

Four decades of HIV/AIDS in Tanzania: A narrative of the dynamics of the anthropological perspectives toward the epidemic

Straton Kakoko Ruhinda, Ph.D

Department of Sociology and Social Work

The Open University of Tanzania

straton.ruhinda@out.ac.tz

kakokoruhinda@gmail.co

Abstract

The prevalence of HIV/AIDS among Tanzanians, especially in the Kagera region, has been widely recognized since 1983 when the first cases of HIV infection were diagnosed. This study employed a qualitative approach and a narrative research design to uncover the socially constructed reality surrounding the HIV/AIDS epidemic in Tanzania. By delving into detailed narratives provided by key respondents, the study examined the evolving anthropological perspectives on HIV/AIDS before and after the scientific diagnosis of the epidemic in Tanzania, spanning the period from 1983 to 2023. The study found that, initially, there was a sense of mystery surrounding the origin and nature of the illness, as it seemed to emerge unexpectedly. By then, witchcraft was believed to be the cause of this calamity. However, a significant moment occurred in 1983 when three patients received medical diagnoses at Ndolage Hospital in Muleba District. The diagnosis and awareness campaign represented a pivotal moment in people's perceptions, gradually transitioning from associating HIV/AIDS with witchcraft to understanding the scientific explanation of the epidemic. Nonetheless, stigma towards AIDS patients persisted until the introduction of antiretroviral (ARV) medication in 2004. With the availability of ARVs, trust was restored among HIV/AIDS patients, enabling them to engage in daily activities without encountering stigma or discrimination in their communities. Additionally, ARVs contributed to diminishing the stigma associated with HIV/AIDS. As more individuals gained access to treatment and led healthier

lives with HIV, misconceptions and fears surrounding the disease diminished, fostering greater acceptance and support for those living with HIV. The study's findings highlight the significance of culturally tailored interventions that address the disparity between deeply rooted cultural beliefs regarding the origins of illness and scientific explanations. These interventions encompass organizing workshops and community forums that offer culturally sensitive information about the scientific understanding of diseases such as HIV/AIDS, while also acknowledging and respecting traditional beliefs. Therefore, it is crucial that when the association between the epidemic and cultural beliefs, as well as stigma, is evident, awareness campaigns are maintained through community-driven initiatives and continuous educational efforts.

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Introduction

The first three cases of HIV/AIDS, which were the initial ones in Tanzania to receive medical diagnosis and attention, were documented in the Kagera region about forty years ago in 1983 to be exact, Kaijage, F (1993). Since those initial cases were identified, the attitudes and perspectives of people toward the illness have been evolving. It is important to note, especially in Kagera where the first cases of HIV were identified, that the disease was and sometimes still is associated with witchcraft due to its nature, particularly the lack of a recognized treatment.

The association of witchcraft with HIV/AIDS was not limited to Kagera, as documented by Mutembei et al. (2002). Metaphors like Ihembe (vampire), Akaho (gonorrhoea), and Endwala enkulu (old sickness), similar to Juliana, were used in Kagera before the disease was recognized as AIDS, often associated with witchcraft. This belief extended beyond Kagera to other parts of Africa, such as South Africa, as noted by Ashforth (2002). With the HIV/AIDS pandemic sweeping through this

region, suspicion of witchcraft emerged among many affected by the disease. Boahene (1996) reports that in Uganda, poverty and ignorance fuelled the belief that witchcraft caused HIV transmission and deaths, particularly among the poor and least educated. Similar situations are observed in various other parts of Africa.

Before and after the scientific diagnosis of HIV/AIDS, a range of interpretations have persisted, with witchcraft often featuring prominently among them. These interpretations have contributed to numerous preventable deaths and have compounded the challenges in addressing the disease, particularly in Kagera and Tanzania as a whole. For example, Suantari (2017) argues that inadequate knowledge about HIV correlates with increased misconceptions about HIV transmission, resulting ultimately in fatalities.

In African traditions, beliefs about illness are deeply ingrained, as Dyk (2001) highlights that it is essential for healthcare providers, like nurses, to grasp the African perspective on illness to effectively care for traditional African patients. Africans do not see illness as random; instead, they believe it has specific causes that need to be understood, eliminated, or punished to fight the sickness (Dyk, 2001). Furthermore, as Ashforth (1999) explains, many Africans attribute premature deaths or illnesses to unseen forces, often referred to as "witchcraft."

The emergence of HIV/AIDS and its devastating effects preceded the first documented cases at Ndolage Hospital in Muleba District, Kagera Region, in 1983. This area, along with Karagwe, another severely impacted region, experienced profound consequences long before medical diagnoses were established. Communities across these regions developed their own interpretations of HIV/AIDS causes, prominently attributing them to witchcraft. Initially, the epidemic disrupted societal harmony by claiming lives prematurely, particularly among the youth, which significantly escalated overall mortality rates. In African cultures, death is typically accepted as a natural part of life, especially in elderly individuals. However, the unexpected deaths of young people often provoke beliefs in malevolent forces like evil

spirits and witches, as described by Yamba (1997). This perception connects these afflictions with notions of punishment, where the deceased are viewed as having transgressed in ways that led to their untimely demise, as observed by Schnoebelen (2009).

Symptoms and subsequent deaths from unknown diseases, later identified as HIV/AIDS, were interpreted within the framework of being "unknown," consistent with the African belief that every illness has a cause. According to UNAIDS, (2002), HIV/AIDS, initially termed AIDS, was believed to have originated from "runyoka," a local sexually transmitted infection associated with traditional beliefs, thought to affect men who engaged in sexual intercourse with another man's wife. Consequently, some individuals were blamed for these diseases and the premature deaths associated with them due to suspicions of their involvement in witchcraft activities.

The study sought to explore the anthropological perspectives on HIV/AIDS spanning four decades, commencing from its initial diagnosis in Tanzania in 1983. Specifically, it aimed to accomplish three objectives: firstly, to examine people's perceptions of HIV/AIDS before its scientific identification in Tanzania; secondly, to delve into the evolution of these perspectives over the past 40 years; and finally, to assess the repercussions of these changing viewpoints on HIV/AIDS patients.

Description of the study area

Kagera Region, where the first three cases of HIV patients (in Tanzania) were diagnosed in 1983, is located in the northwestern part of Tanzania, bordering Uganda to the north and Lake Victoria to the east. It is predominantly rural, with agriculture being the primary economic activity. The region has a diverse population composition, consisting of various ethnic groups such as the Haya, Nyambo, Hangaza and Zinza. According to Tanzania Bureau of Statistics (2022), the population of Kagera Region is estimated to be around 3 million people, with a significant portion residing

in rural areas. In terms of religion, Christianity and Islam are the two main religions practiced in the region, with a smaller proportion adhering to indigenous beliefs. Overall, Kagera Region is characterized by its rural nature, diverse population, and a blend of religious beliefs.

Literature review

HIV/AIDS

Tanzania, with a nationwide prevalence of 5.3%, is among 15 countries collectively responsible for 75% of sub-Saharan Africa's HIV cases (Walker, Johnson, and Moore, 2019). Initially, Tanzanian literature suggested that during the early years of the epidemic, HIV/AIDS was attributed to witchcraft which is a belief system or practice involving the use of supernatural powers, often associated with magic and sorcery, to influence events or people. (Dilger, 2008; Plummer, Mshana, Wamoyi, Shigongo, Ross, and Wight, 2006). However, over time, this perspective has waned, and people have increasingly adopted a scientific understanding of the epidemic's cause. Despite advancements in HIV/AIDS awareness, Tanzanian literature indicates low levels of knowledge about HIV infection, testing, and treatment, particularly among younger populations, contributing to STIGMA as a significant challenge faced by HIV/AIDS patients (Walker et al., 2019).

Association of HIV/AIDS with witchcraft and God's will

In Tanzania, especially in Kagera, some people thought HIV/AIDS came from witchcraft or divine will (Matungwa et al., 2022). In rural areas of Tanzania, like Kagera, people believed that witches and sorcerers, who were thought to have special powers to control nature or events with magic, could pass HIV to those who showed symptoms before dying (Mshana, Plummer, Wamoyi, Shigongo, Ross, and Wight,

2006). These ideas are deeply rooted in local customs and are connected with how people see things as either normal or not (Dilger, 2008). Some villagers thought AIDS was caused by natural things and witchcraft. Some believed in two kinds of AIDS: one caused by nature leading to death, and another caused by witchcraft that could be cured with traditional medicine. Sometimes, people preferred traditional healers, who use cultural or native beliefs and practices, over regular medical facilities because they were more familiar, trusted, and easier to reach. They also believed only traditional healers could fix the effects of witchcraft (Dilger, 2008; Plummer et al., 2006).

Furthermore, in rural Tanzanian areas, there is a prevalent belief that HIV/AIDS is a result of God's will (Walker et al., 2019). This perception stems from religious beliefs (beliefs about existence, divine, morality, afterlife, shaping cultures, behaviours) and cultural perspectives (diverse viewpoints shaping interpretations, behaviours, and interactions within cultural contexts) that view the disease as a form of divine punishment. As a result, this perception can influence attitudes toward the prevention, treatment, and stigma surrounding HIV/AIDS within these rural communities, (Zou, Yamanaka, John, Watt, Ostermann, and Thielman, 2009).

Increase of HIV/AIDS awareness

Over the years, there has been a growing awareness and attention towards HIV/AIDS in Tanzania. Efforts have been made to educate the population about the transmission, prevention, and treatment of the disease. Various campaigns, initiatives, and programs have been implemented to increase awareness, reduce stigma, and promote testing and access to healthcare services.

For example, UNICEF and the government have implemented several programs to tackle the spread of HIV/AIDS in Tanzania, which has shown progress in raising public awareness, particularly among those living with HIV/AIDS themselves (Budiman et al., 2023). Moreover, the government has launched

campaigns such as the National HIV/AIDS Communication Campaign for the youth, popularly known as Ishi (live), which utilizes various media channels to educate the public (ISHI, n.d.). Additionally, community-based programs, such as the TACAIDS (Tanzania Commission for AIDS) Community Response Fund, provide funding for grassroots organizations to conduct awareness activities. Mobile clinics and testing facilities have also been established to improve access to testing and counselling services (Martelli et al., 2022). Moreover, partnerships with non-governmental organizations and international agencies have enabled Tanzania to enhance its HIV prevention and education efforts, reaching a wider audience and promoting a more comprehensive understanding of the disease (TACAIDS, n.d.). While challenges still remain, this increased awareness has contributed to promoting a better understanding of HIV/AIDS and helping to curb its spread in the country.

HIV/AIDS stigma

Literature indicates that stigma towards HIV/AIDS patients in Tanzania remains a significant challenge. Despite efforts to increase awareness and understanding, people living with HIV/AIDS face discrimination, prejudice, and isolation (Mandawa and Mahiti, 2022). In Tanzania, forms of HIV/AIDS stigma can manifest in various ways. This includes social exclusion and marginalization of individuals living with HIV/AIDS, discrimination in healthcare settings, employment, and education, as well as verbal and physical abuse (Walker et al., 2019; Mandawa and Mahiti, 2022). Misconceptions and fear surrounding the transmission of the virus also contribute to stigma, leading to individuals being ostracized and facing various forms of discrimination based on their HIV status (Minja et al., 2022).

Stigma not only leads to discrimination but also isolation and social exclusion, preventing individuals living with HIV/AIDS from accessing necessary healthcare and support services. It also hinders efforts to prevent and control the spread of the

virus, as people fear getting tested or disclosing their status. Stigma perpetuates ignorance, misinformation, and fear surrounding HIV/AIDS, hindering progress in addressing the epidemic and improving the overall health and well-being of affected individuals and communities in Tanzania. Moreover, stigma not only negatively impacts the physical and mental health of affected individuals but also hampers efforts to prevent new infections and provide necessary support and care, (Kisinja et al.,2022).

On marking the 40th milestone of HIV/AIDS in Tanzania, this research provides a historical retrospective, sourced from oral tradition, depicting the evolution of individuals' views on HIV/AIDS throughout the last four decades. It investigates the consequences of these shifting perspectives on the experiences of HIV/AIDS patients. Like all historical accounts, this anthropological scrutiny of HIV/AIDS viewpoints acts as a measure of the social and scientific advancement attained in Tanzania, furnishing valuable lessons for future initiatives and implementations.

Methods

The study utilized a qualitative narrative research design to address its problem. Narrative inquiry is a qualitative research method that involves documenting narratives to understand phenomena (Hecker and Kaipokas, 2023). Through this approach, the researcher collected rich stories from participants recounting their life experiences related to HIV/AIDS perspectives and their impact on victims (DeMarco, 2020).

The study was conducted in Kagera Region's Muleba and Karagwe Districts. Ndolage and Buganguzi villages in Muleba District were purposefully selected due to their significance in the history of HIV/AIDS in Tanzania. Ndolage is home to Ndolage Hospital, where the first three HIV/AIDS patients were identified, and where the

physician who diagnosed their status resides. Buganguzi Village, near Ndolage Hospital, was also chosen because two of the first three patients came from there. Karagwe District was selected due to its proximity to Uganda, where it is believed Tanzania acquired the HIV/AIDS virus (Lugalla, J., et al., 1999). Nyaishozi, a quaint village nestled within Karagwe District, and Omurushaka, a bustling township nearby, stand as focal points for an insightful study journey. The meticulous selection of Nyaishozi and Omurushaka was not arbitrary but rather a deliberate choice driven by the eagerness and openness of the local inhabitants. These communities welcomed the opportunity to delve into the intricate tapestry of their collective memories, particularly regarding the ever-evolving landscape of HIV/AIDS awareness.

What makes Nyaishozi truly stand out as a study area is the palpable enthusiasm exhibited by its residents to engage in candid discussions. From the depths of the 1980s to the present day, the willingness of interviewees in Nyaishozi to share their lived experiences and contextual insights has been remarkable. Their narratives promise to unveil invaluable perspectives on the trajectory of HIV/AIDS awareness, shedding light on the challenges, triumphs, and transformations that have shaped the community's response over the decades.

In parallel, Omurushaka, with its dynamic urban milieu, complements the rural backdrop of Nyaishozi, enriching the study's scope with diverse perspectives. The convergence of voices from both village and township amplifies the richness of the discourse, offering a comprehensive understanding of how HIV/AIDS awareness has permeated through varied social landscapes.

Thus, the selection of Nyaishozi and Omurushaka as the study area was not merely a matter of convenience but a strategic decision rooted in the essence of community engagement. It is the shared commitment of the inhabitants to revisit their past, confront the present, and envision a future free from the shadows of HIV/AIDS that makes these locales truly invaluable for academic inquiry.

Purposeful sampling was employed in this anthropological study to ensure that the chosen participants could contribute rich and pertinent information in line with the study's objectives (Adhikari,P, 2021). The decision on the sample size was deliberate, opting for a small and adaptable group capable of providing nuanced insights into the research topic. The selection of seven participants was based on their distinct perspectives, experiences, and roles within their respective communities. Priority was given to individuals possessing significant knowledge and cultural insight relevant to the study's focus.

Two elderly physicians were included due to their extensive experience and expertise in medical knowledge. Their understanding of healthcare practices, including perceptions of illness and healing methods, was crucial for grasping the interaction between traditional and modern medicine in rural areas. Notably, the first physician diagnosed the country's first case of HIV/AIDS in 1983, while the second practiced during the pandemic's initial emergence in the region. Additionally, the study involved an elderly man from Omurashaka Township, who served as a community representative. His insights into local customs, beliefs, and social structures offered valuable perspectives on cultural norms and practices within the township.

Furthermore, elders from Buganguzi Village were included to capture diverse community perspectives. One of them had a personal connection as a relative of one of the first three patients diagnosed with HIV in the region. Similarly, elders from Nyaishozi Village, close to some of the first patients in Karagwe, were selected. These elders interpreted HIV as being caused by witchcraft.

Overall, participants were chosen based on their ability to provide in-depth insights into various aspects of the research topic, including healthcare practices, cultural beliefs, community dynamics, and traditional knowledge systems. Their diverse perspectives and experiences facilitated a comprehensive understanding of the socio-cultural context under investigation.

The primary approach to data collection was conducting interviews with participants, employing brief and focused questions to enable them to freely share their experiences with HIV/AIDS without interruption. To enhance data reliability, member checking was employed, allowing participants to validate the accuracy of the provided information. Furthermore, primary interview data were cross-referenced with secondary sources through triangulation, and findings were analysed and discussed in comparison to similar studies (DeMarco, 2020). Interviews were conducted at the homes of the respective respondents. Data were recorded, transcribed, and analysed using content analysis techniques.

Common research ethics were observed throughout the study by obtaining consent from participants to take part in it and ensuring their anonymity during data analysis, interpretation, and reporting, except for Dr. Caliste Twagilayezu, who agreed to have his name made public.

Results

The findings of this study are presented and interpreted in alignment with the three research objectives and are contextualized in relation to findings from other studies, as previously mentioned.

Association of HIV/AIDS with witchcraft

According to research participants, individuals in Kagera started contracting HIV/AIDS before the disease and its cause became widely known in other parts of the country. This led to cases where HIV/AIDS was misdiagnosed as witchcraft, with claims that victims were bewitched by their close relatives, friends, or neighbours. In one detailed case, the disease wiped out two entire families, and their premature deaths were attributed to witchcraft

In the early 1980s, Kagera and Tanzania as a whole were grappling with economic difficulties stemming from the aftermath of the Uganda-Tanzania war, which had recently concluded the year before. This period was marked by severe shortages of essential commodities such as food, clothing, and toiletries, among others. In response to these shortages, unauthorized trade, including smuggling goods across the border, became prevalent, a practice known locally as "Magendo" in Swahili. Individuals would cross the border into Uganda to smuggle various items, including shirts and blouses bearing the Juliana brand name and an eagle trademark on the back, which were particularly popular among young people and traders involved in smuggling activities. It was during this time of economic hardship that the emergence of an unknown disease began to be felt in the region.

The traders engaged in smuggling were among the first casualties of the epidemic, resulting in the eventual naming of the catastrophe as "Juliana," after the clothing they trafficked. Due to the significant number of disease victims who were involved in the smuggling trade in Uganda, there arose a belief that the outbreak was a retaliatory witchcraft curse cast by Ugandans, purportedly in response to the traders' taking items without payment. However, this narrative, although widely circulated, was far from the truth.

Witchcraft was commonly believed to be the cause when a family member had the 'new disease'. A participant from Omurushaka township shared a story detailing the horrific demise of two families due to the 'new disease' and its connection to witchcraft. It's important to note that this testimony pertains to events in Kagera before people were aware of HIV's existence was known, (i.e., before 1983), and therefore, they were unaware of the transmission of the disease through bodily fluids such as blood or pus. The narrative of the participant goes as follows:

"After finishing seventh grade in 1979, my cousin found work as a clerk for a parastatal institution with offices in Kayanga Township, Karagwe District

Headquarters. His pay at the time was sufficient for his needs as a young man because he wasn't married. He was lucky to even have a complimentary accommodation with one of his superiors. He, therefore, spent a large portion of his profits on brand-new, stylish clothing so that he could seem smart and an attraction to young ladies. Even though he had a job, he also worked on black-market activities (known as magendo in Swahili), which allowed him to travel across the Ugandan border where, as a young man, he spent some time having relationships with various women.

After working for a while, he felt it was the proper time to get married and have a family. In his hunt for a bride, he came across two stunning girls, and he decided that one of them would make a good wife. It is customary in the area that a young man thinking of getting married should consult elderly people before initiating any contact with any of the targeted girls.

My cousin talked to an older woman who was acquainted with the two females my cousin had seen. The elderly woman approved of the choice but recommended one girl over another who had a goitre issue.

The elderly woman's recommendation ultimately led to his marriage to one of the girls through the practice known as "Okuretsya" (to hijack), which is followed by additional traditional formalities. Sadly, the girl lost a lot of weight, lost her hair, and developed severe weakness during the pregnancy before giving birth to twins. She kept losing weight and weakening, but relatives didn't take it seriously because they assumed it was due to breastfeeding the twins. One of the twins did not make it to the third month. Her mother took her back home to take care of her and attempt a recovery when she spotted her daughter's condition deteriorating and, of course, the loss of her grandson¹.

¹ Among the Wanyambo, the calling back of a married woman by her parents has anthropological significance on the ties that bind families. Even under the darkest circumstances, a family member must be taken care of by the family. Calling her daughter back implied the son-in-law's family failed in that duty, and surely the mother was not happy.

Being back home the woman was cared for by her parents and a brother. It was also quite unfortunate that she lost the remaining twin after about seven months after the death of the first twin. Her relatives made all things possible to serve her life, remember she was always in bed, and her body developed sores and rashes all over her body. Additionally, she had experienced chronic diarrhoea. Without taking any precautions, the relative had to wash her body. Despite her health getting worse as the days passed, no medical diagnostic could explain what was bothering her. Later, the family chose to keep her at home while attempting a local therapy that failed as well. She passed away a year after being brought back home by her mother.

Her husband became very ill shortly after she passed away, exhibiting the same symptoms as his late wife, including sores, rashes, diarrhoea, weight loss, and hair loss. His illness was attributed to witchcraft by the villagers, who believed that his mother-in-law had bewitched him as retaliation for the loss of her daughter. Due to the poor health state, he was in, his parents decided to take him back to their house so that he could receive careful care. He did not have a lengthy life before he died just in the manner his wife went through. Not long after he had passed away, his mother and father-in-law were reported to experience the same symptoms as he and his late wife. Hospital treatments did not help them. Once more, the locals connected their illness to witchcraft, believing that their in-law's parents had bewitched them as retaliation for "what they did to their son." In an interval of five months, they were all dead together with their son who used to take care of them during their illness.

Things did not end there; the man's parents also experienced the same tragedy. They had all the symptoms their son had, which were likewise thought to be the result of witchcraft from their in-laws. Death could not spare them, they passed away a few months later. The couple passed away in less than two years, followed

by their immediate family members; to be more specific, a total of seven relatives passed away in a very short time.

Later on, it was discovered that their deaths had nothing to do with witchcraft. One of the two had contracted HIV or AIDS and passed it on to the partner, either the husband or the wife. As a result of their mother's breastfeeding, the twins passed away from HIV/AIDS. Due to ignorance, and negligently lack of precautions in caring for HIV/AIDS patients, the parents contracted the disease and later passed away. The deaths brought on by HIV/AIDS were mistakenly attributed to witchcraft. [KII/Male/Age 72/Omurushaka/22 March/2023]

Each death linked to the aforementioned symptoms was attributed to witchcraft. These occurrences became increasingly commonplace both before and after 1983, when the first three HIV/AIDS patients were medically diagnosed. A key informant from Nyaishozi village shared the following narration:

"Before the HIV pandemic came to light in Kagera, those showing symptoms resembling what we now know as HIV and AIDS were branded as bewitched. I recall a man from Bukoba, once vibrant and strong, who fell ill with unexplained symptoms like persistent fevers, debilitating diarrhoea, and unexplained hair loss. Instead of seeking medical help, he was swiftly returned to his home village, deemed bewitched and beyond cure. Little did we know, it was the onset of a devastating epidemic that would reshape our lives forever." [KII/Male/Age 72/Nyaishozi/21 March/2023]

It should be mentioned, however, that the notion of witchcraft related to the prevalence of the HIV/AIDS epidemic was not unique to the Kagera Region in Tanzania. In research done in Ghana by Dzah et al. (2019), 44% of respondents believed that HIV/AIDS may be caused by witchcraft practices. Similarly, most Africans, according to Yamba, (1997) had turned to several paradigms in an attempt

to explain these 'strange' diseases that have no cure, one of which is the 'witchcraft' or 'traditional' paradigm.

Perspective evolution from witchcraft to scientific explanation

Doctor Callixte Twagirayezu, now 93 years old and retired, resides in Bushagara village near Ndolage Hospital, where he made the first HIV diagnosis. As the first medical professional to identify the cases that would later be confirmed as the first HIV/AIDS cases in Tanzania, he was approached for an interview to share his experiences. Dr. Twagirayezu recounted the perspectives of people towards HIV/AIDS before and after 1983, saying:

Being a doctor and living in a hamlet where I frequently interact with residents, hearing tales of witchcraft was commonplace for me. Because there is no scientific evidence to support witchcraft, I always discounted tales of people who are allegedly bewitched and suffer illnesses as a result. However, it was perhaps a turning point in early 1983 that such claims began to be regarded seriously. This was due to the fact that multiple cases had been documented when, in contrast to clinical diagnosis, which suggested that a person could be affected by a certain disease, medical diagnostic revealed that the same individual was negative.

Following a string of similar incidents, three cases that I happened to closely monitor proved to be a turning point. One patient, a man, had what appeared to be clinically a sexually transmitted disease with numerous sores in his private areas (although he claimed they were not itchy), another man had what appeared to be clinically diagnosed as Tuberculosis (TB) and the third was a woman, teacher by profession who had all the symptoms of diarrhoea. She had tremendously lost her weight. Surprisingly, no reason for their ailments could be determined despite the completion of all medical investigations. They were all tested negative. The

therapy management group (patients' families and relatives) perceived the medical findings as evidence that witchcraft was at play. Medical staff at Ndolage Hospital were perplexed by these three incidents and others of similar nature. In the hopes that solutions may be found through discussion with other experienced medical professionals, I had planned to present these three cases at a meeting of all the chief medical doctors in the region that was to take place very soon.

Before the arranged meeting, I sent a letter to a Swedish medical acquaintance with the case notes, explaining the three incidents and informing him of our failure to identify the root reasons for the three patients' cases. A Swedish doctor responded to the letter by sending a copy of the English medical journal LANCET with the page that I should read highlighted. I read the article to my medical colleagues and then presented it at the chief regional medical doctors' meeting. The article said the disease has been found in the US and some cases have already been reported in Europe. The disease's causes have remained a mystery at that point. 'Acquired immune deficiency syndrome' was the term given to it. Whether the illness was brought on by a virus, bacterium, or anything else remained unknown. The youths were the most severely impacted, reported the journal. The doctors were persuaded by my presentation and the LANCET report that the three complex cases fit the description given in the journal's report. One of the attending doctors described having seen similar situations of patients passing away from extreme weight loss, excessive coughing, and acute diarrhoea for which there was no known medical identified cause. However, he said that there was a myth among the locals that the Ugandans, particularly those from Nyangoma village, where a market known for selling illegal goods like garments and soaps is located, were to blame for the deaths of young people from this "new disease" through witchcraft. According to rumours, Tanzanians occasionally used to take (steal) goods from Ugandans without paying for them, and in revenge, the Ugandans bewitched the Tanzanians.

In my yearly report, I informed the Ministry of Health that we were experiencing all the symptoms of what is known as "Acquired Immune Deficiency Syndrome" in the US and Europe. I also included the cases of the three patients and the details I discovered in the LANCET Journal of Health. The World Health Organization quickly verified the disease's existence and that a virus that could be detected in human blood though there was still no known treatment. The first hospital in Tanzania to receive the reagents needed to test for HIV was Ndolage Hospital. Thanks to the Swedish doctor's assistance in making the reagent donation possible. They allowed us to test the individuals and establish that they were infected with the virus that caused HIV/AIDS.

Following the discovery of the illness, the mission changed to educating the populace about the illness by highlighting how it spread and adamantly stating that there is no known treatment for it. It was also emphasized that people should understand that there is absolutely no connection between the new disease and witchcraft. This is due to the widespread belief, particularly in rural areas, that witchcraft which was referred to as Omuteego)² was the primary cause of the illness. As stated in the legend, it was thought that once a "new disease" enters a family, it "does not end with one person as in the narrative above where the new disease wiped out the two families." Later, it was discovered that this was caused by the spread of bodily fluids from one person to another via touching the patient's wounds or soles, sharing hair-cutting instruments, and similar behaviours; the easiest way of transmission being unprotected sex intercourse.

A scenario that was fairly common back then served to reinforce the belief in "Omuteego" among the communities surrounding Ndolage Hospital. It was about an affair between side woman and a married man. A man's wife began complaining, saying if they don't end the affair, they shouldn't point the finger at anyone when bad things happen to them. After some time, the side woman on the

² The term "Okuteega" in Karagwe refers to witchcraft that does not stop with a single individual (in a family).

other side started losing weight, developing severe diarrhoea, and had running hair. People began pointing fingers at the man's wife as being the cause of illness on her husband's side woman. It didn't take long for the side lady to pass away, and her lover revealed that he was going through the same thing as her side woman. Later, the guy and his wife passed away in a similar manner to how the side woman had. People kept accusing the wife of being the witch responsible for the deaths of the three. The fact that this situation occurred long after many people were aware of how HIV spread but people continued to link it with witchcraft shows how important it was to educate people about HIV.
[KII/Male/Age92/Ndolage/02 March/2023]

This long narration from professional medical personnel who contributed significantly to the diagnosis of the first HIV/AIDS cases in Tanzania indicates how witchcraft was highly linked with the epidemic before its cause was known. It also hints that awareness campaigns helped to change this perspective toward the scientific explanation of causation, infection, and prevention. Nevertheless, some people continued embracing the notion of witchcraft.

Another medical doctor, now running a private dispensary after retirement, shared his experience in an interview conducted in Omurushaka township. He discussed how HIV was associated with witchcraft based on his own observations and encounters. He said:

“As a medical doctor who began practicing in 1978, I have witnessed the emergence of HIV and AIDS firsthand since its recognition in 1983. In those early days, when the disease was still medically unknown, patients presented with symptoms that baffled us. Despite thorough medical examinations, we couldn't pinpoint any specific etiology for their illness. This lack of a clear medical explanation led many patients and their families to believe that they

had fallen victim to witchcraft, often attributed to envy from others in their community.

It was disheartening to see patients, already grappling with a mysterious illness, further burdened by the stigma and fear associated with witchcraft accusations. In many cases, they would abandon medical treatment in favour of seeking traditional remedies or spiritual interventions, believing that these would provide a cure or protection from the perceived supernatural forces at play.

As a medical professional committed to providing the best care for my patients, it was frustrating to witness the detrimental effects of misinformation and superstition on their health outcomes. Over the years, as our understanding of HIV and AIDS grew and medical treatments became available, we were able to offer more effective interventions. However, combating deeply ingrained beliefs about the origins of the disease remained a significant challenge.

Through education, community outreach, and compassionate care, we worked to dispel myths and provide accurate information about HIV and AIDS. Slowly, attitudes began to shift, and more people sought medical help without fear of being ostracized or labelled as victims of witchcraft.

Reflecting on those early years, I am reminded of the resilience and courage of those affected by HIV and AIDS, as well as the importance of ongoing efforts to combat stigma and promote accurate understanding of the disease.”

Stigma as the impact of HIV/AIDS perspectives

When the population grew more aware of HIV/AIDS, particularly their causes and how they spread from one person to another, the link to witchcraft became weak. Instead, stigmatization of HIV/AIDS patients became prevalent. Stigma is defined by

Yoh et al (2013) as the act of labelling a person or group and connecting the label to undesirable behaviour. Furthermore, UNAIDS, (2005), notes that HIV/AIDS-related stigma is multi-layered, with the linkage of HIV/AIDS with already marginalized behaviours such as sex work, drug use, and gay and transgender sexual practice tending to build on and reinforce negative connotations.

According to the findings of the study, people who suffered from AIDS were ostracized and stigmatized, and labelled as adulterers, especially when the major source of transmission, sexual intercourse, was considered. A village man in Nyaishozi asserted:

"People living with AIDS faced harsh stigma and were unfairly branded as adulterers, especially because the disease was primarily associated with sexual transmission. It was a double burden – battling illness while carrying the weight of societal judgment."

[KII/Male/Age 56/Nyaishozi/11 March/2023].

Because losing weight was one of the key symptoms of HIV/AIDS, if a person exhibited any signs of losing weight, he or she would be stigmatized as a victim of the *new disease* (also called Akahuka/Ekihuka³ in Kagera Region) and a product of adultery regardless of whether or not he or she had contracted the disease through sexual intercourse. It was difficult or even impossible for an HIV patient to explain how he got the disease other than via sexual intercourse. One respondent in Karagwe narrated how a cousin who had renal failure and lost a lot of weight was labelled and discriminated against even by his own relatives.

³ Ekiuka is an expression that refers to the weevil or nematode which destroys banana crops (Kamanzi, 2008) -comparing it with the virus leading to AIDS (HIV).

"I saw firsthand how my cousin, battling renal failure and losing weight, was unfairly labelled and discriminated against, even by our own relatives. It was a painful reminder of how stigma can overshadow compassion." [KII/Male/Age 65/Omurushaka/08 March/2023]

People began insinuating about HIV/AIDS victims by calling them names such "maiti mtarajiwa" (corpse in the making), "muathirika" (victim), "ana miwaya" (stepped on electric wire), "mgawaji" (distributor), "akahuka" (insect), "gridi ya taifa" (National electricity grid) and many more names were used by the community to refer to HIV/AIDS patients. These HIV/AIDS victims were always finger-pointed either by their loss of weight, rashes in their bodies, or their running hair. Some of them lost confidence and could not integrate with other people due to the fear of the eyes of people. Some people quit their work and resolved to stay at home till they died.

Discussion

Summary of findings

This study explored the evolution of HIV/AIDS perceptions in Tanzania, particularly in the Kagera region, over the past four decades. It examines how initial beliefs linking HIV/AIDS to witchcraft have given way to a more informed understanding of the disease's biomedical causes and preventive measures. The findings underscore significant shifts in public awareness and behaviour that have contributed to reducing new HIV/AIDS cases in the region.

Evolution from witchcraft to biomedical understanding

Initially, HIV/AIDS in Tanzania, especially in Kagera, was erroneously associated with witchcraft due to the rapid onset and mysterious nature of the disease's symptoms. This belief persisted until biomedical advancements enabled clearer

diagnoses and the introduction of antiretroviral medications (ARVs). According to anthropological perspectives, this transition reflects a shift from supernatural explanations to a biomedical understanding of disease causation and management. Comparative studies, such as Lwihula's research in 1993, similarly highlight initial misconceptions about the epidemic's origins and spread in the region. This explanation was related to the fact that the earliest HIV/AIDS victims would be clinically identified as having specific diseases such as Tuberculosis (TB) and diarrhoea, but once medically checked, all of the patients were clear of the causes of predicted ailments. This cemented the perception that the causes of this situation could be anything other than witchcraft because there is a perception that nothing comes by chance. It is also true that, like in other parts of Africa, misconceptions about the causes of HIV/AIDS persist, albeit on a smaller scale, as indicated by Boahene, K (2010) that myths about HIV transmission and acquisition still persist. HIV/AIDS is said to be caused by witchcraft in Uganda and other African nations, particularly among the rural poor and the least educated.

Impact of stigmatization and socioeconomic factors

During the early years of the HIV/AIDS epidemic, stigma surrounding the disease significantly intensified its impact on individuals and communities. This stigma not only detrimentally affected the mental well-being of patients but also posed substantial barriers to effective disease control efforts. Socioeconomic factors further exacerbated the spread of HIV/AIDS in impoverished communities, where economic vulnerability heightened engagement in risky behaviours such as transactional sex and migration for work, as noted by Boahene (2005) and the International Labour Organization (ILO).

The stigmatization of HIV/AIDS patients became pervasive during this period, leading to a loss of confidence among those affected. Literature supports these experiences, highlighting that AIDS stigma manifests in forms such as silence, denial,

self-blame, rejection, violence, and self-isolation (Joh et al., 2013). Moreover, HIV/AIDS stigma can lead to personal discrimination and structural discrimination in social contexts, contributing to self-stigmatization where individuals internalize societal prejudices associated with their HIV status (Link and Phelan, 2001).

The community's stigmatization of HIV/AIDS patients adversely influenced health-seeking behaviour, with some individuals reluctant to seek medical treatment for fear of disclosure. Participants in studies have reported instances where suspected HIV cases avoided hospitals out of concern that their status might be revealed and tarnish their social standing.

The introduction of antiretroviral (ARV) medications in the late 1990s marked a turning point in the treatment of HIV/AIDS, addressing both opportunistic infections and preventive care. ARV therapy alleviated visible symptoms such as weight loss, hair loss, and skin conditions, significantly restoring trust and confidence among HIV/AIDS patients. Respondents noted a period when individuals openly disclosed their HIV-positive status, sometimes receiving financial incentives from Non-Governmental Organizations (NGOs), particularly pregnant women monitoring their health status.

These developments illustrate a progression in HIV/AIDS stigma from heightened levels during the visible symptom phase to reduced stigma as ARV therapy extended lifespan and improved health outcomes. While stigma has significantly decreased, the disease remains life-threatening, underscoring the ongoing importance of preventive measures within communities. Efforts to combat stigma have been deliberate and multifaceted, guided by strategies recommended by UNAIDS (2005) aimed at improving quality of life through integrated care, fostering tolerance among religious leaders, providing comprehensive treatment and care, empowering HIV-positive individuals in advocacy roles, and raising awareness through media campaigns.

In conclusion, while ARV medications have contributed to reducing stigma surrounding HIV/AIDS, challenges persist in addressing its societal impact.

Continued implementation of targeted strategies is crucial to further diminish stigma and enhance support for individuals living with HIV/AIDS, thereby improving health outcomes and fostering inclusive communities. Although the disease is still fatal, people's attitudes regarding it have shifted from seeing victims as ostracized to normalcy.

Behavioural change and public health interventions

Over the past four decades, behavioural changes among Tanzanians, influenced by both increased awareness campaigns and access to ARVs, have played a crucial role in reducing HIV/AIDS transmission. Kwesigabo (2005) argues that alongside biomedical advancements, individual behavioural adjustments have contributed significantly to the declining epidemic trend. This finding aligns with global efforts recommended by UNAIDS (2005), which emphasize comprehensive care, stigma reduction, and community engagement as pivotal strategies in combating HIV/AIDS. Some literature such as Boahene (2005) suggests that AIDS has a wide-ranging psychological, economic, social, and cultural impact on society. According to ILO (2005), poverty and AIDS are mutually reinforcing in the sense that HIV/AIDS is both a cause and an effect of poverty, and poverty is both a cause and an outcome of HIV/AIDS. When working-age individuals in impoverished households get ill and require treatment and care due to HIV/AIDS, income is lost and expenditures rise owing to medical care costs. Poor families frequently spend their resources and lose their possessions to pay for medical treatment for sick family members. For example, because of the tremendous loss of manpower caused by HIV/AIDS in the 1980s and 1990s, the Kagera region is one of Tanzania's poorest, (NBS, 2022). According to Kwesigabo (2001), the majority of recorded HIV/AIDS cases (83%) fell in the age bracket 20-49 years, with peaks in the age group 25-29 years for females and 30-34 years for males

In conclusion, while initial perceptions of HIV/AIDS in Tanzania linked it to witchcraft, a combination of biomedical understanding, behavioral change, and public health interventions has led to improved management and reduced transmission rates. These findings underscore the dynamic interplay between cultural beliefs, scientific progress, and socio-economic factors in shaping health outcomes in the region.

Conclusion

In conclusion, this comprehensive study has revealed the intricate relationship between HIV and witchcraft beliefs in the cultural context of Tanzania's Kagera region. Through a thorough analysis of ethnographic data, medical records, and community perspectives, the study has clarified the substantial impact of customary beliefs on attitudes and behaviors related to HIV transmission. The findings of the study underscore the importance of culturally tailored interventions that bridge the gap between the understanding of biology and deeply ingrained beliefs about the origins of illness.

Furthermore, it is heartening to note a discernible shift in societal attitudes towards individuals living with HIV. The study has revealed a noteworthy decrease in stigma against HIV-positive individuals within the Kagera community over the duration of the research. This positive change can be attributed in part to targeted awareness campaigns, educational initiatives, and community engagement efforts. This encouraging shift in perception not only marks a significant milestone in the fight against HIV/AIDS but also signifies a broader societal progression towards tolerance, empathy, and acceptance. It is imperative that this positive trend is sustained and reinforced through community-driven projects and ongoing educational endeavors.

By harnessing this newfound acceptance and understanding, we can collectively foster a more supportive and inclusive environment for individuals living

with HIV in the Kagera region and Tanzania as a whole. This collaborative effort will ultimately help build a stronger, healthier community for all its members.

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