' To deal with the problems she bought a wide range of AICAM products and altered her diet as specified by the people who sold the herbal products to her. These were other women who had experienced relief and actual healing from the same condition she had, hence she felt that this was worthy trying out. Her condition did not improve much since she continued to experience excruciating pain such that she had to resort to a biomedical surgical procedure to remove the fibroids. Though her problem did not disappear, she did not blame the medicine but gave room for personal aspects which could affect the healing process.

> '*Maybe it is my blood type, or the limited time I had or even genetics which affected my chances of getting healed*,' she noted.

Despite their divergent experiences both women's experiences showed the gendered nature of reproduction and how ailments were not only natural biological malfunctions, but they also had social implications. For the married woman, it was about childbirth as it was also about eliminating pain in the body, whereas to the unmarried woman, the issue also affected presentability and her social standing among her peers. For her the promise of a noninvasive therapy which could eliminate her problem was overwhelming as opposed to the risk associated with tempering with her womb, which essentially meant tempering with her future reproductive capacities. She noted that most gynecologists usually considered the marital status of a woman seriously before proceeding with the operation. In manageable cases they would advise women to soldier on till they get married to avoid the problems associated with operating on the womb.

The last case I also traced was of Martha, a young woman who was suffering from backpain. She complained of inability to wake up early to do most chores which women in the community are expected to. She said',

> Whenever I bend down to sweep the yard or to do laundry, I feel excruciating pain shooting through my body. The doctors prescribed that I should only do light manual tasks for a limited time to avoid putting a lot of stress on my back. However, not everyone will understand my predicament since I was married recently. Everyone in the family expects me to do all the wifely duties to show that I am a woman worth her salt. I recently heard about the massager from my neighbor that is why I have decided to try it out so that I become normal like everyone else.

This case enlightened on the importance of a properly functioning body in society and how it means for womanhood. The woman expressed fear of being seen as inadequate both in the community and in the eyes of the in-laws. Fear to shoulder such blame drove various women to seek remedial actions to any illness which could render them incapable of fulfilling their social roles. Failure to feel expected social roles could mean being at the receiving end of societal ridicule and it also meant carrying the blame of marital problems as the woman lamented,'

> if my husband is seen taking a girlfriend or a small house, it is because I have failed to do what other women do for their men. Obviously, I will have to shoulder all the blame so that people will not say I drove my man into being unfaithful.

Both reproductive and productive roles of women were also at the center of their illnesses and responses to it. Even though consumption of AICAM products somehow, furthers the modern global capitalist agenda, the participants may not be willing individuals drawn to the glitz and glamour of modernity. Rather, I see individuals desperate to fit into the dominant narratives of their communities. These narratives consist of diverse social roles which individuals are expected to fit into and fulfill. These expectations may include the dominant modernity narratives, but they are also much about the historical local expectations. Behind the visible aspects of consuming AICAM, lies a deep desire for community belongingness. Individuals feel the need to fully belong to different social fields, in the home, among their peers and other circles of relations. As noted by McGraw (2018), the desire to conform to communal values, relationships and identities becomes the conscious and unconscious foundation upon which decisions are made. It is not simply about being part of global circuits of consumption but how these 'global' products are creatively weaved into local cultural milieu, values, and culture. It

is about fitting at local level, while using what is global as an instrument to attain local cultural expectations.

5.4 Beauty, presentations and AICAM.

The issue of beauty is one which is culturally determined (Pedro, Micklesfield, Kahn, *et al.*, 2016). The medical fraternity has also jumped into the bandwagon of seeking relevance by medicalizing beauty. Looking at the biomedical model a lot of celebrities and those who can afford have gone 'under the knife' to get the desirable body (Brooks, 2004). Just the right size and shape of boobs, inflated lips and uplifted butt, women have pursued everything it takes to fulfill the insatiable desire of beauty. Issues of beauty and presentation have driven most AICAM perceptions towards the idea that the global neoliberal agenda has succeeded in creating a market among the local urbanites. As noted by Hornberger (2019), Chinese medicine represent a somewhat backdoor attempt at achieving the features of modernity, characterized by science and technology as seen by an attempt by most practitioners of AICAM, to incorporate 'scientific' diagnostic tools. Hence, in the discourse of AICAM one does not escape the entrapping of globalization, science, and modernity. Definitions of beauty flow from global mass media images, and they have been infused with local discourses creating an intricate syncretic perception of beauty. On one hand individuality is promised whilst on the other individuals are expected to blend into popular cultures and images. The message is you can be whoever you want to be, but at the same time you must achieve what the local communities and cultures approve, so that you do not suffer from the unwritten sanctions in societal eyes.

In Zimbabwe, discourses of beauty and bodily appearance have not been spared by the globalizing effect of the mass media. As noted by various scholars, the beauty industry has been at the forefront of championing body independence as well as driving people towards certain universalized notions of beauty and appearance (Brooks, 2004; Hatef, 2018; Motseki & Oyedemi, 2017). It is not uncommon to encounter competing narratives on beauty and presentation. The foreign and the local have converged to give current urban discourses of both feminine and masculine beauty. Some of the desirable things from the fieldwork included fair and flawless skin, bodies with enhanced features and curves 'in the right places', flat tummies, slim bodies and just the right body weight. Various intervening variables such as age and sex determined people's subscriptions to a particular kind of body. Colorism appears to be an irresistible determinant in defining beauty in the context of Masvingo urban. Most young

respondents exhibited bias towards light and fair skinned women. This could be seen in the '*yellow bone'* [light skinned woman] phenomenon which seemed to excite most young men and women. Being in a relationship with a good looking, light skinned woman was something which was prized, and even lighter men had higher scores on perceptions of beauty. My conversations with Nathan and other young men whom he hanged around with was often punctuated by the young men passing comments on young women who would be passing by. In hushed tones, you could just hear one saying 'eight out of ten', then everyone would look around to see the passing woman who would be the subject of the judgement. Mostly those who were awarded the higher marks, were the yellow bones with well-defined bodies which accentuated different body parts. Hence, some women were driven into chasing these appearances at all costs, including through using AICAM and a host of other banned substances. This represented an element of mimicry where beauty in the postcolonial city was interpreted through a mix of colonial remnants of white supremacy and the modern illusion of choice prevalent in the globalization discourse (Hunter, 2011). In the modern city, you can choose who you want to be and how you appear. The body is not something given, which must be embraced in its form, but becomes something which one must work on to improve and attain the desired outlook. AICAM and other herbal medicines were forwarded as options which one could take to enhance their beauty and appearance.

AICAM has raised the banner of 'natural' and side effect free supplements which are supposed to take the client to the desired body shape and size. Medical supplements meant to achieve the real perfect body in AICAM have also been marketed and sold to people. Some of the products which were popular on the market included herbal soaps and skin care products. Some of these were claimed to include plant and animal derivatives such as skin cream which contained sheep's placenta and soap which is made from bamboo charcoal. These products were marketed as products which could enhance beauty through rejuvenating and smoothening the skin. The body beauty cream also claimed to eliminate stretch marks, restore skin by reducing wrinkles and the effects of aging on the skin such as sagging skin.

Other products also included teeth whitening toothpastes which were also said to be created from natural products. These products were popular among urban clients due to their ability to fit perfectly into the contemporary expectations of beauty and bodily presentation. Both the younger and older generations of women in the city could give anything to have products which

could enhance their beauty and appearance among their peers. Local perceptions of beauty were now being made and remade by the infusion of both local and foreign ideals of bodily presentations. The desirability of younger youthful women has been a dominant discourse among urban women, such that anything which could claim to bring back, maintain, or restore the coveted appearance of youth could become an instant hit among the urban women. One of the distributors whom I interviewed gave me a long list of prominent women who were her regular clients, and who were also ready to give their experiences with the products which she sold to them. One of the women testified about how the charcoal soap and body creams had repaired her skin making it smoother and soft such that even her colleagues were also drawn to try out the products due to the visible transformations they saw in her. For her, these beauty soaps could erase the effects of age on her appearance and make her feel young again. There was this connection of feeling young and looking young which brought a glow and motivation to her life.

The creation of these products presented a level of mimicry where traditional or natural products were infused and transformed to manufactured products which were marketed as health and beauty products. The packaging and presentation mimicked what one could find among the range of medicines under biomedicine. Apart from just being beauty products, these creams and soaps were also marketed as having healing powers which could deal with anything from acne, ringworms and other skin infections as well as improving the vitamins which the skin needed. The biomedical field in Zimbabwe has been slow to take up the gap of using medicine to enhance beauty and appearance. Hence AICAM has also exploited this loophole to gain popularity in the city. Another fascinating thing was the promise by AICAM to deliver just the right kind of body for a specific individual. It did not matter whether one wanted to lose or gain weight, medication, and supplements for all those conditions were offered from AICAM's bottomless medical basket. AICAM promised the reengineering of the body in a manner which could deliver just the right kind to different individuals.

5.5 Masculinities and AICAM

The preceding section discussed mostly issues in relation to feminized representations in AICAM. In this section I am interested in pursuing some dynamics of masculine presentations which were evident in the alternative medicines. Defining 'the man' in the local society could

be seen to have implications on consumption patterns of men. Masculinities have been understood in various way and one basic definition of masculinity views it as the outward expression of being biologically male (Olanrewaju, Ajayi, Loromeke, *et al.*, 2019; Oliffe, Rice, Kelly, *et al.*, 2018). Some of the major aspects on masculinities were the ways in which AICAM approached illnesses relating to men, the patterns, and determinants of men's consumption of AICAM products as well as the implicit depiction of what manhood means, which was presented in the cultures of AICAM. Masculinities were also expressed through the type of illnesses which men sought treatment for. The types of diseases which man often sought to cure highlighted the underlying existential conditions of man in the city. The last indicator of masculinities could be seen in the health seeking behavior of men. The time at and manner through which men sought treatment was indicative of the cultural dictates of masculine behavior (Robertson, 2007). The habitual tendency for men to seek treatment late, to be secretive when faced with illness and to seek discrete healing methods also showed the expectations of masculinity in the city (Olanrewaju *et al.*, 2019; Robertson, Williams & Oliffe, 2016; Thompson, Anisimowicz, Miedema, *et al.*, 2016).

Though there were other common aspects of illness which did not present a gendered experience of AICAM, I saw the element of sexualized masculinities as something peculiar and a selling point for attracting men towards AICAM. The study noted a proliferation of sexualized masculinities as noted from one of the adverts on some herbal aphrodisiac. The advert went like,

> *Murume chaiye haasiye mukadzi ane nzara pabonde* [a real man does not leave a woman hungry for sex].
>
> *Murume chaiye haakurumidze kusvika mukadzi asati pabonde* [a real man does not orgasm before the woman during sex]
>
> *Murume chaiye anotendwa nemutupo* [a real man is appreciated through totemic praise after sex].

Sexualized masculinities showed that the relationship between masculinities and consumption of AICAM was closely linked to men's bodily functions. The failure of the body to fulfill expected functions drove men to seek out remedies which could enable them to operate within

the expected standard of manhood. As noted in the above advert, real manhood was only conceptualized in relation to a fully functional sexual body. The findings of the study are in line with observations made by other authors who observed that men's health seeking behaviour was highly linked to the alleviation of impediments to a body's expected functioning (McGraw, 2018; Noone & Stephens, 2008; Robertson, 2007).

To explain further on how AICAM promoted sexualized masculinities, I will recount a discussion we had with my key informant and a group of four men who were regular customers. As we sat in the office of my key informant the men narrated their experiences. One of the men started by testifying of how the sex coffee which he had been given by my key informant was making him perform wonders at home. He made a comparison with traditional herbs which he looked down upon whilst praising the smartness and good packaging which the sex coffee had. Another one noted that wherever you see a group of men, usually somehow issues of sex and sexual satisfaction come up. That is why men will be directing each other to the latest solutions on sexual problems because their minds are often preoccupied with sexual satisfaction and prowess. I posed a question, 'does it mean that all that defines a man is satisfying a woman in bed?' It is a question whose responses showed beyond a figure of doubt that inability to have a fully functional reproductive system was considered traumatizing and humiliating for a man. It was the major reason that men, even the older men who are naturally affected by the passage of time seek to enhance their sexual capabilities. Locally, even traditional medical healers often peddle their herbs in the city which are meant to enhance men's sexual function. As one of the discussants noted, since time immemorial men's meetings were sometimes punctuated with helping each other attain the true marks of manhood, such that getting herbs for enhancement was not something unusual. He however lamented on how Christianity and modern urban life for bringing guilty and shame to normal cultural practices. He remarked,

> *Ukaona zvimadhara zvakagara zvega padare zvinenge zvichitotambidzana guchu nemishonga yekusimbisa musana ndosaka zvimadhara zvisingapere.* [If you see the old men seated alone, they will be giving each other herbal medicines and concoctions to strengthen themselves, that's why they never lose strength].

AICAM came as a relief for the men due to its presentation which makes it easier for people to access without fear and shame at the exposition of their weakness. As one man remarked,

> *zvitori far much better kunzi uri kumwa tea than kuti vanhu vakubatikidze uchimhimhidzana nemagubhu akazara makwati*. [It's better if people find me having tea than finding me gulping concoctions from containers full of herbs].

The 'modern presentation and packaging was quite attractive, and the environment easier for one to openly buy sexual enhancers and other products. The presentation was quite discrete and at the same time open enough to accommodate the shy individuals. The setup of the hospital was also seen as too pensive and too formal to scare any man. The men exhibited a fear of rebuke if ever they had to go and lay bare their problems in a hospital setup. The quasi-formal presentation of AICAM distributors became another important driver for men to open in confidence. This was also well illustrated in my personal experiences with the nurse whom I often accompanied on her trips to attend to her patients. One of the days she convinced me to take a scan from her machine. After the results generated, she proceeded to warn me of some of the deficiencies which were in my body including some related to the prostate and bone structure. One of the comments she passed was

> Bhudhi, munozorwadzisa maiguru kumba uku matadza kuita basa. Mofanira kumwa masupplements aya then tozotester futi zvinhu zvisati zvashata. [My brother you will hurt your wife by failing to perform in bed. You must take these supplements then we will retest you before it gets bad].

Though, I was skeptical about the diagnosis and prescriptions I was being given, I was struck by how the informality of the whole consultative platform was and how it even enabled to tackle topics which are considered taboo and difficult to deal with. It will take a lot of courage for a man to walk up even to another male doctor to start a conversation about his sexual weakness or problems. Even general medical problems were something which men in the city could easily divulge such that a condition had to be a bother for a man to start seeking help in most instances. However, my field experiences showed how the atmosphere under which consultations were done in AICAM was important in enabling the solving problems which bring shame and discomfort to men. Anything which point to weakness is anti-masculine hence the tendency of men to keep their problems to themselves for longer.

The difficult in mounting up enough courage to go to clinics was also another factor which led to men being frequent clients for some of the healers I interacted with. As opposed to the biomedical model which waits for clients to walk into the clinics and confess their ailments,

practitioners of AICAM, marketed their products and even employed personnel who would walk up to a person in the streets, convincing them to pass through their clinics and buy their products. Some men will be walking around carrying health problems which they may not be able to share with anyone. However, the way in which some of the advertising agents cajole them, ultimately led to some men divulging their health problems and buying remedies from AICAM. They have mustered the art of wheedling even men to the extent that they can stop by and try out their products, something which works better for most men who find it difficult to divulge their most intimate health problems. Although I had my fair share of doubts concerning most of the AICAM remedies, spending more time interacting with consumers and distributors, presented a platform for easier understanding such that when I got pushed to try the medicines, it became easier. By introspection, I could see that as a man most of the times bringing out issues about personal health, to a stranger and even people within my circle of relations, was something which is difficult. Most men would rather keep their medical and other problems to themselves than bringing them up for fear of being ridiculed. AICAM seemed to have been able to crack the shell of hegemonic masculinity which is often blamed as the basis for men's general reluctance to seek medical attention.

Masculinities have also been often associated with behavior which exhibit one's bravery and a show of courage rather than exhibiting weakness. The very idea of going to clinic and being found lining up for consultation would not occur unless the situation is severe. Hence men often found AICAM a welcome avenue which could save them the embarrassment and shame of being seen at clinics. Such scenario is best illustrated by the case of Brian, a 40-year-old man who was diagnosed of high blood pressure. During the early days of the diagnosis, he became stressed, changed his diet, and even stopped drinking habits completely. However, upon being introduced to some AICAM products, he started taking herbal tablets for almost a month and completely stopped taking the prescribed pills given at the hospital. He argued that,

> I cannot take these pills for my whole life, and I am tired of explaining to my colleagues why I have stopped consuming my favorite bottle. These clinics just want to make money out of us so I will rather try these new products than just appearing to be a weakling who moves around with a pouch of tablets.

After about a month he stopped consuming the AICAM products since he started to feel better and even started consuming alcohol again. He said he was a testimony that these things can

work although the experience may differ with the specific individual. For him, sickness was not supposed to control him such that he fails to do what he enjoys as well as pursuing the interests which he enjoyed with other men. From following his experiences, I saw several aspects in relation to masculinity and health. Firstly, some men would rather die than have an illness stop them from pursuing life passions. Though his medical doctor had advised him that blood pressure control tablets are taken for life, he risked it all and threw it away as an opinion solely because he could not come to terms with consuming tablets for the rest of his days on earth. AICAM became the quickest way out, since it promised natural medicine which could heal his situation. Even before running the full course of AICAM, he stopped consuming the herbal tablets as he felt strong enough to live according to his pre-diagnosis days. Secondly, masculinities resented the control and taking away of powers which occurs in the healing setups. The man could not stomach being instructed to consume lifelong tablets; hence he was always on the lookout for a quicker way out. Generally, self-diagnosis and prescription were some of the habits associated with masculinities, with most men customizing the medical advice they are given, to suit what they feel and want at different times.

In relation to deportment, the most popular problem of the body which men dealt with was the issue of weight loss. AICAM offered various herbal solutions, exercise regimes and diets which were meant to deal with obesity and overweight. I interviewed and followed up several men who had weight problems and who were purchasing weight control medications from AICAM distributors. Most of the products which the men bought included slimming teas as well as an exercise regimen which involved climbing up a vibrating machine which was thought to bring benefits such as slimming, toning the body and muscles as well as improving general cardiovascular health. These remedies were thought to simplify the slimming process something which augurs well with a masculine approach to health, which often seeks the simplest but most efficient shortcut to achieving good health.

In terms of the local cultural expectations, focus on beauty for men has never been a prominent issue. However, when weight impaired a man's ability to perform other duties, it became something which drove men to look for easier way to tackle their body size. Mostly middle aged and older men struggled more with weight problems, whilst there was an emerging crop of urban youth who were also conscious about their appearance hence could also be seen purchasing skin and body care products. The most popular products among these young men

included teeth whitening creams, facial care, and sunscreens as well as lotions. The privacy associated with AICAM was also important for those seeking these skin enhancement products discreetly. However, the consumerism by these young men presented an interesting dimension which question dominant narratives of men as generally shunning beauty and appearance. Some of the young men I followed up were so much obsessed with looking good, taking selfies, and posting their pictures on social media. Hence, looking good was a desire which they prioritized even to the extent of buying products to enhance their skin and looks. The emerging city culture among the youth corresponded with the emerging global models of appearance among men, where witness an increase in emphasis on men looking good. The beauty industry has extended its reach to cover young men who are conscious about their appearance and want to look good, bringing about what some could call feminized masculinities (Sowad, 2017). These young urbanite men reject the depiction of the rough and tough image of man in favor of presenting a gentle and beautiful fashion-conscious man. They subscribe to what the local young men term a *swag* culture characterized by money, consumerism and looking good (Mason, 2018; Memela, 2018). AICAM feeds well into this discourse by providing remedies which are thought to help someone to achieve these modernized identities which appeal to most young men. Hence, we also see the desire to belong and fulfill certain identities, being at the center of some conscious and unconscious decisions to consume AICAM products.

The urbanized youth culture has also made young men willing participants of the consumption of AICAM products to fulfill sexualized masculinities. The urban culture of swag and consumerism has also seen youth engaging in premarital sex in the city. Their idea of sex evokes elements of conquest, where one must perform beyond the expectations usually of the female partner. This has led to most young men being clients of herbal teas and other illicit drugs which are given to enhance sexual performance (Nyarko-Sampson, Dabone & Brenya, 2017). Some distributors often convinced young men to buy their products by including sex-linked explanations in advertising their products, for example products meant to correct blood, and cardiovascular health were touted as having trickle benefits to sexual performance. This attracted young men and was seen as a better shortcut of maintaining health as well as achieving the expected and desires of youth culture. It fitted well into the image of a young man with ‘swag’, the style of a truly urban youth. Medicalization of beauty and sexuality can thus be seen to be influential in determining patterns of consumption of some of the AICAM products.

Furthermore, the economy is not working for most people, most men (old and young) are not formally or gainfully employed. This brings its own pressure and stress on the individuals. Due to hegemonic masculinities, most men have been socialized into the breadwinner mentality, which looks at men as the providers in the home. To cope with the mismatch in perceived roles and the reality, there is a shift towards romantic/sexualized masculinities (Groes-Green, 2009). AICAM can thus be seen to be instrumental in enabling the pursuit of sexualized masculinities due to several factors which work in its favour. Relatively, it is cheap (no consultation fee, quantity depends on one's need) as compared to prescriptive biomedical remedies such as Viagra whose usage is subject to various regulations such as prescriptions and comes in standardized packages. However, most AICAM products are readily available and come in different types (instant and delayed) and for all age groups. Their provision is flexible, responding to individual needs and affordability. Groes-Green (2009), made an observation in paper on masculinities among Mozambican young men, that sexualized masculinities may at times be used as an adaptive mechanism to neoliberal insecurities. Hence, the fact that men may be excluded by the neoliberal system may influence the ways in which men seek to obtain relevance and a sense of self-worth. These masculinities are no longer about merely conquering females but also about satisfying them. Here AICAM become part of technology of the self, characterized by the refashioning of the body for social and cultural function (Mauss, 1973).

5.6 Reshaping gender dynamics and healing

> '*There is no man, there is no woman, and anyone can become a distributor. All you need is just your manuals, your kit, and your people skills'.*

After attending one promotional workshop held at Masvingo Civic Centre, I had an opportunity to have a chat with one of the charismatic conveners who had travelled all the way from Bulawayo to teach and recruit people interested in pursuing the trade of being medical distributors. Commenting on the opportunities which existed, he noted that their trade was blind to the gender issues in characteristic of the society. For him this was something which anyone could take up as long as you are sufficiently trained and consulted widely from others. It is from this perspective that I also observed the instrumentality of AICAM in changing gender dynamics especially in the healing enterprise. In patriarchal African societies, most of the important positions have been dominated by men. Traditional medicine has also been

dominated by men as evidenced by the overwhelming presence of men in influential positions of societies governing the operation of traditional healers, such as ZINATHA. Structural barriers and imbalances have also meant that even in biomedicine, the important positions in healing are populated by men.

Many medical doctors are male whilst females dominate the feminized trade of nursing. However, AICAM experiences in the area under study points to a greater liberation and reshaping of gender roles in ways which overturns male dominance in health and healing. One of my major informants was a woman, and she helped enlighten on how the 'new medicine' reconfigured male dominance. As she remarked, "my brother I am my own boss, and I have everything which is needed to diagnose and heal people. It is something which empowers me unlike at the hospital where I must wait for the doctors' approval even on matters which I can resolve on my own." The centralization of roles in one individual ensured that the control and power over healing encounters was firmly in the hands of the distributor. There was no chain of command, no hierarchical power structures, though distributors could help each other as peers in the same trade.

One other clinic where I also extensively conducted my study at was dominated by women, with four ladies and two men working at the same premises. The equipment they used, such as body scanners belonged to one woman who had recruited and taught the others how to become distributors of AICAM. Mostly the field of AICAM exhibited a flat structure, devoid of hierarchies which could bring power positions among distributors. The only aspect which could bring seniority pertained to the knowledge and experience which one had, but this did not translate to hierarchical positions in the organizational structures of the distributors. The setup of AICAM had an effect of evening out power dynamics in terms of how distributors worked. Some distributors employed people who would stand on street corners and along major traffic points to distribute fliers as well as to solicit for customers. These also showed an interesting pattern of female dominance in the field of alternative medicine. Many women could be found in the streets, soliciting for customers and persuading people to come in and have their health issues checked. Women's empowerment was seen in terms of business ownership, control over the medical processes without any outside influence and the capacitation which flowed from having a stream of income. For some of my informants, the income they realized from selling herbal therapies surpassed the household contributions which their spouses could provide.

In terms of consumption, most distributors noted that the scale tilted towards the female side. Women were the major consumers of alternative medicine products. Also looking at the fliers one could note that it contained more of the issues which affect women than men. Female reproductive health concerns and outward appearance drew the chunk of the alternative remedies meant to improve people's health. Though consumption dynamics could be linked to a business sense, where women could be regarded as the biggest consumers, the wide coverage of female issues could also show freedom and liberty to choose from variety of alternatives. Traditionally, healthcare systems have been rigid and had a tight grip on the medical choices of women. Hence that ability to choose from various providers could be interpreted as representing a liberation of women's health choices. Hence alternative medicine can be credited for reshaping women's healthcare choices in ways which restore the decision-making power to the women themselves.

The increased representation of women in the alternative medicine arena was also applauded for bringing the female perspective to experiences of health and illness. This could ensure that it becomes easier to define and understand problems which other women were experiencing. The severity and urgency associated with a medical condition is best explained by one of the people who experiences those problems. The cases of some of the women presented at the beginning of the chapter, showed the importance of gender in addressing medical issues. Some of the women were more comfortable presenting their experiences to another female and felt more understood by females rather than having to narrate their ordeals to men.

Although there seems to be some gains in terms of restructuring gender arrangements, it should be noted that most AICAM activities sit on the border of formality and are regarded more as falling into the category of informal sector. This may also explain the gender skew and female dominance of the sector. Traditionally the least paying informal sector activities relating to vending were dominated mostly by women. The nature and character of most distributorships had features akin to vending of medical products. Men found in the informal sector are often found in trades which are labour intensive, and which often require more physical exertion. This was characteristic of most informal industries where trades such as welding, and mechanical repairs were undertaken. The characteristics of distributing AICAM products could be viewed as work which did not impose a physical strain, hence appearing to be a feminized trade. Few men were found partaking in the sale of AICAM products, and most of those found

could be seen to aim for those roles which paid more benefits. One example was that of the massage clinic which was owned by a man who had acquired the equipment and skills required to run the clinic. However, this is not to downplay the fact that some men could be found in the lower positions which were low paying. The owner of the clinic was the only one who could sufficiently explain the operations of his massage machines and the philosophy behind this healing approach. Two women worked as nurses in the clinic, helping people onto the beds and doing other clerical work.

Gender dynamics were seen to be significantly altered in the practice of AICAM. The sex distribution of the healers and the characteristics of the consumer base were all evident of how gender was an important factor to consider in the understanding of how AICAM operates. Traditional masculinities and femininities come to the fore when one peers into the gender dynamics of providing and receiving healthcare within AICAM.

5.7 Conclusion

This chapter has examined how gender comes into the matrix of the consumption and distribution of AICAM. The ways in which gender is represented shows the wholesome nature of health and healing as well as the extent to which the tentacles of society can stretch to. It can be noted that gender influenced the experience and treatment of illnesses in the city. I have argued, in the chapter, that the distribution and consumption of AICAM can be interpreted in line with the gendered nature of the community under study. It reflects the medicalization of gender and how social processes structure the experience of health and healing. Masculinities and femininities were also important in setting the desired standards of being male and female. The chapter attempts to dismantle the overreliance on the consumerism argument through showing how gender processes shape medical consumption. Hence, rather than consumption being a desire to satisfy neo-liberal consumerist urges, it is evidence of greater motivations stemming from societal and individual considerations.

Gender expectations influenced the kind of problems which people would require medical services for, hence gender influenced the type of patients and their problems. Gender also influenced the distribution division of labour and contributed to the skew found in the composition of practitioners and distributors of AICAM. However, it goes further to argue that the character of AICAM in Masvingo point to greater local aspects apart from being evidence

of a greater global web. It represents, local aspirations and it represents the ills of society which must be remedied through AICAM. It calls for a closer analysis to observe factors influencing the gender patterns of consumption of AICAM. Addressing people's ailments also brings a conversation with the gender issues of society, hence discourses on AICAM awaken questions of gender in the community. The presentation of the gender dynamic may however fail to correctly capture the viewpoint of the consumers themselves. Though gender may present performative acts, it is also important to understand the experiential dynamics of consumers themselves. The next chapter attempts to achieve this through examining the experiences of various consumers.

CHAPTER SIX:

IN SEARCH OF A CURE: THE QUEST FOR HEALING IN MASVINGO URBAN

'...at the end of the day, what we all need is to get well, regardless from where the help comes from.' (AICAM Consumer).

6.0 Introduction

Hunting for the ultimate medical solution dots most of people's interactions with AICAM. To save life, to feel better, to relieve oneself of pain marks most of the respondents' accounts of their brush with AICAM. For some it ended well in testimonies and for others it brought more confusion whilst some outrightly rejected the efficacy of AICAM. This chapter is an exploration of patients encounters with AICAM. It captures the narratives and experiences which most users of AICAM went through as well as reveals how these encounters shape their perceptions towards AICAM. The search for a cure is determined by several issues which include, patient perception of health and illness, information available to the patient, the range of remedies one must choose from as well as patient trust and experiences with given medicines. However, the search for a cure is devoid of simple means ends rationality. It will give the observer puzzling questions as to why people end up choosing different medicines. The chapter also looks at some outward explanations which have been given to account for AICAM choices among urbanites in Masvingo. General cultural expectations are explored in a manner which exposes how this might influence people's medical choices. Such phenomena as consumption practices and people's attitudes may help define the ways in which people interact with AICAM products. As noted in the previous chapters, some of the common perceptions have been to profile individuals who dabble in complementary medicines as those who are terminally ill seeking to manage or cure their ailments, or to view it as a manifestation of global capitalist consumerism. Another recent view has also been to regard consumers as unsuspecting victims of fake medicines which is shrouded under a veneer of science and authenticity. However, this chapter weaves together some of the experiences in complementary medicines from the perspective of medical uncertainty. All other justifications may come in handy, but the failure of medicine to be true in all instances seem to underlie a general dissatisfaction and mistrust of healing approaches. Although not outrightly rejecting some observations which have been made concerning AICAM, this chapter examines the intricacies which surround consumer choices of AICAM products.

6.1 Theorizing the search for a cure (The habitus of modernity and a risk society)

There are various facets which can be used to understand and theorize health seeking behavior and consumption patterns of users of AICAM. This section examines arguments forwarded to rationalize the ways in which patients seek medical assistance and their consumption of AICAM. These arguments are situated in the broader Bordieuan framework of the habitus. One approach is to look at them as individuals who have been conditioned and inclined towards medical syncretism. The readiness with which people embrace AICAM products brings a feeling of individuals who have an unquestioning approach to phenomena presented as medical remedies. However, one must check where such readiness to embrace medicines and to just accept without in-depth research about the efficacy and ingredients of the medicine come from. The Bordieuan concept of habitus is important in understanding how consumers have certain dispositions towards medicines and often are uncritical of medical remedies unless they have a personal encounter and experience with the medicine. Bourdieu conceptualizes habitus as the internalized structuring structure, which often gives the actor an uncritical approach at social phenomena (Angus, Kontos, Dyck, *et al.*, 2005; Lo & Stacey, 2008; Samuelsen & Steffen, 2004). The worldview is shaped by what the actor has internalized and has been accustomed to. When one looks at the presentation of AICAM, it can be seen to be a healing approach which resonates well with local conceptions of medicine and healing. The way in which local indigenous medicine, and the mainstream biomedicine are presented have given people expectations on what a medicine can be like. Hence the presentation of AICAM products in the same fashion does not present a novel approach to healing.

The aspect of medical syncretism is further understood within the general etiology of the local people. As highlighted in previous chapters, there are multiple etiological explanations of diseases, and this often determines health seeking behaviour. Some scholars have observed the existence of the personalistic and naturalistic explanations which are often attached to diseases and illness (Payne-Jackson, Alleyne & Alleyne, 2004). Personalistic causation is seen in the belief that human or supernatural agents may influence one's sickness whereas naturalistic causation is explained from the perspective of diseases as a product of natural impersonal conditions which are devoid of any human or spiritual force's influence (Payne-Jackson *et al.*, 2004). As noted in previous chapters, some of the personalistic factors included notions of witchcraft as some believed that human agents, through the supernatural use of dark forces

could cast sickness on enemies. These underlying perceptions have been noted to influence health seeking behaviour where the first line of treatment has often been herbal therapy in the home. The second line of seeking health was through the utilization of biomedical clinics whilst the spiritual or occult practitioner occupied the last resort in seeking health. Hence, internalized conceptions of health and illness had considerable influence on how patients seek a cure. AICAM can be contextualized within this framework and their products have often been viewed more as home remedies which do not require a lot of expertise, whilst in some instances they also act as therapies of last resort in situations where biomedicine falls short or becomes too expensive.

The second is to look to the aspects of familiarity. This concept is intertwined with the Bordieuan concept of habitus since a habitus creates things which are familiar, and which do not present themselves as strange or new to the consumer. The medicines must be presented in a way which is palatable, or which appear in the form of acceptable medicinal artefacts. As previously observed in the preceding chapters, one can note that presentation of AICAM products in the form of powders, pills, liquid syrups, injections and even the setups of the areas of healing mimicked the form and structure of both indigenous and biomedicine in Zimbabwe. Although the explanations and etiology presented with AICAM medicines, most of its presentation and structure does not make a significant break from what is known and what has been experienced by the consumers of AICAM products. AICAM mimics both the biomedical model and the indigenous healing systems in a way which makes it fit perfectly in the corpus of local healing knowledge. By insisting that their medicines are herbal, whilst simultaneously presenting them in a modern biomedical form, AICAM managed to bridge the gap between indigenous medicine and biomedicine, at least in the eyes of consumers. Some AICAM distributors ended up selling both traditional medicine and AICAM products. One lady sold what she termed Indian sex sweets, which were purported to be fruit-based sweets for enhancing women' sexual experiences. However, she also sold some paraphernalia common to African folk herbal medicines which were expected to deal with infidelity and bring money. These included what she called a love stick and a money stick, which were supposed to protect relationships and improve finances, respectively. These products are well known and widely used in traditional healing. The aspect of money stick resonated well with the Shona concept of *kuromba* which essentially involved one acquiring wealth through the usage of spiritual and herbal means (Banda, 2019; Biri, 2012; Pfeiffer, Gimbel-Sherr & Augusto, 2007). *Kuromba*

can also be for different purposes, as seen through usage of the practice to enhance relationships and have prowess in different functions such as healing and divination (Banda, 2019). The incorporation of AICAM into these practices show the ease at which discourses of AICAM, and existing cosmologies could fit perfectly well. AICAM products existed within the range of the acceptable, the expected and the familiar.

The third perspective has been to link the consumption of AICAM with the desire of consumption of the foreign. This augurs well with theories of globalization, especially concepts of domestication which make an analysis of how foreign products are consumed within a particular space (Fadlon, 2005). It also speaks to issues of the status of foreign objects as symbols of power, wealth, and modernity discourse. Issues of status and identity have often been linked to consumption of various artefacts. In the Congolese writings of the *La Sape*, it has been noted that people often consume particular appearances and dress as a response to domination whilst simultaneously appropriating specific identities linked to the consumption of particular types of dress (Leff, 2019; Steinkopf-Frank, 2017). In the modernity discourse of health there is an increasing emphasis on living healthy lifestyles in the midst of a risk society (Chen, 2013; Karn, Amarkantak & Swain, 2017). AICAM products, present themselves as the near perfect medicines of modernity, characterized by products which are one hundred percent organic, which are accurate and devoid of side effects among the users. As people become more health conscious, watch their diet, and strive towards living modern healthy lifestyles, AICAM products claim to fill in that void of a truly genuine, sustainable, and safe medicine. Chen (2013) asserted that modern health worries constitute a significant contributor of people's choice of alternative medicines. Fear inculcated by perceptions of a risk society where different things such as food, the environment and medication, are seen to have a direct link to disease etiology has given rise to the popularity of AICAM as it makes claims to restore health in a natural manner (Collyer, Willis, Franklin, *et al.*, 2015; Crawford, 1987; Karn *et al.*, 2017; Korstanje, 2020).

The concept of globalization has also worked to prop up AICAM through the globalization of conspiracy theories. Medical conspiracy theories have provided an anti-establishment narrative, pushing through ideas of profit motive and collusion as the dark underside of modern biomedicine (Andrade, 2020; Andrade & Hussain, 2018; Marcon, Murdoch & Caulfield, 2017; Waszak, Kasprzycka-Waszak & Kubanek, 2018). Coupled with social media and an increased

access to technological devices, medical conspiracy theories have permeated the society, with different individuals forwarding information whose origin they cannot ascertain. Such information has been taken to be true in the absence of counter narratives offering accurate views on diseases and healing. The views that biomedicine may be unsafe, and that the chemicals used in biomedical drugs have side effects which outweigh the benefits, seemed to be a common belief among frequent users of AICAM products. Global conspiracy theories fomented a general mistrust with medicines such that biomedical products are always viewed with suspicion. Since AICAM presents an alternative truth, scrutiny of its claims has not been rigorous with users being eager to have an alternative 'scientific' view. The claim to have natural products gives AICAM a strong foundation to challenge biomedicine in an environment already poisoned by medical conspiracy theories. One AICAM practitioner claimed that surgeons can cut out everything except the cause. Such claims seemed to cement the idea of weakness in biomedicine and that the alternative natural way was far much better than the physician's scalpel. People are ready to receive new perceptions and remedies for their ailments and may even try to avoid going to clinic at all costs. As noted earlier, the search for a cure is dependent upon the information available to an individual, therefore global medical conspiracy theories seem to have succeeded in swaying people's views on healing. This has worked in favor of AICAM practitioners who seem to provide an alternative route to the much suspicious biomedicine.

There have been two interlinked discourses flowing out of the consumption of AICAM products. One which has been discussed in chapter 5, looks at how people try to appropriate appearances through using AICAM products as a gateway of body transformation to have the desirable bodies. Whilst the first point to attempts to fit in, the second discourse is linked to an attempt to show off abilities of consuming high-end products, thus it is a show of affluence. Being health conscious, consuming natural and organic products are all part of an expensive lifestyle which many cannot afford. Some of the consumers of AICAM products purchased expensive Aloe Vera juices, immune boosters and other herbal supplements which were said to enable one to live a healthy lifestyle. Issues of age and income were crucial in these trends of consumerism. The consumption of anti-aging remedies was common among the affluent elderly individuals whilst young professionals also consumed products to make them look and feel good and healthy.

Hence even the products themselves had a hierarchy based on cost, with some being sold on platforms of the relatively affluent. One such immune booster, which was a cocktail of different herbs cost USD80 for a 500ml bottle. Such amounts of money could not be afforded by many people, given that most of the working class are civil servants earning a monthly salary of around USD30. Whilst the consumption of AICAM products should be seen to be a search for cure, for some it is a search for a healthy lifestyle, characteristic of a paranoid rich class of urbanites who want to live healthy lifestyles at all costs. They have the abilities and finances to experiment with different expensive herbal concoctions, whilst for others it is really about the ability to continue living. An interesting conundrum was the usage of eastern medicine in the pursuit of western notions of the body and appearance. Whereas health standards and appearance conformed to the Western definition of health and beauty, the maintenance of such ideals were pursued using even eastern medical products. One social media update vividly brought out some of the Western ideals of beauty which people pursued. It read,

> The coveted hourglass shape is the type of figure you have likely seen on billboard ads, magazines, and celebrities on the red carpet. Well known beauty icons might come to mind when you think about this famous body shape. Good news is you can lose inches around your waist or tone your shoulders, hips, or chest using our healthy natural products and methods. Dietary habits, lifestyle choices and tweaks to your fitness routine will definitely influence the way your body looks. **FOR NATURAL HIP AND BUTT SUPPLEMENTS AND ALSO NATURAL METHODS TO BE CURVY INBOX/CALL ME**. An hourglass shape typically consists of a smaller waist balanced by a larger bust and curvier hip.

The advertisement sought to further a common discourse of appearance replete in local media. A glance at that local media will quickly show a heavy influence of Western ideas of beauty and appearance. However, the AICAM distributor in this instance, seeks to give alternative ways of reaching the similar goal on appearance through the consumption of Asian herbs, which he presented as natural and harm free.

The last paradigm relates to perceived efficacy and is based on the experiential dynamics of different consumers. As the consumers experienced the usage of AICAM, a discourse of what works and what does not, has been created. In a way this has created a considerable amount of information on what to use and what not to use. However, the experiences are varied and subjective, thus making it difficult for AICAM to find a stable formal recognition. What may work for someone may somehow fail to help the next person. The case of Sihle discussed in this chapter and in chapter 4 illustrates the importance of perceived efficacy in determining the

utilization of AICAM products. The fact that some people who had cancer experiences recommended and she also managed to have positive experiences with the AICAM products she bought, managed to convince not only herself but also her family members on the potency and potential benefits of the products which she consumed.

Some would like to argue that AICAM products may be exploiting the placebo effect where the body responds to perceived curing properties of an otherwise harmless substance with little or no effect on the body (Friesen, 2019; Kaptchuk, 2002). The body starts to act and react on the faith that because the individual has taken 'medicine' therefore something must happen in the body. Interpretive anthropologists have noted how the body can physiologically respond to different stimulation during healing (Kirmayer, 2004; Laderman, 1987). These may be incantations or other mythical procedures which invoke a response from the patient (Douglas, 1970). AICAM can provide a symbolic object which can induce a physiological response even though one can fail to ascertain the efficacy of the given medicine.

Healing, at times may seem to be a perfectly timed moment, which can make it difficult for one to pin down the exact source of their healing, hence resulting in different attribution errors. At the end of the day, the faith in the last method used can lead one to conclude that it is the source of their healing, albeit failure to prove a direct causal link between the method and healing. Several cases attested to this phenomenon. One lady, Mai Nyasha remarked that whenever she used some pills purchased from an AICAM distributor, her child got better. The child had a problem of fainting and seizures which would occur temporarily. Mai Nyasha never attempted to go to hospital with the child since she saw improvement after the consumption of the AICAM tablets. However, a quick opinion from a biomedical doctor revealed that the problem could be a result of a drop in blood pressure and could improve even by dietary changes and better fluids intake. Moreover, the infrequency of the fainting episodes made it difficult to be accurate as to what has caused an improvement in the condition. Though patient speaks authoritatively on the perceived source of their healing, several factors can come into the mix making it difficult to isolate the source of the cure. Some of the aspects which patients often give credit for healing include their religious beliefs which are discussed in the following chapters. The issue of finding an explanation of what brought relief is often clouded in the mix of medical syncretism of the patients. This makes it difficult to ascertain with accuracy, the authenticity and potency of some of the medical claims put forward by AICAM practitioners.

It has been noted that health and healing occur in an ambiguous environment. Various factors influence health seeking behaviour. Both personal and impersonal issues must be understood to establish an understanding of health seeking behaviour as well as people's consumption patterns of AICAM products. Therefore, the following sections attempts to give a coherent search for a cure by looking at the concept of medical uncertainty. It is within a context of uncertainty that the patient must seek medicine to get better. Uncertainty can be manipulated by the distributor, since no one has control over what can happen in the next moment. Uncertainty can drive the patient to try out new things which they have just been introduced to, in the hope of getting better. As remarked by one consumer, '*you lose nothing by trying out new medicine*'. This gave a drive to venture into novel healing strategies and paraphernalia.

6.1.1 Understanding medical uncertainty

The issue of healing is not something which cannot be given assurances for since there are many intervening variables. Even the most scientific and sophisticated medical systems can never give assurance of success in a medical procedure (Fox, 2000; Malterud, Candib & Code, 2004). Something can go wrong anytime. This gives rise to medical uncertainty, something which makes the whole institution of health and healing an enterprise built upon trial and error. Such trial-and-error cascades to the patients who may end up consulting any promise of healing in the hope that it may bring relief to their suffering. Some scholars have documented how medical decisions in biomedicine are often a result of common practice rather than best practice, meaning most of the times physicians make medical decisions based on popular action given a similar scenario (Atwell, 2003). It is the nature of the medical enterprise to fail to have all answers concerning health and illness. This gives a huge leeway for questioning any healing approach and to dispute any claims to authenticity and truth within medical systems. Individuals must search for a cure because answers to medical problems are not readily available. Experiences differ. What works on one individual may not work on another. Hence, seeking health is a struggle which takes the patient through a maze of medical decision making. In that maze, people try to make a compass of the experiences which others have gone through as they sought healing in their bodies. However, this often creates multiple experiences and truths therefore presenting difficulties in creating a singular narrative of the working of AICAM.

The inconclusive nature of healing systems may be an important factor influencing medical syncretism among patients in Masvingo urban. I will consider the case of one woman who

suffered from respiratory complications which led her to mix both biomedical and AICAM therapies. The case was briefly introduced in chapter four where I looked at some of the patients who bought and consumed AICAM products. The woman identified by her shortened name Sihle, started having an unending cough, loss of appetite, wasting of the body. When she went to the hospital there were tests which were done which diagnosed her with tuberculosis. The explanation for the tuberculosis diagnosis was that Sihle was suffering from hyperthyroidism, which had resulted in some sort of internal goiter. This was thought to block the effective expelling of sputum from the lungs such that sputum collected within the lungs thereby providing sufficient conditions for bacteria to infect her. She was put on TB treatment but after a few weeks her condition changed for the worse. Further scans were taken, and she was later told that the TB diagnosis was wrong hence she had to stop taking the TB medication. However, a worse condition had been discovered as the scans confirmed the problem as cancer. After a few weeks, she was put on chemotherapy whose side effects affected her ability to consume food properly as she would often vomit any food, she consumed. In that confusion and sickness, a relative introduced her to STC30 stem therapy and after a few sachets she felt ability to handle the side effects of chemotherapy, since the AICAM product enabled her to eat food without feeling nausea. For her, this product was seen as producing good results in conjunction with the treatment she was receiving at hospital. The chemotherapy could be used for killing cancer in the scientifically proven way whereas the AICAM product could clean up the side effects of the hospital treatments, and perhaps improve the chances of successfully fighting the disease. In her own words, the various AICAM products she consumed helped to calm the heart and enable her to combat nausea. She said,

> *moyo wangu unovhurika pandinomwa maherbs ndokwanisawo kudya. At times mapills anonditadzisa kudya but kuti ndisimbe nekuwana ropa rakakwana ndofanira kutodya chikafu chakawanda*. [My heart opens and is receptive when I consume the herbal medicines and I can take in food. Sometimes pills make me have difficulties in eating whilst I am expected to take food to improve strength and sufficient blood].

Sihle's case gives a glimpse into the difficulties the patient faces in making a medical choice. Whereas the hospital treatments' authenticity was not doubted since it was the pillar of health seeking behavior, its effectiveness was greatly questioned. The uncertainty, misdiagnosis, and inconclusive nature of biomedicine made Sihle, like many other patients, consider having a

basket of medical remedies since no one could be sure which one would work best. This explained the medical syncretism which was often characteristic of the health seeking behavior of AICAM users.

6.1.2 The exploitation of uncertainty in AICAM

Although it is evident that the field of health and healing is fraught with numerous uncertainties, these manifests themselves more prominently in AICAM's operations. As one man who was seeking weight loss observed,

> the medications I was given did not seem to help me much. Perhaps it is because I failed to stick to the required dosage as I failed to purchase the whole slimming package, but the days I consumed the medicines, I failed to notice any major difference.

Uncertainty is a major gap which can ensure that any medical claim can get attention as long as individuals have not been able to show that it is ineffectiveness. The burden to prove effectiveness is lesser than the burden to prove that a medicine does not work. People would continue using drugs even in the face of contrary information since they also want to have firsthand experiences with different products. The claims given by most AICAM products makes it difficult to find fault in them since there are infinite possibilities. As one respondent noted;

> You can never do enough with these medicines. At times you just cannot afford to buy the full course and you never know whether the failure to get healing should be blamed on medication. Imagine the full course of this therapy requires USD 210.00. Where can I get that kind of money in this economy?

Most of the time people could never fully comprehend the extent to which the medicines were beneficial or not (Evans-Pritchard, 1937). In some cases, a person could get better after taking small dosages of AICAM products. However, in such scenarios people had difficulties understanding if healing had come from the medical paraphernalia or it was a product of the body's natural healing capabilities. Moreover, the active promotion of medical syncretism by some AICAM practitioners makes it difficult to pinpoint the source of healing. Most products are given as herbal supplements and often some practitioners do not recommend an individual to stop their biomedical treatments before they feel fully recovered or are advised by their biomedical doctor to stop the treatment. This gives a problem when trying to single out the exact source of healing, hence extending the veil of medical uncertainty which shrouds the exact source of healing. As illustrated in Sihle's case, her cancer treatment was taken simultaneously with the biomedical therapies. Since she started feeling much better after also

consuming AICAM products, it was easier for her to attribute the improvement in her health to these products. Trying to establish the authenticity was out of the question since her personal experiences were the base of her conviction that the products work.

6.2 Self-diagnosis and consumption of AICAM

The study has looked at various individuals who have been consumers of note when it comes to AICAM products. In the previous chapters, I have looked at cases of individuals who have consumed AICAM products to treat disease such as back pain, diabetes, obesity, cancer, and sexual problems. Though their health seeking behavior has been tied to various issues this section analyzes how such actions are coherent with emerging trends of approaching health and sickness in Zimbabwe. One notable practice which I saw to underlie patterns of consumption was the aspect of self-diagnosis and self-treatment. There is an emerging trend where individuals, rather than looking for expert advice, simply take the easiest route towards diagnosis and treatment of diseases. One of the respondents opined that, rather than going for consultation, he often looks up messages related to health on social media and depend on similar experiences which others have gone through and how they resolved the illnesses they faced. Most of the respondents I interviewed showed limited reliance on expert advice and more trust in experiences which others in similar situations experienced. Only a few who had chronic illnesses, consulted AICAM as just but one of attempts at resolving their illnesses. Nature of most herbal treatments which were available to the consumers often promoted self-diagnosis and treatment, especially on those which used scans, manuals and booklets for diagnosis and generating prescriptions. One could simply read the manual and look up symptoms which corresponded to their experiences then get the prescribed remedy to that problem. Self-diagnosis and treatment also relied on popular experiences as exemplified in the case of one popular AICAM product that is an anti-mosquito called *tsunami*. The green substance sold in a small transparent bottle of 3.5 ml, was popular in the city and available in many small shops, informal markets as well as among street vendors. During a discussion with some of my key informants, one narrated how the medicine helped him deal with a severe case of flu. He stressed:

> *I just took a drop of tsunami and mixed it with hot water then steamed myself with the mixture by taking a blanket, kneeling, and covering myself over the steam. The flu disappeared the following morning.*

These are the claims he made about how tsunami had assisted him to deal with a case of a severe flu. Another elderly relative of mine also used the same liquid as a rub for inflammation and pain in her shoulder. She insisted on having tsunami which she claimed gave her relief from the pain which she was experiencing. Looking at these two cases, they showed how self-diagnosis and treatment were also an outcome of both individual experiences, experiments as well as the availability of recommendations within the public domain. Most of the users who consumed *tsunami* mentioned that they had started using through referrals from individuals and information in the public domain. Their convictions and satisfaction after usage of the product added to the information available in the public domain, since their testimonies added to the societal repository of substances which work and how they work. If their experiences had produced negative results, it meant that their voices could add to the discrediting of the product as fake, hence making it unpopular. This also demonstrate the power of individuals to add into the construction of a medical discourse in the community. The potency of the drug is celebrated via public opinion as many individuals attested to the efficacy of the drug. One respondent shared his experiences of his father-in-law who suffered a severe flu. He noted that several relatives recommended that he takes tsunami, but unfortunately after consuming more than the small dosage recommended, he collapsed. He had to be resuscitated at hospital and spend a few days in bed. Rather than looking at the potential fatalities of the concoction, people were in awe of what the small bottle of wonders could achieve. It strengthened their view that only a small drop works, whereas the affected in-law vowed never to use the substance again.

Another interesting observation was the versatility of the AICAM products, which even led people to just use the medicines in various contexts. As noted from the experiences of tsunami, people used it for a wide range of ailments including, common colds, body pain, headaches and some used it even to treat their livestock. Cases of negative effects were fewer as many people testified the positive outcome of the drug. One newspaper article also noted an interesting story of how some local traditional medicine men were incorporating tsunami in cleansing homes of evil spirits and goblins ("100% Tsunami: Use at own risk | Celebrating Being Zimbabwean", 2018; Mpofu, 2017; Ncube, 2019). Underlying the consumption of these AICAM is a tendency for people to self-diagnose and self-medicate. The innovativeness of people as they expand their imagination and attempts to tame diseases and illnesses is seen in the different ways they use and abuse medical products. Parallels could also be drawn with the ways in which people also even abuse biomedical medication. One respondent also narrated

how he uses amoxicillin in the treatment of his broiler chickens. He claimed that usually he notices a great improvement in sickly birds within twenty-four hours of administering the drug. The examples above show how people were in the habit of pursuing self-diagnosis and self-treatment.

6.2.1 Self-diagnosis, self-treatment, and power dynamics

Patient power has also been understood in terms of control over the healing process. How one gets to make the decisions concerning illness and the remedies which are taken shows power dynamics in healing behaviors. Issues of self-diagnosis and self-treatment are also key in understanding the popularity of AICAM products and their usage. As one consumer noted:

> When you go to the clinic it is not your duty to tell the doctor what you are feeling. They simply require you to give the symptoms and if they want, they can tell you the problem but if they are busy, they simply scribble a prescription and off you go. However, sometimes I am the best person to know what I am feeling. I usually go online to look at the pills I am given and weigh for myself if they are appropriate and do not have a lot of side effects. Sometimes I do not take the medications and I just buy herbal products. It has worked for me.

The conversation brought some of the issues which were prevalent in the interviews with consumers of AICAM. A lot of self and parallel diagnosis and treatment occur within the arena of healing. Though people may go to see their doctors, it does not follow that they are going to take the recommendations which they will be given. The clinic simply became one of the avenues for getting opinions on illness rather than the sole giver of medical knowledge. Though the doctor could prescribe medicines, the ultimate decision on the remedy lay firmly in the hands of the patient. Some key informants in the medical sector also noted that many patients default on their medication as they pursue other healing avenues. Hence, the failure to return for consultation could be evidence of the situation getting better, or one getting help somewhere else. AICAM was one such platform which challenged medical authority and increased medical choices. The existence of medical choices should be seen as placing the decision-making powers on treatment routes firmly in the hands of the patient.

Patients usually made up their own understanding of what they felt despite the existence of medical knowledge. The world of their healing encounter was sometimes constituted by various pieces of information available to them. This included online platforms, referrals by family, friends and other people who may have experienced similar conditions, religious and

cultural beliefs. All these provided information which the patient had to sift and use to arrive at a medical judgement. Some urban consumers could even look up the composition of the AICAM products they were receiving and research on how they function. One patient who was suffering from bone pain, noted that one of the AICAM distributors recommended cordyceps capsules which are also a common product in TCM. After looking up the product online he came across mixed testimonies of individuals who had used the drug. He claimed that the positive ratings and the realization that this was a product used in other parts of the world emboldened his decision to try out the medicine. Some of the commonly used products which could be verified online included activated charcoal, Aloe Vera derivatives, spirulina, and ginkgo biloba. The comfort of finding corresponding experiences from others increased the tendency to self-diagnose and self-treatment. The information age has brought with it more undermining of centralization of knowledge as patients also privately challenge medical opinions and engage in attempts to find the least expensive and most effective remedy for their ailments. Though it may appear that people who take AICAM products are victims of a medical scam (Adler & Fosket, 1999; Hall, 2018), the testimonies and supporting evidence in line with different products also show the rationality employed by patients as they reach medical decisions. AICAM is an attractive method due to the appeal to the claimed natural nature of products.

6.3 Natural medicine and uncertainty

The issue of natural medicine seemed to augur well with the current inclination to fear in the modern societies. A general mistrust of biomedicine and technology has engineered a new wave of fear, such that most AICAM practitioners are exploiting this fear of the negative aspects of technology and scientific medicine by purporting to give patients natural medicines. One of the mottos of some of the distributors read, '*inspired by nature, realized by science'*. This had an aura of the ability to use natural medicine which is backed by scientific efficacy in terms of its potency and ability to treat ailments. Almost all the distributors of various AICAM products advertised their products as being 100% natural: and by implication, having no side effects. This was touted as the major advantage which AICAM had over biomedicine whose products were thought to be replete with chemicals which could introduce more problems than the original intention of healing an individual. Most consumers of AICAM expressed low adherence to biomedical treatment, with some of them reportedly abandoning prescriptions as and when they felt better. In their search for a cure, patients often employed due diligence to

get the most efficient medicine which had limited side effects. Hence, most of the stories of people who had a long relationship in consuming AICAM products, were those skeptical of the benefits of biomedicine, and who viewed AICAM as a better alternative to the mainstream biomedical products.

The claim that there is a healing way that is natural as opposed to biomedicine which was portrayed as containing many synthetic chemicals with hidden side-effects created a degree of uncertainty in the mind of the patient. This uncertainty stemmed from the inability to tell if the medicines which one consumed will bring them to health and at what cost. One respondent who avoided taking high blood pressure medication argued that it was better for him to avoid taking tablets which will be taken for life. He rather opted for AICAM than embark on a medical journey which could only end in death. Moreover, the promise of a side effect free medication portrayed a picture of the patient having total control over the disease in a less harmful manner. Most consumers attempted to deal with the issue of uncertainty through consuming medications which were considered natural and side effect free. The no-side-effects claims of AICAM may also help account for the flexibility of use which characterize the consumption of the products. If there are no side effects, then people see no harm in experimenting and attempting to extent the benefits of the products in different scenarios.

The uncertainty environment of seeking a cure could be seen to bring fear. Hence, the study also recognized the importance of fear in regulating consumer health-seeking attitudes in the AICAM market. One of the respondents I discussed in the previous chapter resorted to AICAM for fear of being harmed by the proposed operation to remove uterine fibroids. Stories of botched operations and errors on the physician's table led people to be afraid of adopting biomedical technologies and finding an easier way to deal with their health problems. One family whose member had undergone an operation in the stomach were bitter after the physician threw away the AICAM products which they had brought into the ward. The bringing of a competing medication showed the extent of doubt in the ability of the biomedical facility to effectively deal with the family member's ailment. Sadly, the member died and there were murmurs of disapproval and undertones of negligence as well as incompetence levelled against the doctor. Though the condition might not have improved, the family felt at least they should have been allowed to do something to help their ailing father.

6.4 Consuming the novel and exotic: hagiographies of AICAM

Issues of healing have often been cloaked in mythical legendary stories in local folk medicine. Healers have been known to travel far and wide to get healing powers, charms, and medicines. Authenticity and trust in healing within indigenous medicine often rested on these folklores and grand narratives of how the medicine man would have acquired his medicines and powers. Some indigenous healers pointed to larger than life stories about their initiation into the trade, which sometimes including mermaid abductions and living under water for a considerable time (Shoko, 2018). Some of the local stories narrated of how the medicine men could travel to the sea, to collect remedies for illness. Such knowledge inhabited the habitus of the local Shona people and helped create an expectation on how to judge medicines and practitioners. The narrative may not be confined to the local community under study but could be seen to permeate most of the Zimbabwean expectations on healing. Coupled with the effects of globalization, which has brought foreign remedies closer and creates an easier system for the importation of medicines, this seemed to tickle Zimbabweans' fascination with the foreign and hence influenced the consumption of exotic medicines. This reminds me of one massage therapist who used electric massagers infused with a jade rock which he claimed to have mythical powers to healing. According to the myth, the rock found in Japan, was reported to heal anyone who would rest on it. It is the same rock which was said to have been extracted and infused in the electric heating equipment which was used for massaging people with different ailments. Such captivating stories played well into the local expectations of healing. The cosmological connotations of the mythical, legendary stories behind some medicines are further discussed in chapter 7. The story behind had the power to influence acceptance of the medicine or the healer. Hence most AICAM products carried with them stories which were meant to influence the buy in of consumers.

Trips to China and Asia, which were tokens of appreciation for best-selling distributors and recruiters in multilevel marketing (MLM) based AICAM companies, could be confused for evidence of being a competent healer. The trips afforded prestige and imbued one with an element of being knowledgeable since they would have seen the source of the medicine and received the tutelage of the manufacturers of the medical products. Hence, distributors with such grand CVs did not struggle to find consumers who were convinced by their impressive track records, backed by proven pilgrimage to the source of the medicines. Just like the famed *n'anga*, who would have stories of being captured by mermaids and living under the water for

a considerable period of time ("Face to face with Mwenezi woman who spent 40 years with mermaids - Tell Zimbabwe | Keeping it Real", n.d.), having a story and elaborate track record was an asset in the hands of the distributor. Those were the things which well accomplished distributors will quickly point to in the face of doubting clients. This may also consolidate the argument that the popularity of AICAM may be a result of local people's desire to consume, foreign and novel paraphernalia. The fact that the medicine was exotic could have been reason enough for some people to decide to try out the products. Walking around town, one often encounters placards pinned to trees in the city advertising a *n'anga* from Chipinge, which is an area famed for having powerful *n'angas*. Other placards also advertise herbalists or traditional healers from Malawi. Listening to some of the stories on these Malawian *n'anga*s, claims have been made that they are able to travel supernaturally in winnowing baskets, whilst some people even claimed that some are literally put in large pots simmering with herbs. In the same vein, some of the major captions of distributors of AICAM, would read, '*HERBAL MEDICINE FROM MALAYSIA,* thus corresponding to the local gimmicks of establishing the authenticity of the medicine through linking oneself to an exotic and faraway place. Three things could be useful in selling the medicine. Firstly, it is exotic, secondly it is natural and thirdly it comes from a faraway place. These are factors which could easily appeal to the local expectations on the nature and form which medicine was supposed to take. Consuming something with a grand story was a good marketing strategy in establishing the acceptance of foreign herbal medicines.

Along with bringing exotic medicines, globalization can be seen to introduce new approaches in the satisfaction of different desires and tastes as seen in the redefinition of sexual expectations and body enhancements. The current societal setup has been structured in a way which has put to life certain expectations and has redefined the needs which people have. As noted in the previous chapter, medical remedies do not only address the physical aspects of illness, but they also influence and provide remedies to social problems. Dealing with a problem for a long time often produces familiarity and drudgery in human beings, something which is an outcome of monotonous systems of action. The entrance of AICAM may also be seen as a rejuvenation which brings about a different lens of looking at health and illness as well as the remedies which are offered to deal with illness. It is such a scenario which may lead someone to look at the aspect of novelty as a social currency which can explain the relative popularity of AICAM in Masvingo. It may be true that people are not experiencing a lot of new health problems but having a new way of dealing with an old problem brings a thrill on its own.

Such is the status of AICAM. It is a novel way of dealing with medical problems. Its promises walk right out of a fantasy book, a fantasy which is too good to be true, but which everyone wishes for. The possibility of a natural medicine, with nothing but natural ingredients, and which also do not have contraindications on the users, is something which humanity is waiting for. Hence, the ability to fulfill this gap is a major steppingstone in the success of AICAM systems.

One interesting ailment highlighted in the previous chapters, has been the aspect of sexual health and diseases. It is an area which stirs a lot of interest in terms of expectations which people have, issues of performance and ability to have a healthy functional sexual life. It is one area which distributors have promised heaven to urbanites. Some of the products I came across included what were termed Indian sweets. These were touted as natural, fruit-based products which had no dosage and side effects. One could consume as much as they could afford without having any negative effects. The problems which these remedies were trying to address can be said to be old problems which had not been given adequate attention in medical research. Sexual dysfunction in both men and women were some of the issues which this foreign medicinal paraphernalia purported to address. It is this new way of looking at old problems which sounded enticing to the people under study.

6.5 Chronic illness, lifestyle problems and consumption of AICAM

CAM usage has often been linked mostly with chronic illnesses and problems which generally lie outside the spotlight of biomedicine (Borm, Schiller, Asadpour, *et al.*, 2020; Falci, Shi & Greenlee, 2016; Jeon, Kim & Kim, 2019; Peltzer, 2009). Some of the major arguments have been that CAM provides relief to sufferers of chronic conditions (Onifade, 2020; Sadiq, Kaur & others, 2016). These observations also speak to the current findings on the consumption of AICAM products. Although some AICAM products did not explicitly mention their ability to deal with different chronic ailments, their claims implicitly pointed to claims of eradicating chronic conditions. As one of the advertisements noted, the AICAM products claimed to restore the human body to its original functionality. Those who subscribed to stem cell therapy claimed that these will help rejuvenate the original cells thereby reversing any harm done by different diseases. Stem cell therapy was therefore popular amongst cancer patients. Another chronic condition which was targeted by AICAM was diabetes, with some practitioners claiming to reverse and eliminate diabetes in the body. Immune boosters for People Living with HIV and AIDS were also sold, with some claiming ability to bring down the viral load to undetectable

levels, paralleling what antiretroviral drugs can achieve. This claim to deal with conditions deemed medically impossible to cure became another sticking point in the classification of AICAM as quackery or fake medicine. Whereas biomedicine only offered palliative care for conditions considered chronic, AICAM distributors became merchants of hope by promising to cure the incurable. It gave renewed focus on health from chronic conditions.

Apart from these evidently chronic ailments, AICAM products were also presented as having the abilities to treat conditions such as obesity, arthritis and other health problems associated with modern lifestyles. As noted in previous chapters, AICAM offered different medicines which were expected to deal with issues naturally and effortlessly. Most herbal clinics either had slimming teas or pills which were meant to deal with obesity. Menstrual pain and complications were also another problem which AICAM practitioners claimed to be able to heal. Mostly, these are conditions which have not found satisfactory remedies, hence requiring palliative care. As mentioned earlier, the autoethnography of my body as the object of research also provided a rich analysis of the ways through which people search for a cure. I had a condition that made me suffer a little bit of sporadic pain and inflammation in different parts of the body. Several visits to the clinic yielded nothing as all the tests usually came out negative. However, when I was convinced to take the scan, some of the results were in line with the generalized pain I was experiencing. The failure to receive adequate explanation and treatment at the biomedical clinic made me search for an alternative, or at least something that could promise to offer relief to the symptoms. Like many other patients struggling to find answers and remedies to their suffering, I found myself consuming different kinds of herbal pills.

Though, the chronic illness-alternative medicine script seemed to inform patterns of consumption, there were certain distinguishing features of consumption among the urbanites. Firstly, rather than being a measure of last resort, AICAM came and occupied some of the initial stages of health seeking behaviour. Before an individual went to look for a second opinion from a different expert, they could consult AICAM practitioners. This is because of the relative informality of AICAM and its structure which mimicked traditional medicine. As noted earlier, traditional medicine has been one of the major ports of call for local people. This involves consumption of local known herbs and in serious instances, consultations could be sought from local medicine men. Hence, the form of AICAM products and the way in which these were distributed made it easier for them to be infused in the local systems of seeking

therapy. They easily occupied the domain of informalized healing which depended on self-diagnosis, self-treatment, and occasional seeking advice from neighbours, relatives, and friends. The recommendation from one's social network was also instrumental in influencing the uptake of AICAM products. Hence, though AICAM products could have found a space in the discourses of chronic illnesses, it should be noted that they were not always a measure of last resort but could also inform part of everyday health seeking strategies.

Secondly, most of the AICAM products were complementary rather than alternative. They did not seek to supplant the biomedical discourse per se but tried to present themselves as complementary and more advantageous than biomedical products. Though AICAM might have questioned the efficacy of biomedical products, it did not question biomedical knowledge in its entirety. Hence, it was common to find AICAM practitioners advising their patients to go to hospital, or to consume their products alongside biomedical ones until the biomedical doctor certifies that the problem had been cured. Hence if one were consuming diabetes tablets, they could consume them together with AICAM medications until the doctor recommends that they be removed from the diabetes management medication. Hence, AICAM did not challenge biomedical knowledge and often encouraged medical syncretism. Most of the AICAM distributors, therefore, did not encourage the removal of patients from chronic illness medication, but had faith that through the consumption of their products, the patient's condition could improve hence making medication redundant.

6.6 Encountering AICAM: Power dynamics and the healing relationship

In dealing with illness how does the quest for healing tilt the scale of power towards the patient. Healing is a phenomenon which often bring into questions power dynamics between people who are involved in the healing relationship. One of the major aspects in patient-healer relationships has been the issue of power. Medical encounters have been seen to be characterized by power dynamics where one part wields much power over the other in various ways. This may be social power within the broader community or power within the micro healing interaction. Whereas the biomedical practitioner is seen to possess significant power which stem from his occupation, and the traditional healer is also a respected figure in community, the structure of AICAM dissolves most of these power dynamics and establishes a lateral system. Most AICAM systems simplify healing knowledge such that even the patient can self-diagnose and self-treat. Hence, becoming a medical distributor did not give much prestige associated with healers in other medical systems. The fact that ordinary individuals

armed with knowledge from a two-day workshop and a box of medications was all that it took sometimes to become a distributor, was a factor which contributed to the diluting of the power of distributor. It was contrary to the many years of apprenticeship and learning which characterize both biomedicine and indigenous healing systems. It removed the element of monopoly over knowledge, something which often give prestige to practitioners within the two healing systems.

However, power is a pervasive aspect of social life. Different aspects influenced the currency of power which people wielded. One interesting issue was how power from other sources influenced the interplay of power in healing circles. Some practitioners who had a medical background found it easier to break into the field of selling AICAM. One of my key informants was a State registered nurse and I also interacted with another State registered nurse who had a brief stint selling AICAM. My key informant boasted of healing high profile individuals in the community. She even gave examples of high-profile politicians such as resident ministers whom she attended to. In her interactions with patients, she would often mix biomedical jargons into her diagnosis and treatments. This would give an aura of a natural healing approach which is backed by science. Sometimes she would sell her medicines coming directly from work, whilst still putting on the distinctive uniform which she wears at the hospital. This had an element of exporting the biomedical power which she wielded onto the alternative healing scene. The other nurse also confessed that since people trusted her as a knowledgeable on medical matters, she stood a better chance at selling AICAM products. Few people could question the recommendations made by someone who already worked in the medical fraternity. This created an advantage for her and created hierarchies of power backed by medical knowledge. A distributor who did not have prior medical knowledge could not garner the same clientele as the medically trained personnel. One of the nurses could also further double her profits by repackaging AICAM tablets and putting them in packages like what a patient could be given at the hospital. So rather than selling bottles of pills like others, she would break and give specific dosages. This further helped to make her products comparably cheaper and gave her clients a familiar experience of the medical encounter under biomedicine. She would ‘test’, make a diagnosis and prescription and retest after periods such as weekly or monthly whereas other distributors would just sell whole bottles to clients. This recreation of hospital conditions gave an air of superiority and knowledge, which could be used to convince even people considered knowledgeable. It also presented an element of mimicry of the biomedical

experience and AICAM products facilitated such reproduction of the biomedical encounter due to the form in which their products were presented to the public.

The participation of biomedical healthcare personnel in AICAM seemed to narrow down the rigid distinction between medical systems and showed that medical syncretism was a pervasive phenomenon in health and healthcare. As noted above, the participation of state registered nurses showed that biomedical health personnel were also inclined to believe and recommend the consumption of AICAM products. They even carried over their biomedical jargon, training and understanding to add a dimension of sophistication to their practice. Whereas other distributors could simply sell whole bottles of medicines the nurses would break dosages and do weekly routine checkups, something which was not common among general distributors. Medical training did not automatically mean the dispensing of other forms of healing knowledge as biomedical personnel could also employ alternative healing methods including herbalism and spiritual healing. This represented a multidimensional domestication of AICAM to fit into the existing paradigms of healing.

Social power could also flow from religious circles. Some practitioners were organized around religious affiliation, and this also made them use religion as a currency to recruit both clients and other distributors. In the MLM based systems this would translate to more profits to the recruiter who would earn a commission upon signing on of a recruit and would further earn commission on any sale made by people registered under her name. Religion became a gateway of social power among distributors as it made it easier for them to convince like-minded believers to either buy their products, or to join the trade of selling AICAM products. One denomination supported herbalism to the extent that teachings and practices advocated the exclusive consumption of natural herbs, since they were viewed as biblical, as compared to biomedical products, which were seen as man's innovations. The consumption of herbal products, including AICAM, was actively promoted in church, and some church members would sell the products right from the church offices. In some instances, there was a mix in religion and biomedicine to produce discourses of power. A notable example was when a medical doctor conducting surgeries under a campaign by his church would often direct some patients to AICAM distributors, who also happened to be members of his religious group. This could be seen in Sophia's case who was directed to Adventists who sold AICAM products. Though not often, this constituted a bifurcation of power where both biomedical authority and

religious authority converged to produce categories of power in the healing encounter. It pushed a medicine which was endorsed, not only by medical doctors, but also felt acceptable in religious circles. A further discussion on the religious aspects is also presented in the next chapter, which explores the religion - healing dynamics.

Another source of power for distributors could be seen to be charisma and marketing skills. One could see that the success of some distributors was hinged on personal abilities to sell and to speak to people in a persuasive way. Like one distributor remarked;

> This is business, you must do what businesspeople do. Products do not sell themselves.

Those with charisma and could push volumes were able to command a huge subscriber base. Some of these persuasive marketers earned various prizes from the suppliers of AICAM products. This included household furniture such as television sets and refrigerators as well as prestigious trips to China to see the places where their products are manufactured. Some clients noted that they ended up buying products, not because they were sure of their ability to work, but simply because the distributor who approached them was very persuasive. My personal experiences also showed that some of the distributors I interacted with had honed their marketing skills such that it was difficult to leave their premises without buying something. Some could even offer to do free scans and use the results to cajole a client into purchasing their products.

6.7 Experiencing AICAM: The Search for a Cure

Some of the views by scholars present AICAM healers as cheats or modern-day swindlers who try to make a quick buck out of desperate and unsuspecting sick people (Lavorgna & Di Ronco, 2017; O'Keefe, 2017; Renckens, van Dam & van der Smagt, in press). Coupled with a rise in multilevel marketing scams and other get rich quick schemes, some of the medical interventions have come linked with these questionable investment ideas. This has made it difficult sometimes for the ordinary person to differentiate between genuine alternative medicine which can alleviate ailments and other scams meant to milk unsuspecting patients. The issue of faking is not peculiar to AICAM. Every medical system is replete with fake healing specialists and fake healing products. The different medical systems in Zimbabwe, biomedicine, spiritual healing, and indigenous healing, have all received a fair share of fakery. What comes to mind is a story of a 'doctor' who was arrested at Parirenyatwa hospital, Zimbabwe's ultimate referral hospital. The 'physician' operated for up to six months until

people started to question his credentials as he continuously made questionable medical judgements. The fact that he could operate for such a considerable time, undetected, show the porous nature of medical systems such that anyone can start offering medical services. The country has also witnessed fake miracle healings, fake *n'angas* and witch hunters who would plant evidence and later emerge to claim to have been able to supernaturally retrieve the source of misfortune, diseases, and witchcraft. However, people never lose their faith in the ability of the medical systems to find a cure to their problems despite such incidences of questionable specialists, actions, and medicines.

For someone, the encyclopedic claims made by some AICAM practitioners should at least raise questions to the patient as to the possibility of a super/miracle drug. Such were the questions which were running in my mind as I sat observing a healing session by one of the AICAM practitioners. Most of the herbal medicines in the 'clinic' had an average of five diseases which the doctor claimed it can heal. One woman had brought a prescription which she had been given from the prior consultation with the 'doctor'. From the wide range of ailments which the machine had detected, she had to make a choice as to which ailment to deal with first and what drugs to buy. The doctor placed back the responsibility of choosing what to treat first in the hands of the patient. After confiding her priority to the doctor, she brought out a 20-dollar bill and the doctor gave her three sachets of Ganoderma coffee, a packet of some pills which were to be taken twice a day. The bill landed at 18usd. That was all that the 20-dollar bill could buy. The parting shot was a warning by the doctor that the medicines might not see her through the illness. Hence, she was supposed to come back for refills and to buy other medication which she had failed to take at that time. The search for a cure, is a sifting through numerous healing claims which may cloud the consumers' judgement. Health and healing are a minefield for the patient, whose quest for healing leaves her with multiple choices and a responsibility to establish what is authentic and helpful in the quest to restore health, or at least to lessen conditions of suffering.

The issue of class can also be used to explain the relationship between AICAM practitioners and their patients. Whereas the elites usually have personal doctors who attend to them and have an intimate knowledge about the patient, and even the patient's family, the poor are often exposed to the public health system where the services they get are anonymous, mechanical and lack a personal patient-doctor relationship. In the public hospital you can find one doctor

who gives you a diagnosis and prescription, and when you come for review you find someone else who does not have an intimate knowledge of your ailment. They are not interested in personally knowing you but simply follow a written record of your suffering, which they then use to make medical decisions. AICAM hence, became attractive for offering the poor services which they could not experience in the public health system. The luxury of narrating your problems and participating in the medical decisions to make as well as the strong relationships which AICAM practitioners maintained may also have been the source of its popularity. Personal relationships help in establishing trust and ushering in a collective approach to healing. Some patients did not blame their healers because they believed that their decisions were in their best interest, hence AICAM practitioners could escape the label of fake medicine.

Though the fake medicine label was carelessly thrown around when it comes to AICAM, for some healers you could sense the genuineness and conviction they had in distributing that medical paraphernalia. As one distributor noted;

> Most of my clients are drawn from people I know and meet every day. My neighbours, my relatives and even my family. I would not pass to my family medicines which I know that it may compromise their health. If you look at my clients, most of them we have had a long relationship. Their coming back confirms that they find something useful from what I give them.

From this conversation it is evident that the distributors sometimes have a conviction that what they are selling is genuine and can heal people. This brings into question the accusation that these distributors are fake medical people distributing fake products. For one to be a scammer they should at least have knowledge that what they are selling is not effective or fake. Many issues also bring into doubt the aspects of fake medicine. Operating from formal public workspaces with traceable and fixed addresses is risky for any dubious scam hence the attempts to be visible and make a name for distributing may show that the distributors themselves believe in their medicines. The observation I made was that if AICAM is a major scam, it is an international game whilst local people are just pawns. Both the distributors and the consumers may just be unsuspecting victims of international scams. However, a paradox comes when one considers repeat users of AICAM. How long can a lie be maintained, and someone get tricked all the time? This brings into question whether there are some aspects which are beneficial within AICAM. If something is useful, it will always find consumers, and followers.

The issue of belief also brings into perspective Michael Taussig's observations on mimesis (Langford, 1999). It is simple to argue that AICAM consists of fake practice, which draws its strength from simulating the original ways of healing. As noted above, this will paint distributors as cheats. However, the reality on the ground makes it difficult for one to separate simulations and the truth. It is difficult to believe that any of the different distributors did not believe in their medications. Firstly, most of the distributors lacked the knowhow of the production process of the remedies they sold, being reduced to merely being symptom checkers who would prescribe medication through looking up symptoms and diseases in a manual. Secondly, the assurances and guarantees which distributors gave were filled with an inexplicable trust in their products, such that any slight insinuation that they are selling products which did not in any way assist in healing people, was met with disapproval and anger from the distributors.

Imitations could also be multipronged such that it became extremely difficult to establish the original model and the direction of mimicry. From the machines used in diagnosis, the pills distributed to the herbal concoctions found in AICAM, it was evident that three interrelated field of healing were linked in a circle of imitation and models. Historically, appropriation of medical knowledge has always been part of the trade, with specialists peeping into rivals' knowledge books, to steal whatever could provide solution to different illnesses.

Inasmuch as one can acknowledge a relative popularity of AICAM products, this does not mean everyone has had a pleasant encounter with this healing system. The study also came across people who are bitter about AICAM, who felt they had been conned by these foreign medicines. One case was that of a lady who had been diagnosed with a disease at the hospital. She took some of the herbal products and almost died as her situation became worse. She therefore lamented the negative effects of the herbal products as well as the life-threatening risk which she had been exposed to. Together with her family, she vowed never to use anything which was not certified outside the formal biomedical framework. Some also complained that AICAM was a waste of money and precious time which could only worsen the situation of the patient. As one respondent noted,

> Consider my situation, I suffered from pain in my feet and some of these fake healers brought what they called herbal and natural remedies to me. Instead of getting better, there was no change from the pain. Actually, their medicines had negative reactions to my body as I ended up being hospitalized.

In the search for a cure, not everyone gets successful, and it is always easier to lay the blame on either the unqualified, negligent healer, or to doubt the efficacy of medical remedies which one is given. Though the contraindications of the medicine were an antithesis of the supposed 'natural' and 'no side effect' argument put forward by the distributors, it is difficult to pinpoint whether it is the medicine which is bad, or it is the body which has rejected treatment. This makes the search of a cure an uncertain journey, where one can be directed the wrong way by different opportunists. The multiplicity of medical advice and remedies makes the process difficult for the average (wo)man and making a rational decision in the face of illness may be a difficult task.

6.8 Conclusion: searching for certainty in an uncertain part of human experience.

Our quest for authenticity can never be achievable though people would keep on searching for the right medicine. Medical truths and knowledge can never be complete. This incompleteness can result in medical uncertainty, a situation which leaves the patient in a jungle, searching and sifting for remedies among different and often confusing truths. However, within this jungle of seeking to feel better, look better and live healthy, the urbanites could be seen to utilize the habitus as a compass as they search cures in different areas. From the chapter, there are various factors which influenced the habitus and reengineered it to influence AICAM consumption patterns. The internal issues included tradition, experience, and science. AICAM falls in the domain of the familiar as it has managed to incorporate features of both the traditional and the modern scientific knowledge. It uses machines which mimic science, and it uses products which are like the traditional herbs which people are used to. This creates a familiarity, such that AICAM does not depend on strangeness or shock value to find clientele. At the same time everything which AICAM has to offer presents links and pointers to what is already known and what has already been experienced in seeking healthcare.

The chapter also notes that issues of illness and healing are characterized by a lack of certainty on the outcome of the healing process. This vast arena of medical uncertainty makes it easier for anyone to try out whatever they think can help relieve illness and pain. The patient mostly does not mind where the help is coming from as long as they get better or experience relief from the suffering which illness brings. Uncertainty also compromises the authority of the healer since they are not able to guarantee anything. The power then lies in the hands of the patient who must decide what is best for herself. Uncertainty also makes the sufferer opt for

any option which promises a hope of changing the circumstances one finds themselves in. in scenarios of uncertainty, individuals often look to other sources of support which can strengthen their decision making. The next chapter explores the issue of religion and belief, highlighting how it is an essential component of the healing dynamics of AICAM.

CHAPTER 7

RELIGIOUS DIMENSIONS OF HEALING

Is there no balm in Gilead; is there no physician there? Why then is not the health of the daughter of my people recovered? Jeremiah 8.22 (KJV)

7.0 Introduction

Zimbabwe can be taken largely as a religious nation which harbours a rainbow of belief systems. Among them include Traditional African beliefs, which are predominantly composed of localized, clan and family based religious systems. There is also Christianity, which arguably command the greatest following in the country. Christianity also incorporates a wide range of denomination which include missionary churches and African Initiated Churches. Regardless of this rich and diverse religious milieu approaches to health and illness can be seen to be informed by the varied religious ideologies. Religion also plays an important part in disease aetiology and in establishing acceptable standards of dealing with diseases and illnesses. It is against this backdrop that this chapter examines the intricacies characterizing religion and healing in relation to the consumption and acceptability of AICAM. The chapter also explores the ways in which religion has been used to channel people towards accepting AICAM as part and parcel of acceptable healing methods. The usage of religion in the competition for space between different health systems such as biomedicine, spiritual healing and AICAM is also examined. It is my major argument that religion is an important conduit for enhancing the acceptability of AICAM and for setting claim to medical authority. AICAM can be seen to benefit from a process of naturalization where its healing approaches are discreetly enmeshed into the existing cosmologies of health and illness. Hence religion became an important platform, not only for creating an ideology of acceptability around AICAM, but also for setting an elaborate network of distributors and consumers of AICAM products in the city. Medical distribution businesses were built around religious networks of distributors, whilst subscriber bases consisted also of consumers within religious networks. The cultures of religion are instrumental to the acceptability and the creation of practice around both distribution and consumption of AICAM.

7.1 Religious dimensions of healing: Exploring the historical relationship between religion and healing.

The relationship between religion and healing has long roots (Feierman, 1985; Janzen, 1991). In most religions, healing could be achieved through the intervention of supernatural means

(Dueck, Muchemi & Ng, 2018; O'Brien, 2019). It was within the confines of religion to direct healing activities. Most religions have an encyclopaedic approach to social life; hence no part of human existence is left to chance. Everything is ordered, there is a path and expectations which one must follow, and this also applies to healing. As noted earlier, a multi-tiered health system exists in Zimbabwe, which incorporates biomedicine, spiritual/faith healing as well as indigenous healing (Machinga, 2011). However, the spiritual permeates all sectors and types of healing since the ultimate power to heal is often traced back to the religious deity (Opoku, 2018; Steinhorn, Din & Johnson, 2017). In indigenous healing, most of the time the healer occupied the position of an important religious specialist. She could be a medium of the spiritual and most renowned herbalists often credited their expertise to the supernatural guidance of their ancestors who could show them specific herbs through various supernatural means including dreams and revelations during episodes of spiritual possession. Faith healing, on the other hand often depended upon direct supernatural intervention as seen through belief that one could be healed by the laying on of hands (Musoni, 2018). Even where different paraphernalia are used, they are believed to carry the power of the instruction of the deity to stimulate healing. Hence, one could take ordinary water then pray for it and give the patient as a remedy for illness (Mahohoma, 2017). Healing therefore could not be entirely divorced from the religious aspects, since religious ideologies helped in forwarding coherent explanations into how illness occurs as well as the path to recovery and restoration of health. The religious could also outlaw certain ways of seeking the restoration of health. Hence, regulations of types of substances which one could consume were determined by religious ideologies. Acceptable ways of healing were supposed to correspond with these prevailing religious ideologies on health and healing. The acceptability of AICAM products, thus rested on their ability to conform to the religious cosmologies of the respondents under study. Several Christian denominations could be seen to be against the usage of herbs, which they associated with ancestral worship and evil spirits. To consume herbs was equated with worshipping spirits which were viewed as evil and against the principles of Christianity (Machinga, 2011; Rugwiji, 2019). Extreme cases of religious prohibitions on herbs could be seen in some African Initiated Churches which were even against consuming biomedical medicines. For them prayer, and holy water are adequate to deal with any ailments which their followers encountered.

In a way, AICAM healing products managed to appeal to the wide spectrum of beliefs on religion and health. In situations where patients were faced with dissonance between their

religious beliefs and the consumption of AICAM products, often there was a reinterpretation of religious doctrines to ensure that the patient's faith and her actions were congruent. Religious reinterpretations worked to sanitize the consumption of medicines. It was also not uncommon for some individuals to sneak behind fellow believers and church leaders as they sought different solutions to their health problems (Chavhunduka, 1998; Rugwiji, 2019). Those who clandestinely sought help from prohibited quarters, often reinterpreted the beliefs to justify their actions. They would question church doctrine or appeal to having no choice because of the desperation of the situations. Moreover, contemporary religious practices are also shaped by current trends in the society at large. The acceptability of science-based healing as well as current emphasis of a return to natural organic healing also seem to be important current trends which also influence perceptions towards AICAM products.

7.2 Zimbabwean religions and illness

Zimbabwean religions often regarded illness as something which fell under the religious purview, hence warranting religiously acceptable ways of dealing with such phenomena. Consider several patients I encountered during fieldwork, some professed religious reasons for shunning certain types of healing. For instance, some religious groupings were against the usage of any form of medication, apart from holy water which was given at church. AICAM also suffered the ostracization of herbal use, since it was something closely associated with ATR. Hence the conflict between Christianity and ATR could also be seen to shape the acceptability of AICAM products among some believers. Some Pentecostal denominations have been known to go to extremes when it comes to healing issues, insisting on the laying on of hands as an exclusive method of being healed by faith (Gunda, 2004; Machinga, 2011; Musoni, 2018). Taking substances could be interpreted as having little or no faith since one was expected to get healing simply through faith in prayer and the laying on of hands (Musoni, 2018). Hence, there is often pressure on believers to boycott other health seeking avenues. Religion appeared to be an overarching aspect controlling one's worldview, including one's approach to health and healing. It could even determine the consumption of biomedical products, with some religious beliefs having reservation on invasive surgery, blood transfusion and other medical procedures, for instance the Korsten basket makers (Masowe Apostles) have been noted to be strongly against the use of biomedicine (Dillon-Malone, 1978). They have been noted to only accept going to hospital in extreme circumstances such as accidents and deep cuts, but since that act constituted a defilement of the individual, ritual purification was

supposed to be done before the individual is readmitted into the congregation (Dillon-Malone, 1978). It has always been a difficult task to remove the religious from the everyday life. Hence, in most instances the religious has been used as an overarching ideology informing other life processes including healing. People would pray over medication, pray for the patient, and even pray after recovery. Therefore, religion is always there every step of the way. As Shoko (2018) asserted, healing traditions among the Karanga have mostly been informed by a religious approach which is seen from diagnostic as well as treatment approaches. Shoko found that diviners are often in the matrix of diagnosis and treatment of diseases, whilst paranormal experiences including dreams and spiritual possession are sometimes used to secure the cause of an illness and its cure. Hence, there has been an interface of religion and healing. Taru (2019), discusses how one Pentecostal Charismatic Church (PCC), follower professed to receive healing through a dream. He dreamt the leader of the church pouring water on him whilst having a bout of abdominal pain. When he woke up the pain was gone and from that time, he never experienced a similar kind of pain which had troubled him for many years. This showed the importance of religion in healing as people believed one could be healed even in their dreams.

Moreover, the spiritual has often been regarded as another source of illness. A spirit seeking attention of its family could cause an illness which could only be resolved after performing the required ritual procedures. These were done to appease the spirit causing the illness, since illness and death could be interpreted as a form of punishment from the spiritual world. Dreams, and visions were also other sources of diagnosis within the Karanga community (Shoko, 2007). These usually pointed to a communication between the living and the spiritual world. Hence traditional healing in Zimbabwe is something which is deeply embedded within the indigenous religions. The borrowed Christian beliefs also show a similar pattern and approach towards illnesses. the aetiology of diseases within Christianity general often pointed to the fact that diseases are spiritual. One of my Pentecostal key informants noted that life is more real in the spiritual dimension than in the physical, therefore whatever happens in the physical would have already registered in the spiritual first. Thus, for healing to occur sometimes there was need for exorcism and prayer to rectify the spiritual aspect before the physical healing could occur.

One of my interlocutors, Sophia experienced conflicting views in relation to the religious basis of her illness. As mentioned earlier, she had been diagnosed with uterine fibroids. Prior to her

interaction with AICAM, she had travelled a journey which portrayed the religious syncretism among some individuals in the area under study. Initially, she attended one of the local white garment indigenous churches, prior to her stay in Masvingo urban. As the fibroids troubled her to the extent of causing a miscarriage, she tried faith healing and underwent several prayer and exorcism services. She was given several bottles of water which she was also supposed to pour into her bath water. However, the problem did not go away, as she continued to experience pain. She later relocated to the city where she was staying with a relative who attended one of the mushrooming PCC. The prophetess in the church laid hands on her and placed her on an intensive program of fasting and prayer. The aim was to break the hold of a spiritual husband who was blamed for being the source of not only the fibroids and miscarriages, but general marital problems and marriage breakups. Whilst in the city she also encountered some women in the neighbourhood who recommended her to an indigenous healer. The healer diagnosed her with *sari/ sare*[6], which she blamed for the problems in her reproductive system as well as marriage breakups, since she had divorced twice. Mostly spiritual and indigenous healers were known to perform the procedure of removing the *sari* which causes bad luck and illness in the woman. The effectiveness of the procedure could not be established since it did not eliminate the problem of the uterine fibroids. In search of a remedy for her problem, she ended up signing up for a free medical check-up and bio-medical surgery organized by some members of the Adventist church. The programme was being done in Chitungwiza and she had to travel almost 400km to have the free surgery. However, the pressure at the medical centre blocked her chance of having the surgery. She claims that a medical doctor she met in Chitungwiza recommended that she uses some AICAM products which he believed could naturally solve the problem. Some Christians could be seen to accept and even at times actively pursue herbal healing approaches, as noted by members of the Adventist church who recommended the lady to try AICAM products.

The interlocutor's story showed different dynamics of religion and its influence in shaping health seeking approaches. The patient had to go through, exorcism, prayer and fasting, consuming, and bathing with holy water, as well as undergoing a procedure to remove a skin growth in the vaginal area as she attempted to deal with her reproductive health struggles. Religion featured prominently in most of her health decision making. It gave her the parameters

[6] A skin growth/ tag in the vaginal area. It is believed to cause miscarriages, marital breakups and even death of the children if the mother fails to have the growth removed.

and directions of thought in relation to what was happening to her body as well as the strategies she could use to deal with the problem. The conceptualization of the cause and the method of treatment was directly linked to the religious belief system which she was in contact with at any stage of her health seeking behaviour. I also inquired about her perceived efficacy of all the remedies she had attempted, but she never showed any doubt in any of the medications. She noted that:

> *Handingoendi kwese kwese but ndinenge ndatonzwawo nekuona munhu anenge abatsirika. Ndotarisawo zvandenge ndichinzwa then ndofananidzawo nezvakasanganawo nevamwe. Asi chinoitika ndechekuti miviri inosiyana uye pamusoro pazvose kuda kwaMwari ndiko kunoitika. Chero ukaedza zvese kana Mwari asati atendera kungoramba uchitenderera*. [I do not just go everywhere. I listen to other people's experiences and try to relate to them. However, what happens is that bodies are different, and experiences may not be the same and above all God's will carries the day. You cannot be healed unless God allows it.

This showed an important dynamic of attitudes towards healing where religion was the ultimate answer to all the question which people had. The difficulties of the efficacy of medicines are that experiences may differ and results maybe contextual since it is difficult to eliminate other variables. Moreover, the religious mentality tends to surrender everything to fate and an attitude of what is meant to will be. When the religious is taken aboard, arguments fall away. However, this may be working in favour of AICAM. It reduces scrutiny towards the product by deferring responsibility to a greater force which cannot be questioned. Rather than confronting the healer or the medication, patients who hold deep religious views often chose to place the blame on the religious deity. Hence, for some patients, questions of efficacy have never really mattered. What they simply seek is getting better, and God willing, they will get healed. Observations among the Masowe apostles noted that religious leaders would pray for an individual before they go to get hospital treatment, pray over the medication and pray after the person gets healed (Dillon-Malone, 1978). Such scenarios allowed religion to claim credit for healing and the medicine would be reduced to just a conduit which is used to transmit God's healing power. God can use anything for healing, including the medicines, or even AICAM products.

7.3 AICAM and religious philosophies.

AICAM appeared to benefit from religious ideologies in two major ways. The first related the creation of a client base who were readily inclined to accept their healing philosophies. Secondly, religion created networks upon which the multi-level marketing strategies of some

AICAM distributors became functional. As noted from the quotation at the beginning of the chapter, biblical verses could be used to persuade the predominantly Christian populace of the acceptability of AICAM even before their religious deities. Verses such as Jeremiah 8.22 were used to give legitimacy to the consumption of herbal products. The claim to being natural by AICAM was in keeping with the cosmologies given by some denominations, who described God's ultimate purpose and plan in creating mankind. One distributor noted that, when God originally put mankind into the garden of Eden, he gave man plants for food and medicine. Hence, any natural and unadulterated herbal product could be utilized as medicine by believers[7]. Some of the verses which a Christian based distributor used included Psalms 104:14 which reads,

> '*He causeth the grass to grow for the cattle, and herb for the service of man: that he may bring forth food out of the earth*' (KJV).

This verse was taken to justify the consumption of herbal remedies since the bible documents that God caused the herb to grow for the service of man. This removed the barrier of religion from AICAM since its claims to be based on natural herbal products seemed to be vindicated by biblical support. Since most respondents claimed to be Christians, this was something which mattered since it directly confronted their belief systems. Consuming medications outside the approved channels was something which the Christian community strongly disapproved. The distributors also used other verses such as Revelations 22:2[8], Exodus 15:26[9] and 2 Kings 20:7[10]. All these biblical passages were imprinted on fliers and used to convince consumers of the acceptability of herbal remedies.

In contrast to the herbal medication of indigenous healers, most respondents held the conviction that AICAM products were acceptable since they did not involve esoteric religious beliefs. One respondent noted that,

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[7] See Genesis 1.29 And God said, Behold, I have given you every herb bearing seed, which *is* upon the face of all the earth, and every tree, in the which *is* the fruit of a tree yielding seed; to you it shall be for meat. (KJV).
[8] In the midst of the street of it, and on either side of the river, *was there* the tree of life, which bare twelve *manner of* fruits, *and* yielded her fruit every month: and the leaves of the tree *were* for the healing of the nations. (KJV)
[9] And said, If thou wilt diligently hearken to the voice of the LORD thy God, and wilt do that which is right in his sight, and wilt give ear to his commandments, and keep all his statutes, I will put none of these diseases upon thee, which I have brought upon the Egyptians: for I *am* the LORD that healeth thee. (KJV)
[10] And Isaiah said, Take a lump of figs. And they took and laid *it* on the boil, and he recovered. (KJV)

Aya maherbs ekuChina akanakira kuti asiyana nezvechivanhu zvine mweya nekupira. Iyi ingori miti. Manje zvedu munhu anototanga abudirwa kuti azive makwenzi [These Chinese herbs are good and different from our traditional herbs which are associated with ancestor worship and spiritual things. These are just herbs unlike our system where one must be possessed to know the herbs.]

There was an evident negative attitude towards indigenous herbal therapies, especially by PCC's followers who often equated indigenous herbs to ancestor worship. Pentecostals were also seen to initiate a complete break with the past, as converts were not expected to have any contact with their past especially elements of indigenous religion (Meyer, 1998). The demonization which happened to indigenous religion during the inception of Christianity painted anything associated with ancestors as evil, hence something which should be shunned (Asamoah-Gyadu, 2014). There was an evident hypocrisy where on one hand people rejected local herbal medicines on the accusation of links to esoteric traditional beliefs, whereas the foreign herbs also bear the imprints of the Asian cosmologies from where they originate. However, the adoption of quasi-scientific explanations and the modern presentation of AICAM products may have helped in removing the stigma associated with herbal therapies and indigenous religious beliefs. Moreover, the fact that these products are foreign removed thoughts linking herbalism to traditional and ancestral worship, which are sometimes viewed as occultic. Even some who were not critical of the indigenous Karanga religion had reservations on the link between herbalism and ancestral worship. Though respondents showed a general drifting away from indigenous belief systems, the modes of thinking on disease causation and remedies, somehow remained embedded within the Karanga cultural system. Hence, categories of aetiology did not change much though there were certain aspects which they were critical of when it came to indigenous healing.

As noted in previous chapters, health and illness are aspects which are often attributed to religious causation, hence requiring remedies which are theoretically linked to different religious beliefs. Healing is often tied to an understanding of the causal agent behind an ailment. Most religious ideas of disease causation linked diseases to the work of evil/an enemy. A general look at most AICAM products will reveal a certain pattern of cosmology. It brings out issues like balance, toxins, good and bad energy. These perceptions about the nature of the body permeate most Asian thinking on the body and diseases. Most medications proceed from

a point of attempting to eliminate toxins from the body, hence the first stage was usually being prescribed to take some detoxification herbs and substances. One of the underlying assumptions was that eliminating the toxins removes the cause for most diseases hence restoring natural balance and health. My interviews with one indigenous healer exposed almost a similar pattern. The patient will be given *chifumuro* (exposing), something which was expected to expose the disease and make manifest the underlying conditions of the ailment. Shoko (2007) noted that *chifumuro*, apart from exposing underlying conditions, could also be used for curative purposes. These ideas point to a congruent understanding of the nature of diseases as something which is a result of interaction with a foreign body. For indigenous, Karanga beliefs, the source of the ailment could also be spiritual hence the herb was expected to expose the hand of evil and render its power useless. A binary of belief where disease is believed to emanate from an outward causation can be seen to characterize both AICAM and indigenous healing. The modern Pentecostal beliefs also possesses a similar aetiological thinking, hence the resort to exorcism in faith healing. The idea of disease as an outcome of possession give credence to the power of outside forces to influence internal bodily dynamics, and correspond to the idea of flushing out foreign disease causing agents (Basure & Taru, 2014).

Indigenous religion seldom understands serious ailments as an outcome of natural causation. It is believed to be a result of the work of an evil source which may deposit foreign object in the body of the sufferer. This has resulted in stories of medicine man removing objects from the body of patients in a process known as *kuruma/kudzura* (biting to remove or supplant a foreign object in the patient's body). Exorcism using ritual incantations and burning of herbs were other methods employed by local healers in dealing with ailments. These healing methodologies created expectations in the mind of patients that sometimes for pain to go away, there is need to remove or expel the source of the illness which would have invaded the body. This created a readiness in patients to be receptive to processes such as detoxification, where they are given medicines purported to flush out toxins which are believed to be the source of illness. Religious beliefs contained a holistic approach to health and healing, characterized by a belief in an overarching base for disease. In the same vein AICAM had a holistic approach which was characterised by a belief that real healing could not occur unless the patient undergoes ritualistic formats of healing. Regardless of the disease, detoxification seemed to be

the magic process believed to usher one onto a journey of recovery and wellness. This showed that AICAM operates in 'familiar' territory, making it a bit easier to find acceptability.

Though AICAM appears to be of foreign origin and is composed of products of an exotic source, it is undergoing a process of naturalization, where it is being adapted to the current contours of belief and aetiology of illness in Masvingo urban. These current contours are also shaped by different things which include historical, indigenous, religious, and modern systems which converge to create a discourse on health and healing. The passages above have exposed how the various religious beliefs intersect to create a discourse which makes AICAM palatable. The modern biomedical practices can also be seen to create another dimension of expectation on how medicine should look like. Biomedicine also seemed to be the most preferred healing system for the modern PCC churches which have taken hold of Masvingo urban. Though issues of faith are considered important in healing, most PCCs do not explicitly ban visits to the hospital, and they seem to support the consumption of modern medicine. The fact that the sale in AICAM products, formed part and parcel of Pentecostal entrepreneurial endeavours seemed to be a rubber stamping of the authenticity and effectiveness of these products. From some of my respondents, prominent figures within the Pentecostal churches, including elders, deacons, and pastor's wives were all seen participating in the distribution of AICAM products. Some workshops and meetings to train and recruit new followers could also be seen being done by sections of the church like the women's fellowships. Though the AICAM products were mostly seen as business empowerment strategies, the fact that it is a business which a Christian could engage in, meant that this was a legitimate and honourable way of earning an income. Hence, even the products themselves could thus be treated as authentic since it is not something which was done behind the church's back.

However, some diseases had natural explanation, especially where foul play was not suspected. It was such class of diseases which could be addressed through the usage of herbal medicines. During the fieldwork I encountered some healers who practiced medical syncretism, borrowing different aspects from different healing traditions. The demarcation between the biomedical, the traditional and the spiritual healer sometimes increasingly became blurred. As noted, before, some distributors claimed to offer medicines for problems which could be considered spiritual and some which could be considered natural. One could distribute AICAM products meant to alleviate sexual problems whilst simultaneously sell products meant to invisibly

control a partner in a marriage, something which would fit perfectly in a spiritual setting. Such scenarios were also common among local traders of indigenous medicines, who also sought to expand their business through selling AICAM products. One woman, who used to sell indigenous medicines also started selling AICAM products, dubbed Indian sweets. They had various forms some for increasing sex drive, enhancing the sexual experience, whilst others were meant to control the man. These included, *chiname* (loosely translated to mean something that sticks, so the man sticks to the woman), marry me sweets, and the forget me not sweets. These behaviour-altering herb-based sweets trigger a behavioural change in the individual through mysterious methods, hence pointing to an esoteric dimension of some of the AICAM products.

7.4 Fake religions and fake medicines: Pentecostal discourses and AICAM.

Perhaps one of the oldest struggles has been to understand the reality of religion. For Karl Marx (1844), 'man makes religion, religion does not make man'. This leaves us with an idea of religion as socially constructed, therefore, essentially true only to the people who subscribe to it. When a truth becomes so relative and particularistic, it creates an idea that it is nothing more than the figment of imagination of a certain group of people, or at best an outcome of that group's creation. In other words, it is a fake religion, with no one else outside of it being able to verify its claims. The same applies to the experiences under AICAM. Most claims have been based on anecdotal evidence, with no other source save for the ones who sell and those who consume the AICAM products. It thus appears that we have a discourse of fake medicines and fake religions, whose views and claims are narrow and can only be understood within the framework of a closed group of users. Some respondents from the city who were sceptical of the potency of the medicines expressed doubts on the benefits of consuming the AICAM products. One such man had been struggling with weight issues and he decided to try slimming teas. He narrated how he had been motivated by different online testimonies, where different people testified about the wonders which the teas had done for them. However, after about a month of consuming the teas and altering diet, he did not notice any significant change in weight. The time was more than the expected time frames which some people had been claiming online. Some testimonies were speaking of results within a range of three days to a maximum of two weeks. He argued that:

> *I have done everything by the book, but I do not see any significant progress. I am starting to think that is simply a money-making scheme than actual healing method. These things do not work and if you are not careful you will keep pouring in money without anything in return.*

It appeared there was a growing number of people sceptical about the claims of AICAM products. AICAM has come at a time which is characterized by quick fix solutions in various spheres of social life. Even in religion, some Pentecostal religions grow overnight and falter overnight. It promises instantaneous results, with little input and has grand claims. One could draw parallels between the character of the modern Pentecostal beliefs and the AICAM products which are on offer in Masvingo urban. It seems that the health and wealth mantra which is the maxim for most AICAM distributors in not peculiar to alternative medicine alone, since it has also been found to be prevalent in a particular strand of Pentecostalism which has been dubbed the health and wealth gospel (Mora, 2008). Being a small town, even the people who influence this kind of medicine are the same you will find in some of these modern Pentecostal denominations. The claims from both were extremist with, PCC, forwarding extremist views on religion and belief, whereas AICAM presented outrageous claims on the nature and scope of diseases they were capable of healing. Whereas AICAM had super drugs, Pentecostalism had super healing and super wealth accumulation. The two worlds converged even on the wealth accumulation calculations, with AICAM promising super incomes within a relatively short space of time. Coupled with the gospel of blessings and God's unmerited favour, the combination of Pentecostalism and AICAM created a coherent discourse of living healthy and wealthy in God's blessing. It collapsed together faith and action, where Pentecostalism presented the faith dimension whilst AICAM was the action part. The action could be seen in both the distributor and the consumer. Both AICAM and Pentecostalism could be seen to promote the dual aspiration of acquiring wealth and living healthily.

For the distributor, the sale and distribution of AICAM constituted an avenue for being industrious hence having somewhere where God's blessing could easily manifest. One of the groups which I spent much time with, belonged to the PCC movements and their lives were pretty much occupied with church and selling their herbal remedies. In the words of one distributor, it was, '*the bosom where men could come and pour blessings which would run*

over,' in apparent reference to Luke 6.38[11] which he interpreted the word '*bosom'* as the work which people could come and give you money for. In distributing AICAM products, he was creating opportunity for men to come and bless him. He claimed that God's operation in the realm of mankind was through the normal everyday life activities.

> *There is no way money can just come and rain down on you unless if it comes from witchcraft. You must work with your hands and things which seem ordinary are used by God to deliver his blessings to you. This is how I work with my hands (selling AICAM), and I have seen the hand of God in my work.*

There was a convergence of ideologies which made the sale of AICAM products attractive. AICAM distribution was their source of livelihood and enabled them to earn income so that they could participate in the wider social circles. These circles were mostly made up of likeminded believers and hence there was need for coherence between what one was taught at church and the physical life which one led. One was expected to walk in prosperity and in healing, AICAM seemed to provide an avenue and a promise to achieve both goals. If these people were living a life of illusion, their imaginary world could thus be built upon a fake religion and a fake medicine.

On the other hand, the consumers also claimed their own version of how God could work through their consumption of AICAM products. The pursuit of healing at times proves to be elusive, influencing individuals to go to the extremes in seeking remedies. The dissonance between expectations and reality could influence individuals to look for extra religious methods of propping up their truths. If one could not get well by the simple laying on of hands, they could find other mechanism to try and get better and still attribute the result to their faith in God. Some consumers noted numerous biblical examples where healing could be done through the usage of different paraphernalia. PCCs were inclined to the usage of AICAM because firstly, it was a religion which on one hand encouraged faith healing and the invisible hand of God as a healer, whilst at the same time allowed the usage of foreign healing paraphernalia. The extremist beliefs of PCCs and their belief in following the bible to the letter gave a somewhat uneasy relationship between AICAM distribution and people's faith. As one patient noted;

[11] Give, and it shall be given unto you; good measure, pressed down, and shaken together, and running over, shall men give into your bosom (Luke 6.38a KJV).

maybe my faith is not enough to cause my healing or maybe God will work through these herbs. You can never know the plans which He has for you although I believe it will work out for my good.

Religious beliefs and AICAM created dissonance both in the patient and the healer. It had a bearing on the faith of both parties. For the patient, it evoked questions on faith and a general lack of clarity on how to deal with their illness whereas for the distributor, it reflected on the ethical values which they adhered to. One could not wilfully do things which will question their faith as well as leading fellow brethren onto a path which was anti-religious. The moral compass of the PCC distributors was influenced by their religious beliefs, hence even their business was supposed to reflect their religious moral values. There was an evident reinterpretation of religious beliefs to accommodate the changes brought by AICAM medicines.

Another important aspect they brought out was that it was the individual's responsibility to look after the body, since the body was a crucial tool in service to the Lord. A believer was supposed to be a good steward by keeping their body in the best condition possible. Consumption of AICAM was thus one way through which one could keep their body fit for serving the Lord. The teachings on a healthy lifestyle contained in AICAM distribution was important in drawing out consumers to purchase the products. Individuals could do whatever it takes to have the perfect healthy body which was also an important component of exhibiting a person's faith. One respondent quoted for me a biblical verse concerning the expectations over one's body, claiming that God desired both the body and the spirit to prosper[12]. Thus, living healthily was a manifestation of the physical prosperity of the body. Consuming AICAM was also a way through which individuals exhibited good stewardship over their bodies.

On the other hand, the group of Adventist distributors and consumers whom I also encountered during the fieldwork, adhered also strove to ensure their conduct was not contrary to their teachings and belief systems. This group observed numerous Mosaic prohibitions in a very strict manner. Consumption of any product was supposed to be done in a manner which does not violate the Mosaic code of laws. This placed an even greater obligation on the distributors

[12] Beloved, I wish above all things that thou mayest prosper and be in health, even as thy soul prospereth. (3 John 1:2 KJV).

to ensure that they do not lead others into sin. Therefore, this created a scenario where one had a religious obligation to ensure the purity and acceptability of the products they distributed.

Religion could also be seen in crediting God for the final product of the healing encounter. As one healer captured on his WhatsApp group, we only give medicines, but God brings the healing. This aspect significantly dealt with medical uncertainty. Deferring the authority and potency of the medicine to a greater authority absolved the distributor of any wrongdoing in cases where the medicine fails to work. The distributor/ healer could simply hide behind the fact that they have done what is humanly possible whilst the ultimate power concerning healing lay in the hands of God. This creates an infallible system that highly depends on 'secondary elaboration.' Writing on instances of failure in the use of magic, Evans- Pritchard (1937: 330) notes that the Zande would first canvass for all possible criteria and prerequisites not met to explain failure of magic without questioning the efficacy of remedy, diviner or system (see also Graeber, 2001: 244–245). This constitutes the 'secondary elaboration' whose function is to accentuate the distributor by exonerating him/her. Gifford (2015: 96) aptly terms this 'escape clauses' in situations of failures. In times where there is no healing, patients/believers look up to God seeking reasons for the failure, this leaves distributor and AICAM intact.

An uncanny resemblance to the methodologies of AICAM and religious organizations especially PCCs also existed. A look at how realities are constructed within PCCs could also be seen as similar in the construction of realities within AICAM. Grand claims and the conviction that anything is possible characterise most local religious beliefs. Hence, in faith healing people usually pin their hopes on the conviction that God can change whatever situation they maybe encountering. An analysis of AICAM claims exposes a 'nothing is impossible' attitude, characterised by grand claims to cure even the diseases classified as chronic in biomedicine. Most AICAM practitioners refuse to accept that there are diseases which one may fail to cure and have an unflinching conviction that any disease can be healed through the consumption of their products. Hence most pamphlets will list conditions such as hypertension, cancer, arthritis, and other conditions classified chronic, as things which they can heal. Faith healers on the other hand make such claims that if one believes, anything is possible.

7.5 Religious Communities and AICAM

My initial fieldwork was spent among members of one of the fastest rising Pentecostal Charismatic Church (PCC) followers. The distributors of AICAM I interacted with were knit

together by the religious belongingness. The sharing of similar religious values could be seen to permeate their conduct and relationship as they worked together at the same premises. As noted in Chapter 4 these individuals were brought together by their religious ties, and they shared most of the tools of the trade. These included the office space, the diagnostic QMR machine and the vibrating massager. However, everyone would reap benefits in relation to how many clients s/he managed to serve as well as their capacity to stock enough medicines. The sales which one made were important in determining the individual's level of income. On further interaction with this group, I could not help but notice the congruence of beliefs and motivations, which became an underlying unconscious driver of their quest to succeed. The church which they belonged to, encouraged its members to pursue prosperity as well as to take any opportunity seriously to live the blessed life of a high-income earner. Wealth was one of the unwritten indicators of blessing. The other value was also the aspect of hard work, which encouraged members to take up and not despise any form of work which could result in them accumulating wealth. The desire to have a source of income which could also foster a feeling of belongingness in the church was one of the major motivators in influencing some of these individuals to take up the business of distributing AICAM. Hence, AICAM became part and parcel of penny capitalism in the church (Gukurume, 2020; Maxwell, 1998)

Another major doctrinal teaching which made people cling together was the way in which the church taught its members to work like family (Riches, 2018; Sharma, 2012). A closer analysis revealed that most of the distributors who were working together were united, not by the AICAM business, but by religious ties which brought them together long before their decisions to engage in the trade. The church was the second, if not actually the first circle of family which was supposed to ensure that members are well and relate well. As one of my respondents noted,

> *tiri hama it is my responsibility kusimudzira mumwe wangu. Ndikamuona aine maproblems I do not laugh but help them to be on their feet so that we can all be blessed.* [We are related, and it is my responsibility to uplift a colleague. If he is in trouble, I do not laugh but help them get back on their feet].

This influenced an atmosphere of belongingness, sharing and supporting each other among the distributors. This confirms the strength of the religious values of the family which are emphasized in Pentecostalism. Some scholars have noted the totality of the Pentecostal community as it also influence life not only in church, but also outside the church through

regulating the day to day home experiences of the believer (Maxwell, 2005). Relationships are not confined to the religious but also include the day to day living of the church member. The brotherly or family love therefore translated to attempts at empowering each other through entrepreneurial activities such as the sale of AICAM products. Dube (2018) also notes that African Pentecostalism is bound with constructed familial ties which are important for economic survival. She notes that,

> African Pentecostalism builds networks of survival though creating new kinship ties and channels to borrow or lend money. Everyone is regarded as 'sister', 'brother', 'mother' or 'father' – titles which make the entire church a household (Dube, 2018: 5).

The entrepreneurial endeavour of selling AICAM was also accessed through these religious networks, which created religious communities. Trust and honesty were qualities which were cherished in these familial circles, hence there was higher expectation of moral worthiness which was hinged upon the common sense of familial belongingness (Maxwell, 2005).

A further discussion on the medicines exhibited that this group was mainly concerned with the business dynamics of selling the AICAM products, as opposed to having a genuine interest in the efficacy of the medicine. The issues which they could articulate well were the benefits of selling the paraphernalia, and the income computations which they parroted from the training workshops they held to equip them for the business. The business allowed them to get some income which was key in finding belongingness within the community of believers. From the teachings, it was an irony that someone could be saved and at the same time struggle financially. Hence, believers stretched themselves inorder to gain finances so that they could fit into the common beliefs of the church. Having blessings was also supposed to manifest physically or materially, by the evidence of tangible proceeds of the blessing (Biri, 2018; Bonsu & Belk, 2010; Lauterbach, 2019; Maxwell, 2005). That pressure to be achievers in an environment characterised by limited avenues for formal employment meant that individuals had to hustle inorder to acquire the much-needed income.

Another group which I interviewed was also composed mainly of Adventist believers. Though the thrust of their religious ideology was in direct contrast to the PCC ideologies, their views were also easy to find a foothold in the AICAM discourses. Prior to finding Adventist believers who were engaging in the sale of AICAM products, I had interviewed a woman who had gone to a medical outreach organized by the church. The woman missed the opportunity to have

fibroids removed surgically by biomedical doctors who had been engaged to undertake the medical outreach. The woman was then given an alternative to deal with her fibroids by purchasing herbal medicines from AICAM distributors. From the interviews, I discovered that the Adventists had a strong inclination towards a discourse of wholesome plant-based diets, which they considered to be part of God's original plan for mankind. Hence, the AICAM products seemed to satisfy their desire for a plant-based medicine. Herbal therapy was seen as an ideal way of restoring health and seemed to be part and parcel of a return to God's original plan of existence. It can thus be noted that AICAM products managed to capture the diverse persuasions of prosperity, food, and medicine. Belief systems were reinterpreted to fit into the circle of familiarity. Religious communities were built on ideas and ideologies. Subscription to similar beliefs determined attitudes and patterns of use in relation to AICAM. A community of beliefs meant that certain truths became acceptable as seen in the acceptability of consuming AICAM products. Once they were distributed within religious networks, the acceptability became unquestionable as members of the religious group could readily trust something introduced by one of their own. Coupled with the idea of rank and authority, some people's authority carried greater currency and influenced acceptability. As noted earlier, high ranking individuals including Pastors, deacons, elders, and other influential people in the church engaged in distribution, hence influencing ordinary members to partake in the same activity. Church offices and premises could also be used for stocking and sometimes selling the products. The authority of the religious office was an important power dynamic influencing those who look up to the authority figure to also partake in the consumption and distribution of AICAM.

AICAM benefited from and created religious communities in the city. Distributors organized their networks on religious bases and religion was also important in establishing grounds of trust which made it easier to find trading partners and patients. Religion provided important markets for the distribution of AICAM products since religious networks were also used in finding consumers of the products. One of my key informants noted the difficulty and costly nature of operating an AICAM clinic. Hence to cushion oneself against the operational overheads, people at times find trading partners from their religious networks and share the rental costs and at times the equipment required in the trade. Trust, also another important currency in the distribution of goods, was built upon religious bases since individuals were ready to trust members of the same faith. This translated into even extending credit lines of

products such that some who did not have capital could be given goods to sell and pay after they make sales. This confirms several studies which have noted that Pentecostalism is an important determinant which provides a foundation and motivation for entrepreneurship among believers (Agyeman & Carsamer, 2018; Ojo, 2017). Linkages outside the city could sometimes be traced to the trust built on religious foundations. One can note from the case of the woman with fibroids, who was referred to herbal treatment by an Adventist doctor. The distributors whom she consulted in Harare, belonged to the same faith, and since she resided in Masvingo, they passed her own to other distributors in the city, who were also Adventists. Hence, religion could also be taken to be an important dynamic structuring a web of relations necessary for survival in the business of trading AICAM. Religion created intercity communities, where networks of relations could be establish outside the city and sometimes outside the country (Elo & Volovelsky, 2017).

The phenomenon of religious communities and their interaction with AICAM also shows that the dynamics of AICAM could be conceptualized using the concept of religious social capital. Borrowing from the Bourdieusian concept of capital, the idea of religious social capital captures the ways in which belongingness in a religious group was instrumental in facilitating the consumption patterns of AICAM (Collyer *et al.*, 2015; Maselko, Hughes & Cheney, 2011). The arena of healing is a contested social space which depended on various types of capital. From the trust which distributors earned, which facilitated the buying and selling of the AICAM products, to the actual trade with consumers/patients, the importance of religious based networks could be observed. Hence, religion became an important capital which influenced the circulation and consumption of alternative therapies. Apart from the connections, religion also allowed the accumulation of certain knowledge which was crucial in the acceptance of AICAM products. Knowledge and attitudes towards herbalism and other forms of healing were at times accepted due to the acceptability of the remedies in religious knowledge.

7.6 The thrill of foreign Gods and beliefs.

Though people could be influenced to structure their health seeking behaviour by their religious orientation, a good story is usually a good enough reason to draw some followers. Consider the story of the massage therapist, mentioned in chapter 6, who was using some form of heat therapy to help people suffering from different ailments. The story about his therapy was shrouded in an interesting and exotic story which was embellished in some form of belief.

When I asked about how his method brought healing, he went into a lengthy narration of how the healing method started. He claimed that:

> *There was a jade stone, somewhere in Japan which possessed some healing powers. People would go there and lean on the stone and get healed. The founders of the heat therapy then extracted that jade stone and infused it into the heat massage. This machine works by putting pressure to the six points on the spinal code, which are responsible for general wellness in other parts of the body.*

Further research showed that the jade stone has an important place in Chinese and most Asian healing systems since it is believed to possess purifying qualities. It is also expected to protect the one who wears it and improve their health. Hence the therapist claimed to combine acupuncture, *feng shui* and western methods to bring out one powerful healing method. There was an element of infusing Asian healing beliefs into modern technologies to bring out a contemporary version of AICAM treatments. Even the processing of common herbs into capsules, pills, powders, and injection, was in most cases a repackaging of traditional Asian beliefs into contemporary forms of medication. However, the hold of Asian religious, traditional, and spiritual concepts permeates most of the products which are sold on the AICAM market. The way in which some of these foreign traditional, religious, and spiritual concepts were explained drew considerable interest which captured individuals' curiosity. During observations, I could see respondents listening intently and following the gifted orators of the Asian healing story, culture, and beliefs as well as how these promoted healthy lifestyles. The convincing and colourful stories were sufficient to influence some, especially who had minor conditions, to try out the medicines. Those with terminal illnesses also readily agreed to claims which gave them hope for healing.

Interviews with some consumers revealed that though the stories might have been captivated, they did not feel any connection with the foreign religion but rather felt that they could also get something useful from these exotic healing methods. One respondent noted that the stories felt more like folklore and fairy tales though she felt this desire to try out the products advertised. The stories behind the product were an important selling point for rousing curiosity. Moreover, the exotic and distant nature of the religious claims did not interfere much with local religious conceptions, hence people did not feel like they were breaking their own religious values. There was a form of disconnectedness which foreign products brought with them. This made them

far better than their local counterparts. Contrary to the observations made by Taussig (2010), where indigenous communities infused foreign beliefs, there was a disconnectedness, where people appropriated the medicine and wove it into local frameworks without consuming the foreign gods. This disconnectedness came from a surreal feeling which made consuming AICAM something which could not directly confront people's values and belief systems. It was the realm of the unknown, where local laws, values and beliefs could not capture well. One respondent who used a liquid popularly known as *tsunami*, which was also discussed in the previous chapter, noted that:

> *This is just a rub which I use, and it helps me with pain. I have never thought about whether it is acceptable because I did not even think it may be against my Christian beliefs. I do not see anything wrong with consuming it either.*

For some respondents, these medicines which were being sold freely in shops and some herbal clinics were just the equivalent of over-the-counter medicines. Medicines which people had used and knew could help in different areas. The attempt to question the morality and legality of such medicines was something which they had not entertained in their thoughts. The fascination with the products and the fact that they came from faraway places freed them from the religio-sociocultural dynamics of their production. Unlike local herbs which people could attach to ancestor worship related healers, or some substances which local prophets would give their patients, AICAM products had an anonymous production context which people could not attach values easily. They were traded by the members of the community; people whose belief systems were sometimes congruent to those of the consumers. Thus, the dual aspect of an anonymous production context as well as the exotic nature which brought a surreal feeling could also be seen as helping mask any potential conflicts with the religious belief systems of the consumers of AICAM.

Stories can capture and mesmerize the consumer. Like the hypnotizing effects of the python skin, stories remove the individual from the present reality and teleports them into a phantasy world where anything is possible. Imagine a medicine from a faraway place, which can heal twenty ailments with just a drop of the colourful liquid. Or the magic pill which can give you the desired body within just a week. Or a medicine which can bring the body to its original state just by consuming some herbal substances. Such were the fantasies which characterized the marketing of most AICAM products. Religion, in a way, does the same. The limit of human

reasoning, the mysterious and inexplicable occurrences are all the staff that religion normalizes. Like the phantastic and mysterious medicines from faraway places, which promise relief to any known human ailment, religion does not operate in the dimension of impossibility. Everything is possible if the gods are willing. Though some of them were made up of common herbs used in most of Asia, some were the subject of myths, controversies and larger than life claims. Though the connection with the improvement in health could be hard to establish, the stories sometimes carried patients into a phantasy world where some got back better. As noted earlier, the idea of the exotic is a powerful contributor to the consumption of the AICAM products. The value placed upon distance and effort seemed to add more weight to the acceptability of the medicines. Healers who come from afar, or resided far from patients were held in high regard and often were given greater credibility than local healers, since distance was an important consideration in the acceptability of therapeutic traditions (Parkin, 2014; Raffaetà, Krause, Zanini, *et al.*, 2017). Even in local folklore and contemporary storytelling, cures were not substances which are easy to find but required strenuous effort and sometimes long travels. This has had an effect in qualifying the effectiveness of AICAM remedies by referring to the difficulty in bringing the medicine.

7.7 Conclusion: Redefining the place of religion in healing

The foregoing discussion brings to the fore an important dynamic of health and healing in Masvingo urban, i.e., the aspect of religion. Religion is important in shaping people's worldviews in almost all spheres of life including health and healing. Issues of aetiology and acceptable remedies in the case of illness, are usually outlined from a religious basis. However, the issue of religious syncretism compounds the situation and adds to the varied experiences of the interaction between AICAM and religion. The cosmologies of the production of AICAM and the cosmologies of consumption present two diverse situations which must be considered in an understanding of consumption dynamics. As noted in the chapter, the beliefs shape acceptability, distribution as well as consumption of AICAM products. Religion provides a template of what is acceptable medicine as well as, unacceptable ways of pursuing health. By sitting on the borderline between traditional and modern medicines, AICAM has managed to present faces which appeal to the rainbow nature of beliefs in the area under study. It has managed to give individuals basis for consumption though reasons are as diverse as the religious beliefs. Different classes of beliefs which range from traditional beliefs, Christianity

and other contemporary belief systems managed to find a foothold to justify the consumption of AICAM.

An interesting observation is how the character of AICAM mirrors that of contemporary PCCs in Masvingo. The operation structure, the wide claims and marketing strategies are synonymous, thus presenting AICAM as part of modern-day cultural trends. Such features also include instantaneous healing claims, wealth creation claims and questionable money accumulation strategies, which has earned much of the AICAM traders the label of fake medicines from different theorists. The goals and ideals of both PCCs and AICAM seems to coincide since both claim the result as having a fulfilling life through having more wealth and better health. AICAM distribution has also been noted to be part of the entrepreneurial strategies which empower members of PCCs to achieve the envied goal of blessing through the evidence of wealth,

Apart from dealing with consumption at the ideological level, AICAM can be seen to be reaping benefits from other organizational and cultural dimensions of the church. As noted in the chapter, the concept of community which characterize most of the local religious beliefs, could also be exploited to create a client base for AICAM products. The organizational dynamics have also been crucial in the recruitment of AICAM followers and have proved to be an important dynamic which establish a good support system for individuals seeking to venture into AICAM distribution. Hence the acceptability and business dimensions owe much to the religious dynamics characterizing Masvingo urban. Though the religious was seen as important in influencing the nature and status of AICAM products, the chapter has also noted that the exotic nature of the products, and a general lack of specific religious parameters of regulating AICAM may also be taken to be important considerations determining acceptability and consumption of the products. Having looked at how religion institutionalizes the consumption of AICAM, the next chapter presents concluding remarks by having a relook at the major issues emanating from the study.

Chapter 8

Medicine, alternatives, and consumption patterns

This chapter analyses the major arguments of this thesis and present final arguments put forward by the thesis. The chapter attempts to summarize the interaction of individuals as they seek solutions to their healthcare problems within the framework of AICAM. A number of issues have been discussed which can be said to be pivotal in bringing into perspective AICAM consumptive cultures. These include gender, religion, culture as well as practical issues such as costs. The chapter also revisits some methodological issues which informed this study.

8.1 Thesis arguments in perspective

This thesis has been informed by three major standpoints, which have been used to articulate health and healing experiences. The first standpoint covered in the initial chapters argues that historical contact between different medical systems has ushered in hybridization and mimicry, which is characteristic of present-day medical syncretism in Masvingo urban. Due to cultural contact which dates to precolonial periods, through colonialism and the present postcolonial period, different dynamics have informed and shaped the way medicine is today. Issues of power dynamics have meant that there are differential power relations between medical systems and within medical systems. This not only shapes the designation of some medicines as mainstream whilst others are regarded as alternative and/or complementary, but it also determines the micro relationships between patients and their healers. Throughout the thesis, it could be noted that this aspect determined the character of AICAM, where we can see that AICAM is built around both an acceptance and a rejection of elements of biomedical healing. There is no strict demarcation between the different medical systems as there is a lot of interfaces, borrowing, and mixing of elements from the different medical systems.

Chapter 2 which focused on the historical narratives of medicine brings out the processes which shaped the current global outlook of medical systems. It gave a short journey into the historical events which inform contemporary global medicine, highlighting struggles of domination which divided medicine into mainstream and alternatives. An attempt was made to also situate the study in anthropological discourses of alternative medicine. Of note, is the conceptualization of AICAM which is also revisited in this chapter. Chapter 3 brought the issues closer home by analysing the struggles which brought the current nature of healing approaches in Zimbabwe. These issues have set the parameters which guide patients' quest for

healing. The patient - as the central object in the healing exercise - must negotiate the various ideologies set out in the sphere of medicine. Chapter 4 also looks at the distributional dynamics and networks through which AICAM products move. This is also linked to contemporary and historical factors of contact which have influenced the creation of complex webs of business networks within the country and internationally between countries. The chapter also makes an analysis of the relationship between government and healing, where one can see that political relationships on the international scene are responsible for shaping local health dynamics. Hence, power dynamics shaping relationships between medical systems can also be viewed from a political perspective. The microanalysis of the global contact which influence the adoption of AICAM should be seen in the context of an ideological and political leaning of the Zimbabwean government on Asian states amid the relative isolation of Zimbabwe on the international scene. Whereas Taru (2019) argues that the Zimbabwean state is not a failed state but a captured state, which seeks consolidation of power at the expense of the collapse of other institutions such as health and education, I argue that this collapse is symptomatic of a state at the brink of a total implosion. The state therefore has ended up accepting anything which can divert attention from the imminent implosion and away from the evident failed state institutions. AICAM should thus be viewed as a welcome diversion from malfunctioning international political image, economic, and heath institution. Although one might point to globalization, the directionality of the international contact points to the political dynamics of the Zimbabwean state. Whereas Chigudu (2019) views the cholera epidemic in Zimbabwe as a window into the political and socioeconomic crisis in Zimbabwe, I argue that the proliferation of AICAM also represents an important strategy of the adaptive mechanisms of the state amid the multifaceted crisis. Individual micro-adaptive mechanisms in both health and livelihoods shapes the practice of AICAM and these also occur within the confines of how the Zimbabwean state is situated on the international scene.

The chapter also brings into the limelight the centrality of the individual, who is the end user of the AICAM products, leading us to the second major observation of the study. As noted in the initial chapters, health decisions are increasingly gravitating towards the individual with major decisions lying in the hands of the individual actor (Veatch, 2008). The second major argument articulated in the study brings out the centrality of the body in health and healing. Chapter 5 makes an argument for the ways in which the gendered body is the subject of concern shaping the consumption patterns of AICAM products. How the body is viewed physically and

how it must function practically are issues which feature much in the ideologies of healing and the medicines sold under AICAM. Dealing with the gendered body is seen to be shaping the cultural and socioeconomic conditions of society. The search for a cure, therefore, is not only about individual comforts and wellness, but it is also about how the body is viewed and accepted in society. It is also part of the way in which individuals express their social class, their desires, and aspirations, which are of course shaped by the contemporary society we live in. The centrality of the body is also explored further as I explored personalistic ideologies and individual quests for health and healing in chapters 6 and 7.

The last prominent idea which is visible in chapters 6 and 7 is in relation to how medical uncertainty is a critical factor which informs consumption patterns of AICAM and health products in general. Coupled with the phenomenon of fake medicine, which is explored in most parts of the thesis, it can be seen that the quest for authenticity is salient in people's search for medicines. Hornberger (2019), posits that most of AICAM can pass off as pseudoscientific medicine, and from her experiences, much of the character of this alternative medicine perfectly fits the label of quackery. However, the issue of medical uncertainty complicates people's search for genuineness and authentic medicine. Historical experiences show that what may be yesteryear's fake medicine can end up being today's super drug as in the case of some previously denigrated traditional medicines (Hsu, 2009; Tu, 2016). In dealing with their search of medicine in the jungle characterised by deceit, impostors and grand claims, people resort to various individualistic experiences, which give them a compass on acceptable medicines and those which should be avoided. This includes, personal experiences, testimonies, recommendations from trusted relatives and medical practitioners as well as religious ideologies. Chapter 7 explores in detail how religious ideologies are also integral in the discourses of consumption of AICAM products. Religion sets the conditions for what is acceptable and hence is an important component in consumers' attempts at establishing authenticity in the myriad of medical alternatives.

Though I have not been able to explicitly pass judgement, I have focused on ways in which claims to authenticity are made and sustained. Whilst scholars like Hornberger (2019), trace claims of authenticity to sources such as technology and pricing, I have argued that the acceptability of AICAM mainly resides in its ability to fit into the discourses of the local community. Its ability to identify with local gender and religious discourses may account for

its relative popularity. The state also creates a narrative which is appropriate for AICAM to find acceptability through its Look East propaganda which has been pitted against anti-Western sentiments. Hence, macro, meso and micro level factors coincide to create a default legitimacy of AICAM.

8.1.1 AICAM: Thoughts on a complex medicine

Throughout the study, one sticking point has been the nature of this 'new' version of alternative medicine. As noted in chapters 1 and 2, two factors led me to settle for the acronym AICAM. These included the fact that this medicine existed outside the formal channels, hence the label of alternative. Moreover, the medicine did not seek to supplant the existing formalised biomedical healing structures, thus could be taken as somehow complementary to the existing medical practices. To differentiate it from most of the existing indigenous alternative medicines, I decided to use the Asian origin of the medicine to identify the medicine which I was focusing on. As noted throughout the study, pinning down the alternative medicine to a specific aspect proved difficult due to the vastness of the products used in healing. What proved to be common was the origins and ideological aspects which pushed me to bunch the medical products under the banner of Asian medicines. However further studies may be needed to properly categorize and identify the kind of medicine in question. Healing systems are fluid and permeable, and the process of domesticating them changes the outlook of the medicine and may even transform the original structure and usage. Hence, it is important to explore more on the changing nature of foreign medicine when it is used in other societies. From the study, three strands of AICAM came out. These included products, healing procedures/techniques as well as healing philosophies/ideologies. These three aspects must be explored to fully comprehend the nature and character of AICAM as well as its relationships with the other healing systems.

8.2 Rethinking patient power in healing experiences

If anything, AICAM has increasingly shown that medical choices lie in the hands of the individual. Despite the various prohibitions, advice and sometimes doubts concerning AICAM, it has and continues to draw a considerable following. This ability to survive even in a hostile environment where it is treated as unscientific and unproven medicine, clearly shows that its survival depends on people continuing to purchase products albeit the different challenges. Moreover, people have shown a tendency towards using their own beliefs, intuition, and experiences to make decisions for themselves. Individuals sift through information from different medical systems and make decisions which they perceive to be in their best interest.

The healing experience can thus be viewed as a process which is largely dependent upon the patient's decision making, which is always a person's personal process. Individuals also make use of what has worked for others and for themselves rather than what has been scientifically proven. This makes processes of regulation complex to implement as these are individual driven phenomena, where individuals will always seek both formal and non-formal pathways to ensure their products reach the end users.

The practice of AICAM though it presents novel ideologies and ways of healing should be seen to add to the existing coterie of healing practices. Its usage conforms to already existing patterns of medical consumption which are characterized by multiple consultative processes among local patients. This has been demonstrated through accounts of individuals who will consult biomedical hospitals, indigenous healing, faith healing as well as the newly established AICAM remedies. As noted by various researchers, local patients often seek multiple healing strategies during the course of an illness, depending on different conditions characterizing that illness (Aschwanden, 1982; Ncube, 2012b). Hence, the presence of AICAM does not alter much the health seeking strategies but only serves to add new dimensions of healing which patients exploit. Due to the elaborate and often complex journey of healing, patients often become unable to distinguish or establish the exact source of their wellness. At the end of the day the objective is getting better regardless of the source of wellness.

8.3 Medical pluralism and medical governance

Perhaps one of the emerging observations of this thesis is the structure through which medical pluralism is evolving in Zimbabwe. Whereas it has been observed that medical pluralism has always existed in Zimbabwe, the expansion of and accommodation of different forms of healing point to the ever-changing political and cultural landscape. Whereas chapter 3 has noted that the medical diversity in the post-independent state may have been borne out of a desire to appease the indigenous communities who viewed the embrace of traditional healing into formal channels as some form of decolonisation, the political card can be seen to resurface in the contemporary period which has been characterised by an influx of Asian products on the Zimbabwean market. Though AICAM products discussed in this project were not coming through the formal TCM or state channels, their presence signify a greater relationship and opening of the country to Asian relationships.

The formal side has also witnessed an establishment of a centre for Chinese medicine at the country's largest hospital, as the government portrays a strengthening of ties with the Asian giant (Mugwara & Yuliang, 2020). The centre was opened with the full blessing of the government, signalling a possible policy change towards embracing TCM. Further studies may also need to explore these formal TCM practices which have been registered to examine their contribution to the Zimbabwean medical landscape. Though some scholars have linked the establishment of these TCM clinics as a measure to serve the growing Asian population in Africa, it can be noted that these services are being increasingly directed towards servicing the African populations. Hence, there is need for further research on African encounters with TCM.

The role of the political in medical governance continues to also play an important part. Colonial medicine has generally been seen to correspond to the leading of the colonial regimes, advancing the interests of the colonizing administrations (Keller, 2006; Ncube, 2018; Tilley, 2016). Postcolonial medicine also seems to serve the ideologies and mindsets of post independent governments in Zimbabwe. It may not be just a coincidence that the proliferation of Asian medicines corresponds largely to the period when the governing regime has declared a Look East Policy, characterized by greater links with China. Greater links with the East has brought with it even the smallest product manufactured in Asian countries, facilitating the consumption of medicines which may even be considered alternatives in Asia itself. There is an evident lax in policing AICAM, something which evokes a feeling of kid gloves, characteristic of how the Asian friends have been afforded in other spheres of the economy in Zimbabwe (Alao, 2014).

Medical governance and regulation of medicines can also be seen to be affected by the subjective nature of medicine and healing. As has been seen through consumers' rationality in using AICAM, enforcement which does not take into consideration the perspectives of the consumer may not yield any positive results. Individuals always find navigating strategies to ensure that they access products which they feel may be beneficial to them. The research showed that there is a thriving medical system which exist outside the formal channels, and that system is propped up by the existence of willing clients who patronize the alternatives. Hence though regulation and governing alternatives may be an important issue, the patient and the consumer must be the point of focus as they determine the survival of the systems.

8.4 Crisis medicine and medical adaptation.

Though the outbreak of the coronavirus occurred after the completion of my fieldwork, it also came as I was in the process of compiling my write-up. Some interesting observations were noted as the novel coronavirus took the world by storm. The virus threw the medical field into disarray as experts struggled to comprehend the nature of the disease and the mechanisms to halt its high rate of prevalence. Much of the AICAM world was shaken by the experience as they were not prepared for such a disease, hence in the confusion there was a considerable drop in the activities of AICAM distributors. Questions also arose as to the capacity of AICAM products to deal with the pandemic. However, as new knowledge grew around the nature of the disease, its causation and the most at-risk populations, AICAM practitioners started to twist their narratives so that their medicines could be seen to be relevant in the current scenario. Of note are how immune boosters, and supplements were traded as mechanisms to improve immunity against COVID-19. Since fatalities were high among the elderly and people with underlying health conditions, AICAM practitioners took the opportunity to sell their products as remedies which could deal with underlying conditions and also prepare the body to ward off infection. An interesting perspective emerges of the adaptability of medicine to crisis times. The ways in which narratives are changed to fit crisis situations also shows the dexterity of AICAM. It leads me even to see greater parallels between religion and AICAM. The same manner in which religion is reinterpreted to explain crisis situations could be seen to be almost the same manner in which AICAM got reinterpreted to fit the current settings.

The COVID-19 crisis also exhibited how the state can relax restrictions during crisis and emergencies. We witnessed the birth of various alternative remedies at the height of the pandemic. The government also opened space even for indigenous healers to try out their herbal medicines in the hope of finding a cure to the scourge. At the height of the scourge one indigenous healer was allowed to sell his COVID-19 herbal remedies to willing individuals. Such acts of bestowing power to the healer and the patient reconfirms the difficulties of establishing and enforcing standardized mechanisms in healing. The power remains ultimately in the hands of the patient, whose medical preference carries the day. Moreover, most medicines rise to prominence during times of crisis and uncertainty. Of note, was the increase in the uptake of both indigenous such as *zumbani*[13] and foreign herbal products as remedies to the COVID-19 pandemic. It is such instances, which through exposing the limitations of

[13] Lippia Javanica

biomedicine, encourage the emergence of multiple realities in healing. People are more inclined to pay attention even to discarded ways of healing and those considered insignificant as they pursue wellness.

8.5 Reconsidering the fake

One timeless discussion in the history of medical systems has been the issue of genuine versus fake medicine. In the contemporary period, just like prior historical epochs, we witness the increase in struggles over truth and authenticity among different medical systems. The power struggles can be seen to be within the institution of biomedicine as well as between biomedicine and other medical approaches. During my thesis write up I also observed a Twitter flare up between one medical practitioner, who labelled an AICAM fake, versus followers, some who supported him, and others who were using their personal experiences to support the authenticity of the AICAM product in question. From the responses, the doctor and a section of followers were condemning the product and calling for authorities to clamp down on that specific product. On the other hand, some followers were vigorously defending the product and offering their own experiences as the basis for their view that the medicine should remain on the market. A moral and ethical question thus emanates from such experiences. Should we allow products to be used because they have been beneficial to some people? Should we ban products basing on negative experiences which some people experience? There is a huge debate on the regulation of AICAM products which stem from issues to do with authenticity. Moreover, it does not necessarily follow that only those products which have been proven to be effective from a biomedical perspective should be used in responding to ailments. Whilst there is need to safeguard against false claims, there is also evidence that it will be impossible to eradicate individual choices in the consumption of alternative medicines. The more medicines are banned, the more they resurface on the informal market, whilst their developers can easily hide under persecution and biomedical conspiracy claims. Moreover, how do we deal with the positive results which flow from medicines considered fake? The ethical dilemma comes when we tend to dismiss the medicine because of the unverified process, whilst existing results point to certain positive benefits. As long as these perceived benefits can be testified, it will be difficult to stamp out the consumption of alternative medicines.

I also avoided wading deep into the debate on authenticity, rather focusing on issues which exist in the world of AICAM as well as its consumption dynamics. My avoidance was partly because of my desire to become dismissive of the phenomena when evidence point to a thriving

existing world of AICAM. Moreover, frameworks for assessing authenticity are also political since they depend on different rule books and processes when it comes to what constitute a genuine medical product or technique. Hence, most AICAM products and procedures may not even be able to pass the biomedical tests, but subjecting them to such a test may not bring out much in terms of their functional capabilities and their popularity.

I propose that further studies can be directed towards establishing better policing frameworks for medical claims. Actions which result in medical distributors and manufacturers interpreting policing as persecution, only serve to strengthen their claims to effectiveness. They simply forward a perspective that big capital, global pharmaceutical industries, and the formal biomedical system are reaping huge profits from the health industry, hence the tendency to hide the truth. As long as medical systems exist, struggles over authenticity will remain a contentious issue.

8.6 Conspiracy, health, and healing

Perhaps, one of the most dangerous elements of health and illness issues around the world is the issue of conspiracy theories (Andrade, 2020; Rödlach, 2006). It seemed people are ready to believe that there is a hidden agenda and some kind of collusion between governments, the pharmaceutical industry, and sometimes even evil spiritual forces which are bent on hiding the truth about diseases and their cures. Whereas, under biomedicine, there is a category of incurable diseases, normally referred to as chronic illnesses, to AICAM, everything can be cured if one takes the correct supplements religiously. Those differing approaches have led to AICAM feeding off conspiracy theories where either whatever the patients are told at hospital are half-truths or are narratives pushed to create profits for the big pharmaceutical corporations. Moreover, some of the conspiracies make claims that the pharmaceutical industry is not being truthful about the effects of their synthetic drugs, which are seen as inferior to natural herbal medicines. AICAM benefitted much from this atmosphere of suspicion, where people's faith in science and medicine is already questionable. Interesting discussions also emerged during the emergence of the COVID-19 virus which came in late during my write-up. It was evident that all kinds of people from the laymen, the preachers, and even top academics, were easily swayed into believing claims by conspiracy theorists. It is my wish for a further exploration of the links between conspiracy theories and the consumption of alternative medicines. Future studies can also interrogate the life and dynamics of conspiracy theories in health and healing. A point to note is that conspiracy may also be seen to be an integral part of the aetiologies of

local people. People have always believed that illness in most cases is a result of an enemy who uses spiritual powers to harm opponents (Rödlach, 2006). Hence conspiracy theories readily find a fertile ground among a people whose belief system usually dictates that illness cannot just occur without someone or something causing it. Hence stories about evil people, and greedy companies, or end time, hiding sinister motives behind diseases and medicines can be seen to be a welcome explanatory category to the ailments which people experience. Therefore, it may be worthwhile to pursue an understanding of the dynamics of conspiracy theories and how they influence experiences in health and healing.

In understanding illness and conspiracy, I have also been drawn to the issues of religion and illness. Historical and current experiences have drawn me to the role which religion plays in fuelling doubt over different disease explanations. As noted in chapter 7, religion is an important ideology which guides the interpretation of different phenomena, including illness. Most religious teachings, especially the faith word of Pentecostal teaching, refuse to accept that there can be anything which cannot be changed if one believes (Chesnut, 1997; Hardin, 2018; Musoni, 2018). Though some diseases may be classified as chronic or are considered to be beyond the capability of any treatment, faith teachings refuse such kind of thinking, believing that there is always a way out. The ways in which AICAM steps in and starts to claim solutions to problems where biomedicine has capitulated, seemed to augur well with the religious thinking prevalent in Masvingo urban. It furthers the discourse of possibility and help provide an avenue of searching health filled with hope that any condition can at least improve.

8.7 Rethinking ethnographic research: some methodological observations

This research had an impact on my positionality as a researcher. It made me rethink the influence and role of the researcher as an integral part of the research process. Undeniably, the researcher's interpretations form part and parcel of the meaning making endeavor. Though, I attempted as much as possible to capture people's original ideas and viewpoints, the temptation to make recommendations and to alter one's viewpoint was ever present. Considering that the research dealt with health issues, where individuals could bring out their experiences and life stories, the researcher neutrality which we seek to observe was difficult as I began to empathize with the respondents. Sometimes being a participant drives one to forget the boundaries of research and become engrossed with people's personal lives. With the knowledge I acquired, and observations made, sometimes it was painful to watch people buy products which did not

improve their situation. As a researcher who would be dealing with both the patient and the healer, such scenarios always brought ethical dilemmas as I restrained myself from making recommendations. For the healer, it was not only providing a service, but it was also their work and source of income, and for the patient it was hope for a better functional body. That relationship always made it difficult to intervene or try to change such relationships without upsetting the conditions of the field. I could observe in some instances that some consumers were using their last monies, but their conditions were not changing for the better. However, that continued consumption was a motivating factor giving them hope that one day they will get healed.

Though I participated in the activities of AICAM consumption, it must be noted that my intention was not to alter the ways through which people experience and consume AICAM products. Though some action researchers have tried to use ethnography in a transformative way (Miled, 2019), I sought to use it to bring out understandings of the phenomenon under study. This was partly because of the ambivalence I had in relation to the efficacy of AICAM products and partly because of the sympathetic relations which develop between the researcher and the community under study. Upsetting the delicate relations may have far reaching impacts on the respondents, hence my decision to attempt to bring out a neutral understanding. In issues of healing, bringing out contentious issues such as those relating to fakery and authenticity are usually serious accusations which one cannot just throw at people, especially a researcher who would be sworn to respect the respondents in the study. It is also difficult to imagine having a distributor losing a sizeable number of regular clients after the onset of your study. Hence, I steered clear of judgmental research as well as trying to find victims and villains, but rather chose to focus on understanding the different facets of AICAM consumption.

The study also led me to rethink some methodological features of ethnographic research, especially the idea of boundedness of the research field. Due to the fragmented nature of my research field, my research phenomena were characterized by multi-sitedness. Though my research was largely contained within a specific urban locality, various sites dotted across the city became the research sites. AICAM clinics were numerous in the city, inhabiting different spaces. They operated as different entities, some with similar modus operandi, whilst others had slightly different ways of healing. The term AICAM, therefore summarized different models of healing which coexisted in the same city. Rather than choosing to focus on one

strand, it could be noted that there were various sides to the diversity of AICAM which was crucial to bring out a singular story. The issue of boundedness of the research field was therefore difficult in the nature of the research I carried out. The desire to bring out a singular story, points to methodological holism, which I felt I had to do in an arbitrary manner. The bunching of many micro practices, under a large acronym, though pragmatic and practical, made it difficult to capture some tiny details of individual alternative medical practices as I focused more on commonalities among the different brands of AICAM. However, the uncanny resemblance of the modus operandi of AICAM convinced me that much could be gained from studying them as a system rather than unitary practices. The same way biomedicine can be composed of different branches which create one system was applicable to the operation of AICAM. However, further research may be diverted towards understanding individual systems.

Moreover, the trouble for mapping out boundaries for ethnographic research can be seen in the ways I struggled to find particular strands to follow. Even during the write up, some information could not be absorbed and ended up in the archives of unused research data. The arbitrary systematization of arguments and desire to bring coherence to the story, makes the ethnography a product of more of the writer's choices of the information to use.

8.8 Final thoughts: medical systems in transformation

This research has roused certain thoughts in relation to the shifting dynamics around the consumption of medicinal paraphernalia. As societies change, medical systems also transform in a way which alters power relations, knowledge over diseases and approaches in healing. The search for a cure is a journey which starts in the mind of the sufferer and takes them through different pockets of seeking ameliorative care. The centrality of the patient is therefore an important consideration in understanding the functioning of medical systems. However, the individual is also influenced by a plethora of internal and external forces which affect their position in the medical system. The politics of the day, the sociocultural dynamics, and the options available to the individual are important in determining the course of action in searching wellness.

Whereas formal medical systems have often projected an image of being coercive, all powerful across the world, the study points out that individual choices and actions are crucial in shaping the character of medical systems. Contemporary medical systems can thus be seen to be

influenced by the individuality and fragmentation characteristic of postmodern societies. In a way, medical systems are being forced to bend to accommodate alternatives which sit outside the formal biomedical system since they are increasingly becoming a force to contend with.

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ANNEXURE

APPENDIX A: CONSENT FORM

Informed consent forms

Study Title: In search of a cure. Experiences in alternative medicine in Masvingo Urban, Zimbabwe.

Principal Investigator: Hardlife Stephen Basure

University of Pretoria

This informed consent has two parts;

- Information sheet (to share information about the study)
- Certificate of consent (for signature if you chose to participate)

Information Sheet

I am Hardlife Stephen Basure, and a PhD student in Anthropology at the University of Pretoria. As part of the requirements of my degree programme, I am undertaking a study on the experiences in alternative medicine in Masvingo.

Purpose of the research

The research aims at understanding experiences in the utilization of alternative medical care. It seeks to document the character and dynamics surrounding alternative medicine in Masvingo.

Participant Selection

You are being invited to participate in the study because you have admitted that you have had experiences in alternative medicines either as a consumer and/or a distributor.

Voluntary Participation

Your participation is entirely voluntary; it is your choice whether to participate or not. You may even withdraw in the middle of interview process.

Procedures

I am inviting you to participate in the research project, if you accept I will personally ask you the study questions. as I will also be recording our conversation. You may choose not to answer any question and request to move to the next question. Your identity will not be captured in any form and should you wish to remain anonymous, I will not disclose your details in any way.

Risks

I am asking you to share some personal and confidential information and you may feel uncomfortable talking about some of the topics, you do not have to answer any questions if you do not wish to do so and that is also fine. You do not have to give a reason for not responding to any question.

Benefits and Reimbursements

This is an academic study which you are being requested to participate in voluntarily. You will not be provided any incentive to take part in the research. The study is meant to generate knowledge and will not culminate in financial benefits to you.

Sharing results

The results of the study will be shared with the University of Pretoria and study participants will be furnished upon request.

Right to refuse or withdraw

You do not have to take part in the research if you do not wish to do so and choosing to participate will not result in any benefit accruing to you. You may stop participating at any time that you wish without any consequences thereafter.

Who to contact

If you have any question you can ask them now or later, if you wish to ask questions later you may contact Hardlife Stephen Basure on email u17313122@tuks.co.za phone +263776234037.

Part 2

Certificate of consent

I have been asked to participate in research about experiences in alternative medicines. I have read the foregoing information/it has been read to me, I have had the opportunity to ask questions about it and any questions I asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study

Name of participant: _____

Signature of participant: _____

Email or postal address: _____

Date: _____

I confirm that the participant was given an opportunity to ask questions about the study and all questions I asked have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent and the consent has been given freely and voluntarily. A copy of the informed consent form has been provided to the participant.

Name of Researcher / person taking consent: _____

Signature of researcher: _____

Date:- _____

APPENDIX B Interview guide

This is a guide to issues that were be explored during fieldwork interactions. Some sections are reserved for consumers whilst others are specifically for practitioners. Questions were not necessarily follow specified sequence but were act as a checklist for issues to be discussed.

1. Introduction

- Firstly, make introductions and complete the consent formalities.

2. Biographic data

- I asked the respondents to furnish me with such details as age, marital status, employment and educational status, place of residence.
- Can you tell me a brief history about yourself?
- How did you come to know about AICAM?
- Can you tell me about the issues which led you to seek AICAM?

Probing: Follow-up questions were encouraged respondents to reveal more about their life histories in relation to health seeking behavior. Practitioners were also encouraged to reveal more on how they came to be involved in treating people using AICAM and what they have been doing before venturing into the field of AICAM.

3. (For Practitioners) Knowledge and training for AICAM?

- How did you venture into AICAM healing?
- How long have you been involved with AICAM?
- What are the requirements which you had to fulfill before becoming a practitioner?
- Is there any specialist training required and where did you acquire such training?
- What methods and techniques do you employ in healing patients?
- How do you relate with other healing methods and practitioners?
- Do you operate as an individual or do u have organizational support?

Probing: Follow-up questions were probe issues in relation to the relationship between practitioners and authorities as well as their motives and experiences.

4. (For consumers) Knowledge and consumption of AICAM

- Who introduced you to AICAM?
- For how long have you utilized AICAM products?
- In what ways and circumstances have you taken AICAM?

Probing: More information on patterns of usage, time, and situations as well as rationale behind such consumption. Patterns were also observed paying attention to how different sexes consume AICAM products

5. Experiences in utilization of AICAM

- What have been the benefits which you have experienced from utilizing AICAM?
- How do you compare your experiences in AICAM and other types of medication which you have come across?
- Would you recommend AICAM to others and why?

Probing: both consumers and practitioners would be encouraged to tell their experiences in either consumption and/or distribution of AICAM products.

Thank you for your time and participation.