

JOURNAL OF CONSTRUCTIVE THEOLOGY
Gender, Religion and Theology in Africa

Journal of the Centre for Constructive Theology

Centre for Constructive Theology
Diakonia Centre, Room E308
20 St. Andrews Street, Durban 4001 or P/Bag 62940 Bishop's
Gate 4008, KwaZulu-Natal, South Africa
Tel/Fax +27 (0) 31-310 3570
Tel: +27 (0) 31-310 3571
E-mail: info@cctheology.co.za

Editor

Isabel Apawo Phiri, University of KwaZulu-Natal.

Co-editor

Sarojini Nadar, University of KwaZulu-Natal.

Language Editing/Layout

Gary S. D. Leonard, University of KwaZulu-Natal.

Editorial Committee

Ezra Chitando, Faculty of Theology, Religious Studies and Classics,
University of Zimbabwe
Philippe Denis, School of Religion and Theology, Univ. of KwaZulu-Natal
D. Betty Govinden, School of Education, University of KwaZulu-Natal
Theresa Hinga, Religious Department, De Paul University, USA
Ogbu Kalu, Faculty of Theology at McCormick Seminary in Chicago,
USA.
Tinyiko S. Maluleke, University of South Africa
Frans Verstraelen, Faculty of Theology, Religious Studies and Classics,
University of Zimbabwe.

International Representatives

Jose Miguez Bonino, Instituto Superior Evangelico
de Estudios Teologicos, Argentina
Lydia Johnson, Presbyterian School of Ministry, Knox College, Dunedin,
New Zealand
Erhard Kamphausen, Missionsakademie, Germany
Ursula King, Dept. of Theology, University of Bristol, U.K
J. J. Ongong'a, Faculty of Arts, Kenyatta University, Kenya
Peter J. Paris, Princeton Theological Seminary, U.S.A
Anthony Reddie, Queens Foundation, Edgbaston, U.K
Dana Robert, School of Theology, Boston University, USA

JOURNAL OF CONSTRUCTIVE THEOLOGY
Gender, Religion and Theology in Africa

Publication Information

Volume 13, No. 1 (2007)

ISSN: 1025-5648

Published semi-annually, in July and December, by:

Centre for Constructive Theology

Physical Address:

Room E308, Diakonia Centre

20 St. Andrews Street, Durban

KwaZulu-Natal, 4001, South Africa

Postal Address:

P/Bag 62940 Bishop's Gate

KwaZulu-Natal, 4008, South Africa

Tel/Fax +27 (0)31-310 3570

Tel: +27 (0)31-310 3571

E-mail: info@cctheology.co.za

The *Journal of Constructive Theology* is a **SAPSE Accredited** Journal

JOURNAL OF CONSTRUCTIVE THEOLOGY

EDITORIAL POLICY STATEMENT

The Journal of Constructive Theology is a semi-annual publication of the Centre for Constructive Theology, an initiative of the former Faculty of Theology, University of Durban-Westville. From 2004 its articles will focus on researched papers, which are relevant to gender religion and theology in Africa. The editorial committee will consider for publication submissions of a scholarly standard from any of the theological disciplines or related fields of inquiry, which provide useful perspectives in the area of gender, religion and theology in Africa. Particular areas of interest include the gendered analysis of: innovations in contextual theological education; theological and ethical reflection on social transformation; the significance of new religious movements and African-initiated churches; the role of women in religion and society; interfaith dialogue; peacemaking and reconciliation.

The Journal of Constructive Theology seeks to promote dialogue and response not only within the academic theological community in Africa and beyond, but also faith practitioners working “on the ground” to build a more just society in the region. These may include clergy, other church professionals and laity across broad social spectrums who seek to read their faith against the critical issues confronting society today.

Written submissions to the Journal of Constructive Theology may take the form of researched scholarly articles or essays. Book reviews, brief responses to articles, conference reports and summaries of research projects are also welcome. Submissions are evaluated through an editorial committee screening process. Further, the articles are also sent to a maximum of two competent scholars working in a similar field of interest for peer-review. Prospective contributors of scholarly articles should send two copies of their manuscripts to the editor by post, typed double-spaced, include full documentation in the form of footnotes and bibliography, along with an abstract and a brief autobiographical statement. E-mailed copies should be in Microsoft Word or Rich Text Format. Requests for a copy of the **JCT Guidelines to Contributors** style-sheet should be directed to the editor, E-mail: PhiriI@ukzn.ac.za. Published contributors will receive three complimentary copies of the issue in which their work is published. Opinions expressed by contributors are solely their own, and do not necessarily reflect those of the editorial committee or the Centre for Constructive Theology.

CONTENTS

	Pages
EDITORIAL	1-4
THE USE OF ANCESTRAL RESOURCES IN COMBATING HIV AND AIDS: <i>MUNDURUME'S</i> TASK <i>Julius Gathogo</i>	5-24
NAVIGATING TURBULENT WATERS: THE CHALLENGES FACING WOMEN TRADITIONAL HEALERS IN POST-APARTHEID KWAZULU-NATAL <i>Radikobo Ntsimane</i>	25-38
THE YORUBA BELIEF SYSTEM AND ITS IMPACT ON WOMEN'S REPRODUCTIVE HEALTH <i>Helen Adekunbi Labeodan</i>	39-55
"AN ACT OF GOD?" THE EXPERIENCES OF GIRL-CHILDREN AND WOMEN LIVING WITH VESICO-VAGINAL FISTULA IN NORTHERN NIGERIA <i>Margaret Azuka Umeagudosu</i>	57-67
CARE-GIVING IN TIMES OF HIV AND AIDS, WHEN HOSPITALITY IS A THREAT TO AFRICAN WOMEN'S LIVES: A GENDERED THEOLOGICAL EXAMINATION OF THE THEOLOGY OF HOSPITALITY <i>Lilian Siwila</i>	69-82

**JOURNAL OF CONSTRUCTIVE THEOLOGY
SUBSCRIPTION ORDER FORM**

Year 2007

1 Year (2 issues)	INDIVIDUALS	INSTITUTIONS
Countries in Africa	ZAR40	ZAR50
All other Countries	US\$40	US\$50
Single Copies	ZAR25	
Elsewhere	US\$20	

ENCLOSED is a cheque or money order payable to the **CENTRE FOR CONSTRUCTIVE THEOLOGY** for a 1-year 2-year Subscription or 3-year Subscription in the amount of ZAR_____, or US\$_____.

[Please the appropriate box]

NAME & TITLE: _____

ADDRESS: _____

TEL: _____

FAX: _____

E-MAIL: _____

Please return this form with payment enclosed to:
The Administrator, Journal of Constructive Theology
C/o School of Religion and Theology
University of KwaZulu-Natal, Private Bag X01
Scottsville, KwaZulu-Natal, 3209, South Africa
Tel: +27 (0)33 260 5540 / +27 (0)33 260 6106
Fax: +27 (0)33 260 5858
E-mail: duguidj@ukzn.ac.za

EDITORIAL

As always, it is a pleasure to bring to you a further issue of the Journal of Constructive Theology. As editors, we must first apologise for its late publication. This past year has been somewhat turbulent, having to contend with a number of pressing issues, including illness, a departmental review and a major Pan-African consultation of the Circle of Concerned African Women Theologians, an organisation which is closely linked with this journal. Notwithstanding these delays, we are pleased to finally offer you five interesting and original articles which we hope you will find challenging, but also make a positive contribution to the study of gender and religion in Africa. The articles are varied in focus and scope, ranging from issues of masculinity to traditional healers, from women's reproductive health to care-giving in times of HIV and AIDS. What the articles have in common is a dialogue with African cultural practices and beliefs and their positive and negative impact on African women and men.

Julius Gathogo's article, **The Use of Ancestral Resources in Combating HIV and AIDS: *Mundurume's* Task**, can, according to a peer reviewer, "be located within a genre of writing in African scholarship that seeks to rehabilitate indigenous resources of knowledge as useful tools that can be utilised to meet the plethora of challenges confronting African societies today. Accordingly, HIV and AIDS, that threatens to obliterate the continent and its people, is but one such challenge. Rather than frown upon African indigenous resources as outdated, this type of writing views them in a favourable light as relevant resources capable of moving Africa forward..."

Radikobo Ntsimane's article, **Navigating Turbulent Waters: The Challenges Facing Women Traditional Healers in Post-Apartheid Kwazulu-Natal** utilises oral history methodology to show how the new political dispensation in South Africa, which should have been sympathetic towards *Sangomas*, has instead been hostile towards them. Due to lack of education, the majority of female *Sangomas* within urban areas live in government low-cost housing which is often too small to adequately practice their profession. This article also addresses other issues including the shortage of land for building traditional medicine huts, growing of herbs and producing food for the trainers and patients, and drumming during rituals. It also deals with the challenge of slaughtering beasts in an uncontrolled environment, the use of protected wild animals and plants, being undervalued by biomedical practitioners and the complex system of health insurance and the labour system in South Africa. Finally, their

problems are compounded by the practice of Zulu culture, which is patriarchal.

In her article, **The Yoruba Belief System and Its Impact on Women's Reproductive Health**, Helen Adekunbi Labeodan outlines the challenges the Yoruba belief system poses to the well-being of women's reproductive health. The article uses a focus group discussion to highlight the issues surrounding pregnancy and childbearing, and the ways in which traditional practices and beliefs hinder Yoruba women from having control of their own reproductive health. Finally, it proffers solutions that might help women in having total control over their reproductive health.

Margaret Umeagudosu's article titled, **"An Act of God?" The Experiences of Girl-Children and Women Living with Vesico-Vaginal Fistula in Northern Nigeria** highlights the horrors of fistula (VVF). A gendered and class analysis of the condition reveals that the condition is mostly found in adolescent girls who have been subjected to early marriage, pregnancy and delivery. The author argues that, "There are many socio-cultural beliefs, attitudes, religious practices, norms and taboos imposed on women by patriarchy which probably account for a large percentage of women's health problems. Early marriage by girl-children is one of the causes of women's health problems, even though most would attribute this to poverty." Umeagudosu concludes that further research into the causes of this condition that affects so many young girls in Northern Nigeria needs to be undertaken so that the scourge can be overcome.

To conclude this issue, Lilian Siwila's article, **Care-Giving in Times of HIV and AIDS, When Hospitality is a Threat to African Women's Lives: A Gendered Theological Examination of the Theology of Hospitality** provides an analysis of the concept of hospitality in African cultures and its impact on women who are usually the providers of hospitality, Siwila argues that the noble value of hospitality can also be harmful particularly because hospitality is more often than not conceived in gendered terms. Finally, using a gendered theological examination of the theology of hospitality, the author suggests "a partnership model that will call for a theology of inclusiveness in care-giving in times of HIV and AIDS illness."

We are confident that you will find this issue of the journal thought provoking and inspirational as we continue the struggle for gender justice amidst other pressing challenges such as poverty and HIV and AIDS that face Africa in the twenty-first century.

Isabel Apawo Phiri
Sarajini Nadar

Editors

THE USE OF ANCESTRAL RESOURCES IN COMBATING HIV AND AIDS: *MUNDURUME'S* TASK

Julius Mutugi Gathogo

Julius Gathogo, a Kenyan, is a Post Doctoral Research Fellow at the School of Religion and Theology, University of KwaZulu-Natal, South Africa <jgathogom@yahoo.com>

Introduction

By 2008, roughly fifty million Africans have become infected with HIV and AIDS, with more than twenty-two million having already died. HIV and AIDS continues to be a major developmental challenge, particularly in Sub-Saharan Africa, which is the epicentre of the epidemic. As of December 2005, it was estimated that 24.5 million people were living with HIV in Africa, accounting for 64% of all people living with HIV in the world (NIAID 2007). Since AIDS (Acquired Immunodeficiency Syndrome) was first reported in both Africa and the United States in 1981 it has become a major worldwide epidemic. It is caused by HIV (Human Immunodeficiency Virus), which kills or damages the cells of the body's immune system. HIV thus progressively destroys the body's natural ability to fight infection and certain cancers. People diagnosed with AIDS may get life-threatening diseases called opportunistic infections, which are caused by microbes such as viruses or bacteria that usually do not make healthy people sick (NIAID 2007).

Characteristically, the pandemic differs between countries and within countries—as some regions are hard hit more than others. Indeed, some countries (or regions within countries) experience stabilisation, reductions in new infections and HIV and AIDS prevalence respectively. For example, as the World Bank reports, there are significant variations in HIV prevalence rates in some countries such as Angola, which has a 3.7% prevalence rate, compared to neighbouring nation states of South Africa, Botswana, Lesotho, Namibia and Swaziland, whose prevalence rates are close to or over 20% (World Bank 2006). Nevertheless, the pandemic, generally, continues to reverse life expectancy gains, erode productivity, decimate the workforce, consume savings and dilute poverty reduction efforts.

Even though Kenya stands out as one of the countries in sub-Saharan Africa that appears to be turning the tide, by virtue of the fact that, by June 2006, the proportion of the population infected with HIV and AIDS had fallen from 14% in 1997 to around 4% of the total population of thirty million people, the war is far from over as the 1.2 million (4%) still poses a big challenge to the socio-economic well-being of the nation. Furthermore, the fact that there are 1.1 million children who are now orphans as a result of AIDS is an issue that begs for attention. In some of the poorest parts of the Kikuyu-dominated areas such as the capital city of Nairobi, “every fifth house you come to is run entirely by children—all the adults have died” (Karen 2006). This builds the case for the urgency of calling every one to take responsibility for the entire society. Indeed, this is a hard-hearted war that has hit the sub-Saharan region the most.

As the Third World War, whose battlefield is concentrated in sub-Saharan Africa, it goes beyond the First World War (1914-1918) and the Second World War (1939-1945), where both were mainly fought in Europe, Asia and North Africa. Hence, Herbert Peacock has shown (1987:291-292), by the time the First World War had ended, it had wrought the greatest destruction the world had ever experienced, when an estimated thirteen million people perished. For every minute of fighting, four soldiers were killed and nine were left wounded. In total, the war left about ten million widows and orphans and one million dependents without any means of survival (Peacock 1987:291-292). The cost of the war in monetary terms was calculated as being sufficient to provide every family in America, Canada, Australia, Great Britain, France, Belgium, Germany and Russia with a US\$500 house, US\$200 worth of furniture and US\$100 worth of land, and even then the ‘remainder’ was equivalent to the entire capital value of France and Belgium! Added to this was the vast number of starving people and refugees (Peacock 1987:291-292). Similarly, the Second World War inflicted heavy losses. Fought on the Berlin-Rome-Tokyo-axis:

The allies decided to drop the newly tested atomic bomb on a Japanese city. On 6 August 1945 an atomic bomb was dropped by an American super-fortress on the city of Hiroshima killing 78,000 people at one blast. A horrifying new dimension had been added to war. On 8 August, the Russians declared war on Japan and invaded Manchuria; on August 9 the Americans dropped another atomic bomb on Nagasaki; on August 14 the Japanese surrendered unconditionally. The war was over (Peacock 1987:338).

Interestingly, 6 August was both a sad and joyful day of commemoration. On one hand, it marked the day when an atomic bomb was dropped on the Japanese city Hiroshima instantaneously killing 78, 000 people; on the other, it marked the joyful day when Christians commemorate the transfiguration of Jesus Christ (Matt. 17:2; Mark 9:2).

In general, the HIV and AIDS crisis in Africa has been treated as a major concern by theologians of all persuasions. In particular, African Women's Theologies have gallantly pushed this agenda since 2002. In view of this, Isabel Apawo Phiri has rightly developed the view that HIV and AIDS is an urgent issue for the theology of mission in Africa. She rejects conventional wisdom that "HIV and AIDS is a punishment from God" and explains that such retrogressive views would make it difficult for the church to successfully confront the pandemic (2004:423-424). Rather, HIV and AIDS should be confronted as a challenge that affects all people in tropical Africa with its catastrophic consequences that needs to be addressed with all urgency. With marriage in tropical Africa being at great risk, Phiri contends that HIV and AIDS ought to be treated as a gender issue (2004:425). This, Phiri argues, will guarantee the safety of the African society considering that "marriage is at the centre of the African community" (2004:425).

In general, the HIV and AIDS crisis in Africa has been treated as a major concern by theologians of all persuasions.

Theoretical Framework

The Kenyan Anglophone theologian Jesse Mugambi and the DRC Francophone theologian Kä Mana, both who hold differing viewpoints with regard to the social reconstruction of Africa provide the theoretical framework for this paper. Adept philosophers, passionate Africanists, apt Reconstructionist theologians and committed Christians, each have differed sharply with regard to methodology in providing a theology of reconstruction in twenty-first century Africa. In particular, Kä Mana introduces his analysis of the ethical dimensions of the human crisis in Africa in an alarming way. Painting an alienating and despairing picture of African society, he goes on to suggest that only a radical reconstruction of an African approach to religious and socio-political realities can bring healing to their major shortcomings (Mana 1991:78-9).

Conversely, Mugambi holds that ancestral resources can be creatively exploited to bring about sound economical and political systems capable of assuaging some of the smouldering issues of the day (Mugambi 1995:88).

On the other hand, Kä Mana presents the past African cultural values and traditions as a “decaying reality” or as a “disintegrating reality,” and cautions that any attempt at avoiding Africa’s present problems by going back to its ancient times is a new type of estrangement—which, to him, is equivalent to surrendering ourselves to “the dictatorship of the past” (Mana 1991:79).

In view of Kä Mana’s caution and in considering Mugambi’s passion and hope for Africa, one wonders: Is there a panacea for African tight spots such as HIV and AIDS? Will addressing African disparities be a smooth sailing exercise? Should we go Mugambi’s way or Mana’s way in attempting to address the HIV and AIDS crisis in Africa? While not discarding any of the two viewpoints, this paper intends to approach the subject by acknowledging that appealing to some ancestral resources can also provide a psychosocial reconstruction of Africa. In particular, it will investigate the role of a *Mundurume* (Kikuyu man) in fighting disasters such as war or disease (e.g., HIV and AIDS). It is critical, at this stage, to underline that while *Mundurume* refers, literally, to a brave man, the word *Mundumuka*, for a Kikuyu woman, literally means ‘one who comes,’ thereby implying that the role of a *Mundurume* includes providing security to every person in the community, including ‘those who come and join us.’

The Kikuyu People

Why choose Kikuyu cultural life in this section to demonstrate the role of an African man in combating HIV and AIDS? First, I come from this community, which is the largest ethnic group in Kenya. Second, due to limitations of time and space, it was impossible to survey the more than 2,000 African communities. Certainly, since African communities share many similarities in culture, the cultural patterns taken from the Kikuyu community will suffice; thereby giving us a relevant picture in assessing the whole of Africa. Third, the complexity of HIV pales in comparison to the complexity of the social forces involved in the production and reproduction of stigma in relation to HIV and AIDS. Indeed, stigma rarely acts alone. Patriarchal attitudes and practices are, in reality, part of the complex contributory chain that fuels the continued spread of HIV and AIDS among the members of the Kikuyu community. In choosing the Kikuyu, as a sample, it will thus assist in unveiling the above concerns.

‘Kikuyu’ is the anglicised form of the proper name and pronunciation of Gikuyu. By 2008, the Kikuyu totalled some ten million, equal to about 30% of Kenya’s total population. They reside around the slopes of Mount Kenya in the Central Province of Kenya. The Kikuyu cultivate the fertile

central highlands and are also the most economically active ethnic group in Kenya (see Wanjohi 1997). As one of the Bantu linguistic groups, they are closely related to the Kamba, Embu, Mbeere and Ameru people who also live around the slopes of Mount Kenya. The earliest pre-historic version of their social lives establishes that the Kikuyu were initially a monogamous society. At a later stage, the community embraced polygamy. Indeed, a well-documented creation myth of the Kikuyu describes that *Mugai* (which literary means ‘the divider of the universe’) created a man called Gikuyu and his wife called Muumbi. There is no satisfactory explanation given as to why the first ancestors were called Gikuyu and Muumbi. The only plausible information offered is that a man met a woman who was making pots (*kumba*), and that this woman discovered that the man was sheltering under a wild fig tree (*Mukuyu*). On marrying, they called each other by nicknames, a usual Kikuyu custom, associated with the circumstances of their initial meeting. Thus the man called the woman Muumbi (which means potter), while the woman called him Gikuyu (literally meaning, ‘of the fig tree’) (cf. Kenyatta 1938).

The woman, Muumbi, is described as having been a “beautiful wife” who lived happily with Gikuyu, and together, they had nine daughters and yet no sons (Kenyatta 1938:4). As a result, Gikuyu “was very disturbed at not having a male heir.” When his daughters reached marriageable age, in despair, Gikuyu called upon God, *Mugai* (the ‘Lord of nature’) “to advise him on the situation,” praying that *Mugai* would soon provide men to marry them (Kenyatta 1938:4). As a result of his supplications:

God (*Mugai*) responded quickly and told Gikuyu not to be perturbed, but to have patience and everything would be done according to his wish. He [*sic*] then commanded him, saying: ‘Go and take one lamb and one kid from your flock, kill them under the fig tree (*Mukuyu*) near your homestead. Pour the blood and the fat of the two animals on the trunk of the tree. Then you and your family make a big fire under the tree and burn the meat as a sacrifice to me, your benefactor. When you have done this, take home your wife and daughters. After that go back to the sacred tree (*Mukuyu*), and there you will find nine handsome young men who are willing to marry your daughters under any condition that will please you and your family’ (Kenyatta 1938:4).

As fate would have it, Gikuyu was not disappointed after obeying *Mugai* or *Ngai*. When he returned to the sacred tree (*Mukuyu*), he found the promised nine young men who greeted him affectionately. After recovering from his excitement, with much jubilation, he took these nine young men to his

homestead and introduced them to his family. Following much African hospitality, “the question of marriage was discussed” (Kenyatta 1938:5). During the marriage negotiations, Gikuyu gave “tough” conditions to the young men who were willing to marry his daughters, stating, “If they wished to marry his daughters, he could give his consent only if they agreed to live in his homestead under a matriarchal system” (Kenyatta 1938:5). Due to the overwhelming beauty of Gikuyu’s daughters, the young men readily accepted.

This myth, held amongst the Kikuyu, provides some understanding into the establishment of patriarchy among the members of the community. It also hints at the first major paradigm shift that took place from within—from Gikuyu’s patriarchy where he dominated his wife Muumbi (even in these marriage negotiations, her voice is conspicuously missing), to matriarchy, where women enjoy greater input. This shift towards patriarchy was short lived as men fought very hard to usher in patriarchy and thus have ruled over women to the present day. What are the reasons for this? Under matriarchal paradigmatic governance, the women allegedly became authoritarian and tough fighters. Coupled with this, they also practised polyandry, where they were free to keep more than one spouse. This was obviously a digression from what the first parents set as an ideal for the whole community to follow. Could this have been mere propaganda aimed at discrediting the Kikuyu women (*Atumia*) by men who favoured a shift towards patriarchy?

**This shift towards patriarchy was short lived as men fought
very hard to usher in patriarchy and thus have ruled over
women to the present day.**

How did the society shift from matriarchy to patriarchy? To overthrow their rulers, who were women, *Arume* (men) decided to carry out a successful coup d’état. To do this, they mischievously agreed to impregnate all the women of the tribe, including the leadership. This was done by first planning a date when they would resist women’s leadership while they were pregnant and thereby weak physically (Kenyatta 1938:4). As soon as men came to power, the constitution was changed enabling the shift from a matriarchal to patriarchal system to be put in place. In effect, men took over the leadership of the family and the community at large. As a result, they became the owners of property and the protectors of their families. Because of their actions, the men who were now seen as fathers for the unmarried women and as husbands after marriage owned women (Kenyatta 1938:3).

Nevertheless, after the shifting of the paradigm from matriarchy to patriarchy, the Kikuyu men introduced polygamy as a way of taking full responsibility of the community. Consequently, it has some important implications. First, polygamy was a digression from the original path of a monogamous family. Second, it also shows that among the members of the Gikuyu community, each person is expected to obtain a spouse and live in a monogamous relationship. The question as to how this would be achieved in an unequal society where men hold the ascendancy is seemingly unimportant. Third, in the era of HIV and AIDS, the Kikuyu have to reconstruct themselves by revisiting their history especially with regard to upholding a monogamous family. In other words, to be deemed responsible, a *Mundurume* (a Kikuyu man) has no choice in the Africa of the twenty-first century but to put into practice what the founders of the community left behind—monogamy. Fourth, the way to uphold monogamy translates to being faithful to one's spouse. It means avoiding premarital sex, fornication, adultery or serial marriages—a new concept in Africa. Fifth, the society must ensure that they do not annoy the spirit of the two great ancestors—father Gikuyu and mother Muumbi. Their prayer was for the community to have responsible men who would not only provide for the family, but more importantly, men who would uphold the dignity of the community by respecting family values. Addressing contextual issues such as HIV and AIDS is one of the concerns that a *Mundurume* cannot downplay considering that it has left thousands of people either motherless, fatherless, orphaned, widowed etc. In view of this, it is critical to underline that in the Kikuyu tradition, a *Mundurume* wishing to have a good family must strive to control his sexual desires. Hence, if a father is sexually loose, how can he bring up a good family? Equally, a *Mundumuka* cannot allow anyone to pollute their 'kitchen' (body). They must also protect their sexuality in the same way they protect their kitchen.

The challenge for the *Arume* (plural for Kikuyu man), is thus: “You asked for the leadership of the community and you took over through a coup d'état. Do you want to act irresponsibly by allowing the community to be swept by the HIV and AIDS floods? As the Gikuyu saying goes, 'a leopard is fought by a man and his in-laws.' This leopard called HIV and AIDS is going to destroy the entire society if we fail to collectively invite everyone including the untouchables—the in-laws—to fight it now? How can we be silent when we should be acting against it? Or should we shift back to matriarchy where we experienced 'irresponsibility'?” The Kikuyu men (*Arume*) like other responsible persons in the rest of the African continent must now wake-up, lead from the front, and thus swim into action and stop the boat from capsizing. Indeed, the hour is now!

The Ideal *Mundurume*

In both the ancient and the modern Kikuyu society, a male child becomes a *Mundurume* after circumcision, where the foreskin of a man's genital organs is removed, at around fifteen years of age. Outside this rite, a male person is regarded as a *Kihii*. That is, one who has not graduated to full adulthood through the act of physical circumcision. At this stage, it is critical to appreciate that while the ancient rite of circumcision among the Kikuyu where initiates were taken early in the morning to the river has now died out; we nevertheless have to acknowledge that modern day circumcision for boy-children is undertaken in hospitals where modern medical practitioners have replaced traditional doctors.

Again, it is critical to concede that even though the initiation of both sexes has, from time immemorial, been seen as the most important custom among the Kikuyu—as it was looked upon as a deciding factor in giving a boy or girl the status of manhood or womanhood in the Kikuyu community—the circumcision of a boy-child was seen as more strategic than that of a girl-child, due in part to the boy-child becoming a *Mundurume*. This *Mundurume* was first and foremost, a leader, a warrior, a responsible person, or 'a security officer' of the community—who, as we shall see in the next section, had, as a matter of stipulation, to have a higher calling, to protect the community at all costs.

In his book, *Facing Mount Kenya*, Jomo Kenyatta defended circumcision for both sexes. As with the rite of Jewish circumcision, Kenyatta regarded it “as the *conditio sine qua non* of the whole teaching of tribal law, religion, and morality” (Kenyatta 1938:131). This said, the Kikuyu society has gradually abandoned the practice of circumcising females, otherwise known as Female Genital Mutilation (FGM). Only in limited areas do we still find it being practised today.

Writing in 1938, when circumcision for both men and women was at its zenith, Kenyatta explained that “no proper” *Mundurume* would have sex with, or marry a woman who was not circumcised. Similarly, he noted that no woman would have sex with, or marry a man who was not circumcised (*Kihii*)—as it was a taboo to the community. He went on to explain that the practice of circumcision was “an essential step into responsible adulthood” for many African girls and boys, and that there was “a strong community of educated Gikuyu opinion in defence of this custom” (Kenyatta 1938:132-3). Kenyatta further explains that it was a taboo for a *Mundurume* or a *Mundumuka* (a Kikuyu woman) to have sexual relations with someone who had not undergone circumcision. Kenyatta thus noted:

If it happens, a man or woman must go through a ceremonial purification, *korutwo thahu* or *gotahikio megiro*—namely, ritual vomiting of the evil deeds. A few detribalised Gikuyu, while they are away from home for some years, have thought fit to denounce the custom and to marry uncircumcised girls, especially from coastal tribes, thinking that they could bring them back to their fathers' homes without offending the parents. But to their surprise they found that their fathers, mothers, brothers and sisters, following the tribal custom, are not prepared to welcome, as a relative-in-law, anyone who has not fulfilled the ritual qualifications for matrimony. Therefore a problem has faced these semi-detribalised Gikuyu when they wanted to return to their homeland. Their parents have demanded that if their sons wished to settle down and have the blessings of the family and the clan, they must divorce the wife married outside the rigid tribal custom and then marry a girl with the approved tribal qualifications. Failing this, they have been turned out and disinherited (1938:133).

With the declining value and practice of FGM among the Kikuyu community, a *Mundurume* can no longer say that he cannot 'have sex or marry a woman who is not circumcised.'

With the declining value and practice of FGM among the Kikuyu community, a *Mundurume* can no longer say that he cannot 'have sex or marry a woman who is not circumcised.' Rather, these words will have to be paraphrased (or reconstructed?), to include both genders, to read, 'there should be no sex or marriage until both partners undergo Voluntary Counselling and Testing (VCT).'' This has to be the new law for both men and women among the Kikuyu in this era of HIV and AIDS. Since both VCT and circumcision, (or, FGM for that matter), can be said to be emotionally, physically and psychologically painful, the culture of circumcision among the *Arume* would be enhanced by this new way of managing life in the Africa of the twenty-first century. This is the real challenge for the *Mundurume* as it will reveal authentic responsibility.

The Division of Labour

In this section, which is a revision of a section that appears in my book, *The Truth about African Hospitality: Is there Hope for Africa?* (Gathogo 2001:14- 20), I intend to show how the Kikuyu industries were discharged. That is, how some duties were performed by a particular gender and how some works were discharged by both men and women as a part of a mutual celebration of life. I also intend to show how the modern, professional and

technical society is experiencing tension caused by the contradictory teachings of traditional and modern teachers alike. This sub-topic is crucial particularly when we bear in mind that the Christian culture in modern Africa is intertwined with African culture.

I want to begin by saying that the Kikuyu have a saying that: “*mwana uri kiyo ndagaga muthambia.*” That is, ‘an industrious child will never lack adoptive parents.’ Due to the patriarchal traditions of the Kikuyu community, this ‘industrious child’ was ideally a boy-child who, after circumcision at the age of about 15-18 years, became a *Mundurume*. To be an industrious child could also mean a responsible or hard-working person. In the light of pandemics, misfortunes, natural calamities or war with neighbouring communities or even among the rival clans, a boy-child, who became a *Mundurume* after initiation, was expected to show some measure of industriousness—hence responsibility and creativity—however little it was.

The urge to be an industrious child was sounded right from childhood and climaxed during the time of initiation. During the *Irua* (initiation), boy and girl-children in traditional Kikuyu society were trained to perform particular jobs. Due to the great concern of the Kikuyu to develop productive children, they were taught that even if their parents were to die, the affected child would be reborn ‘with a goat’ to another family. They were informed that there was no task as big as an elephant, and the only one that is difficult is the unperformed one. They were also made conscious of the fact that their initiation ushered them into adult freedom, which was within the framework of the division of labour. In particular, as the boy-initiates grew into adulthood, they had definite duties to perform to all members of the village. These included fortification, protection and the defence of the village. Furthermore, if called upon, a *Mundurume* could assist his neighbour in erecting a house, clearing the bush and cultivating the land. To this end, a *Mundurume* could count on sufficient assistance to build a house in a day or clear a large area for cultivation in a few days, without having to pay for the labour, except that he must supply the workers with a feast. These traditions have changed with the coming of modernity whereby you have to hire professional specialists in every field to do the work e.g., when building a house, you have to employ a carpenter or a mason on a contract basis.

For a *Mundurume*, in traditional Kikuyu society, to be assisted in building a house for his family, first he had to initiate the work himself as a proof that he was not looking for help because he was lazy or wanted to be a parasite that depends entirely upon others. This was partly meant to curb a

syndrome of dependency in the community. Second, he had to be someone who assists others whenever they are in need. He who does not assist others is left alone, as the proverb states, 'he, who eats alone, dies alone' (*muria wiki akuaga wiki*). This was a means of discouraging laziness; for a lazy person among the Kikuyu (and Africa at large) was condemned and abhorred. It was also meant to uphold the African sense of community. That is, instead of the Cartesian, 'I think, therefore, I exist' (*cogito ergo sum*), the African asserts 'I am because we are,' or 'I am related, therefore, I am' (*cognatus ergo sum* or an existential *cognatus sum, ergo sumus*, meaning "I am related, therefore we are.'). This compares with Mbiti's summary of the philosophy underlying the African way of life, "I am, because we are; and since we are, therefore I am" (Mbiti 1969:108). The Akan of Ghana would say, "I belong by blood relationship; therefore I am" (Healey and Sybertz 1996:62). Indeed, this parallels with the concretisation of the Being (*Sein*) as Being-with in the Dasein Analytic in Martin Heidegger's *Being and Time* (1927/1992).

This communalistic African approach to life is equally felt by both genders. Hence, when an expectant mother delivers a child, the neighbouring women sets a date upon which they will bring firewood, porridge, cooked food, sorghum, millet, corn, sugarcane, sweet potatoes and yams to the mother. In turn, men were to ensure that these goods were taken by their wives; if they were not readily available, it was their duty to see to it that they had looked for them, this being a gesture of solidarity with their wives within the spirit of communalism. In this era of HIV and AIDS, a communalistic approach can be exploited for the common good of society.

An interesting thing in the whole question of the division of labour is that an individual was a part of and responsible to the entire country. Duties to one's country included defence, the building of bridges and fire fighting. This was, in most cases, done communally, men taking a leading role. This idea of an individual being responsible to the entire country draws its parallel in Christian Africa from the Great Commission (Matt. 28:16-20), where Jesus commanded his followers to go into all the world and be responsible for the lives and souls of everyone by proclaiming the Christian gospel, in season and out of season.

Religion was another major responsibility that every citizen had. Hence, in time of drought, plague and other calamities, the leading elders (priests of the day), who were mainly men plus a few menopausal women, summoned all the people to gather together for worship. They congregated under the sacred *Mugumo* tree ('tree of God') and gave sacrifice to the Great

Provider. When killing the sacrificed animal, a boy or girl-child and a menopausal woman would touch the animal's head while the (*Arume*) elders slaughtered it and prepared and roasted the meat. As the roasting went on, the smoke that came from the roasting of the beast was believed to intercede to God. This was a symbolic act of inclusiveness and the community's total participation in religious acts. As a result of this collective sacrificing to God, it was believed that faithful worship resulted in God's blessings for all. These blessings included gifts of rain, unity, harvest, health and general prosperity.

...HIV and AIDS is not only a Third World War—a costly war fought mainly upon African soil, but it is more importantly, a genocide that threatens to wipe out the people of Africa—a people who are made in God's image...

Concerning defence, every Kikuyu male was a soldier. During the weaning rite, the boy-child was made aware that he was growing up to be a warrior. Military recruitment started after the initiation. This is where the young men started by being a member of the junior regiment. At this stage, he was under the authority of the senior warrior regiment. After a reasonable duration of time, he was promoted to the senior warrior regiment. This element of every *Mundurume* being a soldier of the community is crucial to the fight against HIV and AIDS in this century. As noted earlier, HIV and AIDS is not only a Third World War—a costly war fought mainly upon African soil, but it is more importantly, a genocide that threatens to wipe out the people of Africa—a people who are made in God's image (*Imago Dei*). Indeed, if an army fails to fight for the nation, it is better that they were not there in the first place! Thus, as in ancient times, the *Arume* must lead in the battle-field, as good soldiers, and combat HIV and AIDS. This provides therefore an opportunity for them to prove their worth as responsible soldiers, who will never shy away from battle, but rather confront the enemy until the nation experiences genuine peace. The challenge for a modern *Mundurume*, as in ancient times, is thus to face the societal concerns, such as HIV and AIDS, responsibly.

Some Reconstructive Methodological Considerations in Fighting the War against HIV and AIDS

Sexual Abstinence as the Ideal Way

Mundurume must lead in upholding sexual abstinence as one practical and ideal methodology that can make a real difference in fighting the war against HIV and AIDS. Indeed, the ancient Kikuyu encouraged strict

control of all sexual desires, and where rules were broken, heavy penalties were imposed on the culprit. For example, even though there were common dances such as *Nguchu*, *Nduumo*, *Mugoiyo* and *Ndaci ya irua* (circumcisional dance), sexual discipline was upheld. In particular:

The grandmothers had a critical role of checking if any man unwound the inner garment of the young ladies. This garment was called *Muthuru*. The grandmothers or *Cucus* tied it safely to protect any promiscuity in young women. Any women who engaged in sex before marriage affairs, and got pregnant could only be married as a second wife and they were commonly referred to as *Gichokio*. Therefore the Gikuyu customs protected the interests of young people against [sexual] abuse. It also ensured [that] some form of entertainment was prepared and young people carried forward the practices from generation to generation (Wikipedia 2007).

In view of this, abstinence is one practical methodology that society in general can employ as one of the ideal and practical lines of attack that can be instrumental in combating the menace of HIV and AIDS. If our ancestors used it to control promiscuity and as a method of birth control, why not modern day *Mundurume* or *Mundumuka*? Hence, some of the ancestral resources can be creatively exploited to facilitate a healthy lifestyle in facing the challenges HIV and AIDS poses in our modern societies.

A Need for a Mugambi: A Trumpet Blowing Mundurume

Among the traditional Embu, the Kamba, the Gikuyu, the Meru and many other Bantu (linguistic) communities, there was a *Mundurume* (called *Mugambi*) whose responsibility was to stand high on a pedestal, as a giraffe, and be ready to caution and alert the community to changing social conditions or dangers that were about to befall the community. For example, among the Kamba community, *Mugambi* is written as *Muambi*—which refers to *Muvuvi wa nguli*, that is, the person who alerts the community in case of need or danger. According to my interviews with Bosco M. Maingi, on 11 October 2005, *Muvuvi wa nguli* was the special person who alerted the people when the neighbouring Maasai tribe came to take away their cattle, believing that all cattle belonged to them. Among the Kikuyu, *Mugambi* the *Mundurume* also refers to the trumpet blower (*muhuhi wa coro*) or whistle blower (*muhuhi wa biringi*). His role was to alert the community on important issues that needed special attention. Similarly, *Mugambi*, as a noun, is a special *Mundurume* among the Embu

and the Kikuyu who alerts the community on contemporary issues that need special societal focus.

Among the Meru, the noun *Mugambi* carries with it the social responsibilities of a statesman, counsellor, advisor, arbitrator or mediator; while in the neighbouring Gikuyu community, it refers to a person who is assigned the responsibility of beating (or ringing) the drum of caution during an emergency. In our society today, a *Mugambi* is a researcher on the changing patterns of HIV and AIDS, an educator on HIV and AIDS, a leader or a prophet who, with regard to HIV and AIDS, leads society to the Promised Land, a preacher or a public speaker who cautions on the dangers of HIV and AIDS. In view of this, an ancient African society that had no *Mugambi* of its own was doomed to certain annihilation. This challenges all of us to take the role of a modern day *Mugambi*, speaking in love and with a sense of responsibility on the issues HIV and AIDS so that society can ascend to a higher plateau where the enemy cannot reach. As Martin Luther King once remarked, “our lives begin to end the day we become silent about things that matter” (a common quotation).

In our society today, a *Mugambi* is a researcher on the changing patterns of HIV and AIDS, an educator on HIV and AIDS, a leader or a prophet who...leads society to the Promised Land...

Story-Telling as a Methodology

As a phenomenon that is rooted in African indigenous religion, story-telling is one of the major forms of informal education in Africa. As such, it is an indispensable means of illustrating important messages in the context of Africa (Gathogo 2001:84). A traditional art form, story-telling creates above all, a deep sense of friendship and community. This finds a parallel in the bible, which is a collection of stories told about a people, namely, the Israelites and the disciples of Jesus (Gathogo 2001:85). As a Reconstructionist, Jesus illustrated his sermons with relevant stories such as the Parable of the Sower (Luke 8:4-15), and the Good Samaritan (Luke 10:25-37).

When those who have been confirmed by medical personnel to be suffering from HIV and AIDS tell their individual encounters with the disease—as opposed to village gossips which are inaccurate in most cases—it helps to destroy the stigma that is associated with HIV and AIDS. As a result, society is able to come to terms with the reality that the ‘problem is, after-all, part of us—as a family, as a clan and/or as a community.’ It has to be handled in love as it affects all our sisters, brothers, parents, children,

relatives and friends. Indeed, we cannot speak in whispers and innuendo, for in the Africa of the twenty-first century, Jesus is beckoning us in his promise:

...I am the light of the world. Whoever follows me will never walk in darkness but will have the light of life (John. 8:12 NRSV).

Stigma thrives on lies. That is, it refuses to acknowledge that every woman, man or child is created in the image of God (*Imago Dei*) whether affected or infected. It refuses to take cognisance of the reality of the sanctity of human life. Additionally, it speaks the language of hate, intolerance, misapprehension and even intimidation. In effect, it brands 'the other' as undesirable, or, as in the words of Erving Goffman (1990), a "spoiled identity."

Stigma thrives on silence, denial, guilt and fear. When the truth about suffering and disease cannot be narrated through story telling, possibly, because of fear of stigmatisation, reality is covered in denial or silence. Denial not only sacrifices the truth, it robs us of our ability to deal effectively with the virus. As a result many have died alone. Or is it a case of "He who eats alone dies alone" (*Muria wiki akuaga wiki*), as noted above in the Kikuyu proverbs? Furthermore, guilt and fear feed on silence and soon rob those affected and infected of their ability to wrestle with the virus in ways that take care of life instead of yielding to desolation and depression. Telling the story of the contacts with HIV and AIDS is one practical methodology which helps to de-stigmatise the pandemic. As Robin A. Mello confirms:

Through transmission of narrative the storyteller allows the powerless to perceive himself or herself as powerful. The storytellers of South Africa during apartheid, for example, told what seemed (to the dominant white political structure) to be "simple folk stories." Listeners perceived these same tales, however, as liberating acts of social protest (Mello 2004:199).

He goes on to explain:

This is not a new phenomenon. Familiar and seemingly innocuous stories, such as the Household Tales of the brothers Grimm, have been entertainments but feature subplots that challenge authority, oppressive attitudes, and the status quo (Mello 2004:119).

In so-doing, Mello appears to agree with Joseph Bruner:

Storytelling should be viewed as a set of procedures for “life making.” And just as it is worthwhile examining in minute detail how physics or history go about their world, might we not be well advised to explore in detail what we do when we construct ourselves through stories? (Bruner, quoted in Mello 2004:195).

In view of this, a *Mundurume* will no doubt lead in employing storytelling as one of the practical methodologies to successfully wage war against HIV and AIDS in twenty-first century Africa. This can best be achieved by encouraging the infected and affected members of society to tell their own stories without fear or harm.

Even though earlier initiatives have borne little fruit, Africa has to trust in the God who guided its ancestors in times of crisis.

Working towards a Vaccine

The need for a vaccine that will medically tackle HIV and AIDS will continue to be of vital importance to twenty-first century Africa. While anti-retroviral drugs (ARVs) have played their part in controlling the disease, a more comprehensive cure from medical science is still required. This calls for everyone to give maximum support for this initiative in our respective ways—as we remember the Kikuyu saying that, ‘a leopard is fought by a *Mundurume* and his in-laws.’ Even though earlier initiatives have borne little fruit, Africa has to trust in the God who guided its ancestors in times of crisis. This same God will provide Africa with a way forward. As medical science works towards a solution, we as Africans must continue to affirm our faith in God, that tomorrow will not be like yesterday, for soon and very soon, we shall overcome.

Condoms as a Lesser Evil

The question among various religious practitioners, whether to use condoms as a method for combating HIV and AIDS, is one of the most debated issues in modern times. Whereas Kenyan Roman Catholics and Muslims are totally opposed to their use, Protestants consider condom use a lesser evil. While it cannot be denied that condom-use can encourage fornication, adultery or general promiscuity, it is essential to consider whether dying of HIV and AIDS as result of engaging in unprotected sex is a greater evil? Certainly, it is significant that the Islamic Medical Association of Uganda in collaboration with certain Christian agencies

have launched one of the most successful campaigns in the region to de-stigmatise the use of condoms. At best, this is in contrast to the famous ‘condom fatwa’ issued and published by Ugandan Imams that has since been used as a point of reference by Muslim scholars elsewhere in the world.

In his seminal book, *Situation Ethics: The New Morality* (1967), Joseph Fletcher advocates a so-called ‘Christian ethic’ based on existential situations rather than prescriptive principles. Fletcher contends that decision-making should be based upon the circumstances of a particular situation and not upon law. The only absolute is love. Love should be the motive behind every decision. As long as love is the desired intention, the end justifies the means. In this theory, justice is not in the letter of the law, but in the distribution of love. More specifically, as Fletcher says, “whether any form of sex is good or evil depends on whether love is fully served” (1967:139). Hence, “any form of sex, which includes hetero, homo, auto, by a man (or woman) has to push his (or her) principles aside and do the right thing” (1967:13). When should we push our principles aside? Fletcher answers, “The ruling norm of Christian decision is love, nothing else” (1967:69). For him, love is the only thing that matters, “only one thing is intrinsically good; namely, love: nothing else at all” (1967:56). Concerning the Ten Commandments, Fletcher states, “...situation ethics has good reason to hold it as a duty in some situations to break them, any or all of them” (1967:74).

The only absolute is love. Love should be the motive behind every decision. As long as love is the desired intention, the end justifies the means.

In view of Fletcher’s argument and in considering that even in African traditional society, where law was followed to the letter, there were various cases of ‘law-breakers’ especially with regard to sexual matters, as evidenced by the fact that even the Kikuyu had a *Gichokio* (referring to a woman who would be unable to control her sexuality and thereby have a child out of wedlock), there is need to face this issue squarely. This clearly shows the difficulty in handling sexual emotions, especially among some younger members of society, hence the need to be sympathetic in the use of condom as a lesser evil in the struggle against HIV and AIDS. Thus, while abstinence is the ideal methodology in the war against the pandemic, the use of condoms, in certain cases should be accepted as a lesser evil.

Conclusion

In this era of HIV and AIDS we must first apply our ethics in reconstructing both our individual and social consciousness. In so-doing, as with the Jews following the Babylonian Exile, we must “start rebuilding!” (Neh. 2:18). A variety of methodologies must be employed in this new project. One such methodology is the use of ancestral resources—that is, appealing to some African indigenous ways of handling disasters or crisis. This compares with Wole Soyinka’s proposal with regard to achieving reconciliation in Africa—where one such resource is the use of myth and ritual. Specifically, Soyinka turns to his ancestral Yoruba tradition. In particular, he recalls the religious pantheon, where the gods come down to the mortals to oversee the atonement festival, reminding them of the necessity for atonement and forgiveness (Soyinka 2000). He thus writes:

Most African traditional societies have established modalities that guarantee the restoration of harmony after serious infractions—see, for instance, the banishment of Okonkwo after involuntary homicide in Chinua Achebe’s *Things Fall Apart*. And, if we may be somewhat whimsical, Emperor Bokassa’s bizarre return to Central African Republic, in full knowledge of what fate awaited him, argues strongly for some kind of supernatural intervention—the vengeful souls of the violated children dragging him back from the security of his French asylum? Certainly, a singularly atrocious act appeared to be denied closure until the perpetrator returned to expiate on the scene of the crime. Maybe, in the sphere of abominations, (African) nature does abhor a vacuum. Are we then perhaps moving too far ahead of our violators in adopting a structure of response that tasks us with a collective generosity of spirit, especially in the face of *ongoing* violations of body and spirit? (Soyinka 1999:13-14).

Second, we will need to critically appreciate Musimbi Kanyoro’s view of cultural hermeneutics, where she suggests that in order for theology (read, African Women’s Theology) to achieve its goal, cultural hermeneutics should be regarded as the first and most important step. In her insightful work, *Introducing Feminist Cultural Hermeneutics: An African Perspective* (2002), Musimbi Kanyoro suggests that the church should be open to change and at the same time maintain the tension that exists between gospel and culture. Accordingly, this tension will automatically invite dialogue between Christianity and African religious cultures.

Kanyoro can thus state:

What is required of cultural hermeneutics is to sift the good aspects of the culture and religion and affirm them, knowing that there is room to reject what is bad (2002:65-71).

Third, we must strongly reject the Afro-pessimism articulated in the West that suggests that Africa is doomed to certain annihilation. Clearly, there is no good reason to suggest that the failures of the past will prevail in the future. Accordingly, as James advises, the challenge for *Mundurume* and African society in general, is to be:

...doers of the word, and not merely hearers who deceive themselves. For if any are hearers of the word and not doers, they are like those who look at themselves in a mirror; for they look at themselves and, on going away, immediately forget what they were like. But those who look into the perfect law, the law of liberty, and persevere, being not hearers who forget but doers who act—they will be blessed in their doing. (James 1:22-25 NRSV).

...we must strongly reject the Afro-pessimism articulated in the West that suggests that Africa is doomed to certain annihilation.

Thus, *Mundurume* (read, the African man) must, as in ancient times, respond decisively and play a leading role in the midst of the HIV and AIDS crisis that is rapidly engulfing Africa. They must be good soldiers of the community and protect the entire society of women, men and children against HIV and AIDS. This is the authentic maturity that is climaxed by the initiation, and for which we all should crave. Indeed, let us now begin the task of reconstruction (Neh. 2:18)!

Bibliography

- Allen, Karen. 2006. Kenya Struggles to Combat HIV. May 31. <<http://news.bbc.co.uk/2/hi/health/5033558.stm/>>. (Accessed 10 May, 2008).
- Fletcher, Joseph. 1967. *Situation Ethics: The New Morality*. London: SCM.
- Gathogo, Julius Mutugi. 2001. *The Truth About African Hospitality: Is There Hope for Africa?* Mombasa: The Salt.
- Goffman, Erving. 1990. *Stigma: Notes on the Management of Spoiled Identity*. Harmondsworth: Penguin.

- Healey, Joseph and Donald Sybertz. 1996. *Towards An African Narrative Theology*. Nairobi: Paulines Publications Africa.
- Heidegger, Martin. 1992. *Being and Time*. Translated by John Macquarrie and Edward Robinson. Oxford: Blackwell.
- Kanyoro, Musimbi R. A. 2002. *Introducing Feminist Cultural Hermeneutics: An African Perspective*. Sheffield: Sheffield Academic Press.
- Kenyatta, Jomo. 1938. *Facing Mount Kenya: The Tribal Life of the Gikuyu*. London: Heinemann.
- Mana, Kä. 1991. *L'Afrique va-t-elle mourir? Bousculer l'imaginaire africain: essai d'éthique politique*. Paris: Cerf.
- Mbiti, John S. 1969. *African Religions and Philosophy*. Nairobi: EAEP.
- Mello, Robin A. 2004. Telling Tales: Journey of an Itinerant Storyteller. Pages 195-206 in *Storytelling Sociology: Narrative as Social Inquiry*. Edited by Ronald J. Berger and Richard Quinney. London: Lynne Rienner Publishers.
- Mugambi, Jesse N. K. 1995. *From Liberation to Reconstruction: Africa after the Cold War*. Nairobi: EAEP.
- National Institute of Allergy and Infectious Diseases (NIAID). 2007. HIV Infection and AIDS: An Overview. October. <<http://www.niaid.nih.gov/factsheets/hivinf.htm/>>. (Accessed 10 May, 2008).
- Peacock, H. L. 1987. *A History of Modern Europe 1789-1981*. Nairobi: Heinemann.
- Phiri, Isabel Apawo. 2004. HIV/AIDS: An African Theological Response in Mission. *Ecumenical Review* 56/4, 423-4.
- Soyinka, Wole. 1999. *The Burden of Memory, the Muse of Forgiveness*. Oxford: Oxford University Press.
- . 2000. The Scars of Memory and the Scales of Justice. Olof Palme Memorial Lecture, Taylor Institution, University of Oxford, 16 November.
- Wanjohi, Gerald J. 1997. *The Wisdom and Philosophy of the Gikuyu Proverbs*. Nairobi: Paulines Publications Africa.
- Wikipedia. 2007. Kikuyu. <<http://en.wikipedia.org/wiki/Kikuyu/>>. (Accessed 10 May, 2008).
- World Bank. 2006. The Facts of AIDS in Africa Today. World AIDS Day 2006 Update. <<http://web.worldbank.org/>>. (Accessed 10 May, 2008).

NAVIGATING TURBULENT WATERS: THE CHALLENGES FACING WOMEN TRADITIONAL HEALERS IN POST-APARTHEID KWAZULU-NATAL

Radikobo Ntsimane

Radikobo Ntsimane is a researcher at the Sinomlando Centre for Oral History and Memory Work in Africa, housed in the School of Religion and Theology at the University of KwaZulu-Natal, Pietermaritzburg Campus <NtsimaneR@ukzn.ac.za>

Introduction

Sangomas, who are one type of traditional healers among Zulu people, used to play a very important role as mediators between ancestors and their living offspring. The adoption of Christianity by blacks and the successful introduction of western culture in South Africa in the 1800s minimised the important role played by the *Sangomas*. They were seen as evil and agents of backwardness. That attitude changed in the new political dispensation in South Africa as is shown by the fact that a *Sangoma* joined President Thabo Mbeki in a nationally televised ritual to welcome the successful bidding on May 15, 2004 to host the 2010 soccer World Cup. The fact that a *Sangoma* performed a ritual of that magnitude does not however mean that the profession of a *Sangoma* is recognised in the country. Indeed, in KwaZulu-Natal and other provinces of South Africa, *Sangomas* are struggling to be recognised by the government as a much needed practicing profession by black society. This lack of recognition marginalises the *Sangomas* so much so that they do not get adequate land to practice their specialised profession.

**The adoption of Christianity by blacks and the successful
introduction of western culture in South Africa in the 1800s
minimised the important role played by the *Sangomas*.**

In this article I shall try to show how the new political dispensation which should have been sympathetic to the *Sangomas* is instead hostile towards them. With regard to the sub-themes, I will address issues of land, places and buildings.

Methodology

This paper will use the material of an oral history research project of the Sinomlando Centre for Oral History and Memory Work in Africa (*hereafter*, Sinomlando), located in the School of Religion and Theology in the University of KwaZulu-Natal (UKZN). The interviews were conducted by Prof. Isabel Phiri and Ms. Lindiwe Mkasi between 2002 and 2004 in the Pietermaritzburg and Durban areas. Of the twenty-one interviews only two were conducted in English. The others were conducted in the Zulu language and translated into English. The research aimed at establishing what role traditional women leaders' play in society. *Sangomas* are an example of traditional leaders. Since the *Sangomas* are cautious by profession, Mkasi used the snowball method to approach them, whereby one *Sangoma* she knew introduced her to another and that one to yet another.

This paper is about gender. While dealing with the politics of traditional healing in the province, it also covers women issues. *Sangomas* are mainly women and their challenges are manifold as a result. They include poverty, landlessness and homelessness, discrimination, and lack of recognition from husbands.

During the duration of the research, workshops were held twice a year with experts in the field. The purpose of these workshops was to share the information gathered and improve the methodology. The workshops helped the researchers clarify various issues, resulting in several additional interviews.

The interviewees agreed to sign release agreements giving permission to Sinomlando to use their information for research purposes. Two volumes of transcripts and translations in Zulu and English respectively are available to researchers. The tapes, transcripts, and translations are kept in the Alan Paton Centre and Struggle Archives at the University of KwaZulu-Natal. Eventually, there are plans to make these transcripts available online. A feedback workshop during which research progress was shared with *Sangomas* took place in Durban 2003.

It becomes clear, when reading the interviews, that some of the interviewees struggled to practice their profession because of the lack of land. This paper makes use of those interviews and other sources to show how the women *Sangomas* navigate in a hostile environment for their survival and the survival of their profession. As *Sangomas*, one has no alternative but to practice the profession when called. Otherwise one dies.

In order for one to understand the challenges *Sangomas* face in their profession, it is appropriate to know how they are called.

The Call and Training of a *Sangoma*

Unlike in western medicine where an individual freely chooses to become a physician, the call to become a traditional healer or *Sangoma* is usually resisted. From the moment an ancestral spirit possesses a chosen person to become a *Sangoma*, this person faces mishap after mishap until they accept the call (Berglund 1978:136). The lifestyle of a healer changes dramatically. They are alienated from their community due to the call to become a healer. Women who have been discriminated against in the male-dominated societies will suffer more than men when they become *Sangomas*. Traditionally, the identification of a woman as a *Sangoma* meant automatic respect and reverence from her community. However, this is no longer the case in the new political dispensation.

Women who have been discriminated against in the male-dominated societies will suffer more than men when they become *Sangomas*.

As has been pointed out, the call of a *Sangoma* is invariably resisted due to the difficulty of the profession. Ancestors indiscriminately call their descendents into this profession. Dreams and visions are often cited as a sign of the call. A dream or a vision will often show an ancestor giving the person divining bones or directing her to a *Sangoma*. The person who had such a dream will then be advised to visit a *Sangoma* of repute for confirmation. Likewise, any illness that befalls a prospective *Sangoma* will be interpreted as a sign of the call, to be confirmed later by a *Sangoma* of repute.

The women interviewed by Mkasi did not pursue university studies, with one exception. Suzan Schuster-Campbell has interviewed five *Sangomas* who were called from lucrative professions: a pharmacologist and researcher, a nurse, an AIDS counsellor, a college graduate and a police officer (Schuster-Campbell 1998). As was the case with Campbell's interviewees, all of those interviewed by Mkasi had initially resisted the call. Many *Sangomas* admit that their training was characterised by traumatic experiences.

In an interview with Mkasi,¹ SM said that she was called at the age of ten and trained for twelve months:

Mkasi: What happened exactly?

SM: You just become hysterical and leave. When I left home, I did not know where I was going. It was at night. It just caught me unexpectedly!

NM told Mkasi that her resistance to the call caused her to suffer miscarriages. She finally gave in.

Interviewed by Schuster-Campbell, Mercy Manci said that after experiencing dreams and visions she started to menstruate. She would menstruate each time she was in the presence of any man. Mercy went to see a healer in Soweto who told her that her call was long overdue for the ancestors have waited too long for her (Schuster-Campbell 1998:121).

After training, *Sangomas* acquire a distinct external identity known by all in their community. They dress in a wrap-around which is mostly reddish in colour. A blown-up gall bladder is pinned on their heads as a sign of the recent ritual slaughtering of a goat. Their necks, wrists and ankles are adorned with white and/or red beads. The number of goat hide bangles is an unmistakable indication of the quantity of goats slaughtered for ancestral rituals.

Land Inadequacy and Economic Space Inaccessibility

In order for the *Sangoma* profession to grow unrestricted, two basic things need to be addressed: the provision of adequate land and economic means. South Africa's urban areas attract many *Sangomas* who follow the move of rural people who come to the cities in the hope of finding a better life. There is both a pull and push towards the urban centres. In KwaZulu-Natal, the new political dispensation ushered a government that was determined to redress the racial imbalances of land ownership. Successive Colonial and Apartheid governments drove most black people from their land, using a plethora of laws like the Native Land Act of 1913, the Land Act of 1939, the Group Areas Act of 1950 and the Creation of Homeland Act. Most of those who were driven from their ancestral lands belonged to self-governing states according to their tribal relationships.

¹ Individual Interview by Lindiwe Mkasi. Tape recording. July 7, 2004. Inanda, Durban.

Economically dependent on the central government, these so-called self-governing states ceased to function when the Apartheid regime collapsed in 1990. Many people flocked to the urban centres unhindered. In the absence of restrictive laws, the *Sangomas* of KwaZulu-Natal followed their clientele, moving to the industrialised cities of Pietermaritzburg and Durban. Some of their clients moved from farms owned mainly by whites who had benefited from cheap black labour for three centuries.²

The *Sangomas* have not yet tapped into the lucrative but highly guarded medical insurance business. The national and provincial governments' reluctance to advocate for the inclusion of traditional medicine practitioners in the recognised medical insurance schemes is responsible for the continued economic marginalisation of *Sangomas* in the new dispensation. The reason for such reluctance on the part of politicians may be due to the fact that the *Sangomas* do not pay income tax. It may also be due to the fact that this profession is not easy to regulate.

Insufficient Land, Inadequate Housing

The pull to the cities is the prospect of a larger clientele, the procurement of herbs and other *Sangoma* paraphernalia, and the social grants provided by the new democratic government. The government has built affordable houses to replace the informal settlements that sprang-up around the cities of Durban and Pietermaritzburg. These houses are small in size (30 square meters) and built on tiny building plots of varying sizes. The size of the plot also makes it difficult for the *Sangomas* to have a sacred hut (*isigodlo*) to practice their profession.³ Since clients want their secrets to remain safe, they do not feel free to speak when everyone from the entire *Sangoma's* household are listening in!

Inadequate Land for Herbal Gardens

The plot size is also a matter of concern for the *Sangomas*, since they need a garden to plant fresh herbs as required in their profession. Without herbs, a *Sangoma* cannot work. In her book, *Called to Heal*, Schuster-Campbell

² Farm dwellers were driven off the land because the new law made provision for farm dwellers that had lived on one farm for a minimum of ten years to legally own their plot. In order to minimise the number of co-owners, the white farm owners retrenched farm workers and turned many farms into game farms which only require a limited labour force.

³ A *sangoma* has to keep her paraphernalia apart from mundane activities lest they be polluted and rendered impotent.

notes that South Africa has a biodiversity of approximately 3, 000 species which are used as medicine. She concurs with her interviewee healer Mayeng that herb trading is a lucrative business:

About 350 are mostly commonly used and traded throughout the country. Although there are no accurate figures available, the unregulated trade in crude medicinal roots, barks, bulbs and leaves is estimated to be worth R1 billion annually (1998:78).

Such herbs are available in the informal market, but there are disadvantages. The herbs displayed on the cities pavements are polluted and therefore impure. Those that are potent when used wet, dry-out from exposure on the city streets. The potency of others depends on the manner in which they were harvested. In one interview conducted in Newcastle, SC explained to Mkasi and Phiri⁴ the harvesting requirements:

Some herbs are dug while one is naked and others are dug with your eyes closed. You choose the one you want and then dig it out with your eyes closed. If you do like that, it will work as it should.

The herbs displayed on the cities pavements are polluted and therefore impure....The potency of others depends on the manner in which they were harvested.

In an interview with Mkasi,⁵ NN, another *Sangoma* stated:

Now we have the problem that some herbs are scarce. When you go into someone's farm, you can either be arrested for trespassing or killed. In defence they will say you we on their farm.

NN further complained about the protection of certain plant species:

And people don't plant anymore because they get arrested. I heard that if you have a particular herb you will be asked where you obtained it and be arrested.

The scarcity of herbs makes them expensive. The solution to the problem is for healers to have private gardens. In an interview with Mkasi and Phiri,⁶ a

⁴ Group Interview by Isabel Apawo Phiri and Lindiwe Mkasi. Tape recording. July 22, 2004. Newcastle.

⁵ Individual Interview by Lindiwe Mkasi. Tape recording. March 17, 2004. Pietermaritzburg.

group of five *Sangomas* shed light on the challenges they face in the new political dispensation. Addressing the issue of an herb garden, a *Sangoma* stated:

When one talks about a traditional healer one talks about having a garden and other things like that.

Inadequate Space for Food Production

Space is necessary to house trainees (*amathwasa*) and to feed them. Vegetable gardens and raising a few chickens would be of help in the struggle for restoring the *amathwasa's* physical health. Invariably, the *amathwasa* come to the trainer in a bad state of health. Their ill-health is caused by their resistance to the call. In order for healing to take place the *amathwasa* need nutritious food. In an interview with Mkasi and Phiri⁷ SC stated:

If there was space for gardening, the *amathwasa* who are well would grow some vegetables and those who are still sick would eat. If the traditional healers had areas like that, things would be much better.

SB mentioned another restriction caused by lack of space:

In this yard I can't even raise chickens. If I do that they will cause damage to the neighbours' plots.

Inadequate Space for Drumming

The challenges that face *Sangomas* of small houses and building plots are not confined to the lack of space for herbal gardens. *Sangomas* are also restricted in their practice by neighbours whose houses are sometimes less than two meters away. SB thus lamented:

We are not happy the way we live. Neighbours complain about the drums we beat for our ancestors. It is important that we beat them

⁶ Group Interview by Isabel Apawo Phiri and Lindiwe Mkasi. Tape recording. July 22, 2004. Newcastle.

⁷ Group Interview by Isabel Apawo Phiri and Lindiwe Mkasi. Tape recording. July 22, 2004. Newcastle.

because they have their role. In rural areas houses are far apart and making noise does not cause any problem.⁸

Especially during the training period, drums are used to bring a dancing *thwasa* (trainee), into a trance. Ancestors are said to be invoked through a monotonous drumming and a special dance performed by a *thwasa*. In his book on witchcraft and traditional healing, *Madumo: A Man Bewitched*, Adam Ashforth laments the noise he and his neighbours had to endure from the *Sangoma* drumming in Soweto near Johannesburg. He writes, “Over and over and over again the distinctive da-da-dum da-da-dum da-da-dum would pulse through the neighbourhood, signalling inyangas in training.” (2000:90). No drumming, no *Sangoma*, SB seems to suggest when she said, “It is important that we beat them (drums) because they have their role.”⁹

**Another impediment to the practice of the *Sangoma* profession
is the problem of slaughtering of beasts in an uncontrolled
environment.**

Restrictions to Acquisition of Animal and Plant Products

Another impediment to the practice of the *Sangoma* profession is the problem of slaughtering of beasts in an uncontrolled environment. Although no interviewee mentioned this point, it is important to note that all *Sangomas* must slaughter a beast—often a goat—to strengthen their relationship with the ancestors. Such slaughtering can only take place at the home of a *Sangoma*. Municipal by-laws discourage this practice in an urban area because of the risk of disease. The Society for Prevention of Cruelty to Animals (SPCA) lobbies for the criminalisation of the uncontrolled slaughtering of animals as it exposes them to undue pain and suffering prior to death. It is not always possible to perform a ritual immediately upon the arrival of a beast to a house. Keeping a beast of sacrifice for a long period of time in a residential area before slaughtering may infringe local by-laws.

Sangomas also use wild animals, most of which are protected. In *muthi* (traditional medicine) shops, a variety of animals and animal body parts are readily available for sale. Snakes, in full and in parts, dried eagles and owls

⁸ Group Interview by Isabel Apawo Phiri and Lindiwe Mkasi. Tape recording. July 22, 2004. Newcastle.

⁹ Group Interview by Isabel Apawo Phiri and Lindiwe Mkasi. Tape recording. July 22, 2004. Newcastle.

are some of the endangered species often on offer. In South Africa, the law which protects plant species¹⁰ also protects animal species. *Sangomas* use both. It is a criminal offence to be found in possession of a protected plant or animal species.

Inaccessible Economic Space

The government pays lip service to the promotion of traditional medicine. In a February 19, 2006 *City Press* newspaper article entitled *Traditional Medicine is Here to Stay*, written primarily to discredit the Democratic Alliance (DA), the national minister of health, Dr. Manto Tshabalala-Msimang praises the government for its efforts to regulate traditional medicine. While promoting the product, the minister does not acknowledge the struggles of its producers.

Apart from the physical space required for the exercise of the *Sangoma* profession, there are restrictions with regard to the legal space. As providers of healthcare services to the population at large in the province of KwaZulu-Natal, *Sangomas* continuously struggle for their rights. Biomedical practitioners, the complex system of healthcare insurance and the labour system do not recognise traditional healthcare providers, despite the fact that many healthcare seekers use this type of practitioner.

Biomedicine is based on modern science. Its practitioners, doctors and nurses, often look down upon *Sangomas* and rarely work with them in healthcare provision. SC told Mkasi and Phiri that biomedical practitioners despise *Sangomas*. SC related that since the 1980s, she has been to many Department of Health workshops meant for co-operation between the two types of stakeholders in healthcare provision. Despite this, SC felt continuously unwelcome when she visits her clients at state hospitals.

The South African healthcare insurance sector which makes profits in the billions of Rands discriminates against traditional healers. When, the people of KwaZulu-Natal are sick they are free to choose from various healthcare systems provided in the province. The problem is that the healthcare insurance only covers legitimate expenses incurred through the biomedical healthcare system. It goes without saying that this type of medicine is offered to people who have healthcare insurance. This practice clearly excludes *Sangomas* from the benefit enjoyed by biomedicine.

¹⁰ For a list of protected plant species, see Scott-Shaw (1999:161).

Another challenge facing the *Sangomas* is the labour system. While in theory, one can consult any healthcare practitioner, biomedicine is given preference. In the case of absence from work, only a sick note from a registered physician will be acceptable. Any employee who wishes to receive a full salary will thus consult a registered physician rather than a *Sangoma*. This arrangement channels financial benefit to biomedical practitioners despite the fact that many people would prefer to consult alternative healthcare practitioners.

Lobbying for Recognition

For centuries, traditional healers have had to struggle for recognition under successive South African white governments. Sir George Grey, the governor of the Cape Colony in the 1800s specifically undertook to render obsolete the traditional healthcare providers he derogatorily termed 'witchdoctors.' He did this in order to entrench Christianity among the so-called '*kaffirs*' (blacks) of his colony. Subsequent white governments also favoured the western healthcare system against that of the traditional, hence, the 1974 Health Act and its 1982 amendment restricted traditional healers from acts related to medical practice.

In the province of KwaZulu-Natal, things have been different since the end of the nineteenth century. The 1891 Natal Code of Bantu Law did not have the restrictions enforced in other areas under white rule. Under the KwaZulu Act of 1981 traditional healers were allowed to practice their profession (Schuster-Campbell 1998:3). Interestingly, this was promulgated by the self-governing state of KwaZulu, because, as a Zulu legislative body it could identify with traditional healing. This shows that it is not improper for *Sangomas* to fight for government recognition of their profession in the new political dispensation.

The Traditional Healers Act of 2005 is an attempt by the new government to regularise traditional healing. The composition of the Council and some of the clauses of the Act are informed by the Acts governing biomedicine. There is a bias against traditional healthcare as the Council designated to govern this healthcare sector includes medical practitioners. Showing a pertinent lack of consideration towards context, the Traditional Health Practitioners Act No. 35 of 2004, Clause 23 (g) stipulated that the Council could regulate by suspending and expelling a *Sangoma* from practicing due to improper or disgraceful conduct (Republic of South Africa 2004). How could the Council that governs by means of regulations decide when and when not *Sangomas* should provide healthcare? I think this act is

patronising towards *Sangomas* and will not play a positive role in promoting the *Sangoma* profession.

Another key area where the *Sangomas* feel patronised is by male politicians and their use of English as their preferred language of communication. This often prevents many *Sangomas* from active participation in decision-making. SC explained to Mkasi and Phiri¹¹ in an interview conducted in Newcastle:

The difficult part is that when we attend meetings they speak in English. Yet, they know very well that the people possessed by ancestors are not educated. You will hear them talking and you wonder whether you were supposed to attend that meeting. Traditional healers have a problem because what you hear is just *shwi shwi* sounds. It is really difficult because there are people in ancestral work who don't know how to write their names.

Another key area where the *Sangomas* feel patronised is by male politicians and their use of English as their preferred language of communication.

Similarly, in the aforementioned *City Press* newspaper article, Manto Tshabalala-Msimang attacked the Democratic Alliance (DA) in their objection to the marketing of a yet-untested new medicine. While dialogue about the efficacy of traditional medicine and biomedicine should be encouraged, space should be created for *Sangomas* to practice.

Traditional healers have formed organisations that speak in one voice in their struggle for recognition and respect. However, these organisations are often weak. In their interview, SB told Mkasi and Phiri¹² of the struggle that lay ahead for *Sangomas*:

We are not going to give up because it is said that the government is giving land to people. It is buying farms for them. Traditional healers are in trouble these days. We are applying to the government for land where we can plant our medicines (herbs) but things are very slow.

¹¹ Group Interview by Isabel Apawo Phiri and Lindiwe Mkasi. Tape recording. July 22, 2004. Newcastle.

¹² SB probably meant the Land Restitution Act which aimed at correcting the pre-1994 imbalances regarding land ownership.

There is a danger in fighting for integration and common use of health centres with western medicine. Western medicine, which has long enjoyed recognition in South Africa, has dominated the public sphere of healing. Its organisation, regulations and protection enjoy a position of bias in national government. Traditional healing should be recognised and organised as an alternative healthcare system.

Isaac Mayeng, a renowned herbalist and pharmacist researcher of international repute, has raised doubts about the success of government recognition. In an interview with Schuster-Campbell, Mayeng responded:

In incorporating the healers into some national system of health care, there must be bridges built between them of institutional way. There must be a separate registering body, not falling under Medical and Dental Council (1998:83).

As a result, an approach that does not require healers to be incorporated under orthodox medical bodies should be sought. PROMETRA (Promotion des Medecines Traditionnelles), an association of traditional healers based in Dakar, Senegal, thus provides its members training in various diseases through various publications and workshops.¹³

While *Sangomas* have this quest for recognition, the risks involved should not be ignored. The training of *Sangomas* should involve the standardised knowledge of basic human anatomy and physiology. Along with the call, training in dream interpretation, diving and herbs, every *Sangoma* wishing to be officially recognised for the purposes of claiming fees from healthcare insurance schemes, should pass an exam in human anatomy and physiology. This regulation and training will protect their clients from exposure to risks due to ignorance.

Some gains however have been made with regard to healthcare insurance schemes. Some workers unions have made remarkable inroads for their members with regard to the recognition of their preferred healthcare system. Eskom, the state-owned and operated electricity utility, has given permission to its employees to use the company's medical plan to claim their visits to traditional healers (Schuster-Campbell 1998:3). These

¹³ One of the books used by Promotion des Medecines Traditionnelles is Gbodossou (2000). The book covers the Formation d'Auto-Perfectionnement des Guérisseurs traditionnels (FAPEG) approach to maternal and child health; child diarrhoeal diseases, and STIs such as HIV and AIDS.

important gains can be used to lobby the provincial government for the practice of *Sangomas*.

Conclusion

Since a great majority of traditional healers in KwaZulu-Natal are women (Berglund 1976:136), they face the cultural barrier of *ukuhlonipha*.¹⁴ Women *Sangomas* adhere to tradition. They are in fact the custodians of this tradition as their ancestors work through them. Women *Sangomas* fight for recognition in a male-centred government. It is commendable to see that the government has made giant steps to acknowledge the importance of women in politics. The gesture should go across the board to promote all efforts of women empowerment, even if they do not yet make a direct contribution to the economic strategic growth of the country. As issues of gender and education sophistication come into play, women *Sangomas* are powerless. Patriarchy, especially in KwaZulu-Natal, is still practiced, despite the national government's efforts to appoint women to positions of power both in government and industry.

**For an effective advocacy, the women *Sangomas* need to know
the procedures of the provincial legislation.**

For an effective advocacy, the women *Sangomas* need to know the procedures of the provincial legislation. They need advice on the various stages of legislation so that they can make submissions to the relevant portfolio committees. Furthermore, they need to unite into one big body to amplify their voice. It is only when one united voice is heard that the government begins to listen. Considering how the new political dispensation came about in South Africa,¹⁵ the new government recognises loud and consistent voices.

I concur with the traditional healer Isaac Mayeng (Schuster-Campbell 1998), who does not see how traditional medicine practitioners can work hand-in-hand with biomedical practitioners, as they have different orientations. It is important, however, for traditional medicine to be recognised. Such recognition should begin with a special provincial budget for the development and protection of the Greytown herbal farm mentioned

¹⁴ Among other meanings, *ukuhlonipha* for women refers to being subservient to men and avoiding direct eye-contact with them.

¹⁵ The Mass Democratic Movement (MDM) and the United Democratic Front (UDF) of the 1980s brought the Apartheid regime to the negotiating table.

above. Furthermore, the patients seeking health from *Sangomas* should be allowed to use their health insurance and not be penalised by employers.

When women *Sangomas* will be able to earn as much money as western-trained physicians, they will be able to afford larger plots in suitable locations. The South African and KwaZulu-Natal provincial government's uncritical preference for western biomedicine makes the competition unfair. As is the case with western biomedicine, traditional medicine needs to be regulated with common standards and common procedures for all practitioners. A standard charging regulation for consultation and medications should be put in place by the government and practitioners alike. A government that prides itself in promoting women dignity and initiative should be made to listen to the challenges of women *Sangomas* and provide space, both physical land and economic.

Bibliography

- Ashforth, Adam.2000. *Madumo: A Man Bewitched*. Cape Town: David Philip.
- Berglund, Axel-Ivar.1976. *Zulu Thought-Patterns and Symbolism*. Cape Town: David Philip.
- Gbodossou, Erick Vidjin' Agnih. 2000. *Healers' Self-Proficiency Training*. Dakar: Imprimerie Saint-Paul.
- Republic of South Africa. 2004. Statutes of the Republic of South Africa: Medicine, Dentistry and Pharmacy.
- Schuster-Campbell, Susan. 1998. *Called to Heal: Traditional Healing Meets Modern Medicine in Southern Africa Today*. Johannesburg: Zebra Press.
- Scott-Shaw, Rob. 1999. *Rare and Threatened Plants of KwaZulu-Natal and Neighbouring Regions*. Pietermaritzburg: KwaZulu-Natal Conservation Services.

THE YORUBA BELIEF SYSTEM AND ITS IMPACT ON WOMEN'S REPRODUCTIVE HEALTH

Helen Adekunbi Labeodan

Helen Adekunbi Labeodan, is a member of the Circle of Concerned African Women Theologians and is a Lecturer in the Department of Religious Studies, University of Ibadan, Oyo State, Nigeria <kumbial@yahoo.com>

Introduction

This research attempts to identify and evaluate the influence of the Yoruba belief system on women's reproductive health. The Yoruba belief system is all encompassing taking in the totality of the individual. It is an almost impossible task to separate the Yoruba person from her/his beliefs and it is for this reason that the Yoruba are referred to as an 'incurably religious' people.

However, there are certain belief systems that do not augur well for women as far as their reproductive health is concerned. It is evident that these traditional beliefs and practices contribute immensely to the poor status of women's reproductive health. One such belief, which is the cause of many controversial issues among Yoruba women is that of *oko lo lori aya*, 'the husband is the head of the wife.'

This study seeks to critically analyse the issue of women's reproductive health from a Yoruba perspective. By using a focus group discussion and taking into consideration traditional beliefs and practices, the study will explore Yoruba women's reproductive health vis-à-vis pregnancy and childbearing. Focussing on the barriers that hinder Yoruba women from having a say in their reproductive health this study will further provide a gender analysis of the relationship between men and women concerning women's reproductive health. Finally, it proffers solutions that might help women in gaining total control over their reproductive health.

Conceptual Definition

Woman/Women

A common dictionary understanding of the female of the human species is that which belongs or relates to a woman, or the sex that gives birth to young or produce eggs. Although the distinction between a man and a woman seems obvious, it is better understood at a chromosomal level; that is, the genetic material within both male and female: XX for woman; XY for the man.

Health/ Reproductive Health and its Implications for Women

According to Ram (1988:314), health is a dynamic state of well-being, in harmony with others, with nature, the environment and with God. In biblical terms, this is known as *Shalom* (peace), a state of right relationship. It is very important for a person to have a right relationship with her or himself, with family members, community, with God, and with nature. A disturbance in any one of these relationships can cause ill health. Healthcare should be understood to mean more than medical care, for it includes more than the physical dimension; as human beings we are healthy when we function well both mentally and emotionally. The mind affects the body and the body the mind. Health is therefore a state where body, mind and soul are in perfect harmony. To be healthy is to function well within the environment which is a combination of nature and society. Accordingly, Grane and Kaye (1988:28) speak of a healthy society as one which responds successfully to challenges. As the Beijing Declaration and Platform for Action (1995) has stated:

Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health...implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility...and the right of access to appropriate health-care services.... (United Nations 1995).

According to Sonia Correa (1997), the reproductive health domain cannot be viewed strictly in biological, demographic or quantitative terms. It requires the input of other elements and instruments of analysis including, subjectivity culture, politics, economy, social relations, ethics and values. Thus, in this article, religion is added as an important element of analysis of reproductive health. Other components of reproductive health rights include prevention and treatment of infertility, sexual impotence in both men and women, termination of pregnancy, and sexual and reproductive security.

Judging by these definitions above, we can rightly affirm that the Yoruba society is not totally healthy since it is not ready to accept the challenge posed by the empowerment and emancipation of women. If the statements above were to be critically examined, the Yoruba woman is not healthy because she does not have right relationships with those around her. If she did, there would not have been any need to discuss her reproductive health and rights.

For women, health is freedom from disease, mental and emotional stress, threats of, and actual physical and sexual violence, freedom from constricting social roles and unequal relationships.

For women, health is freedom from disease, mental and emotional stress, threats of, and actual physical and sexual violence, freedom from constricting social roles and unequal relationships. The health of women in all stages of their life cycle is important because it promotes the health of the generations to come through their impact on children. The challenge is not only to define what constitute women's sexual and reproductive health and rights but also to overcome the systematic obstacles that deny women these rights. Another challenge is that these rights are so intensely interrelated with the presumed prerogative of men. It is for this reason that we need to undertake a critical analysis of the relationship between men and women over women's reproductive rights.

Who are the Yoruba?

The Yoruba comprise several clans which are bound together by language, traditions, religious beliefs and practices. These clans are the Ekiti, Ijesha, Ondo, Igbomina, Yagba, Awori, Egbado, Ife, Ijebu, Egba and Oyo. Although speaking Yoruba with various dialects, to a large extent the clans are united by a common culture, tradition and origination in the town of Ile-Ife. The language today is written in the Oyo dialect. According to

Idowu (1977:5), the key aspect of the Yoruba is their religion. In all things they are religious. Religion forms the foundation and is the all-governing principle of life. As far as the Yoruba are concerned, the full responsibility of all the affairs of life belong to the deity; their own is simply to do as they are ordered through the priests and diviners whom they believe are the interpreters of the will of the deity.

The religion of the Yoruba permeates their lives so much that it expresses itself in multiple ways. It forms the themes of songs, makes topics for minstrelsy, finds vehicles in myths, folktales, proverbs and sayings, and is the basis of philosophy (Idowu 1977:5). In Yoruba religious belief, God who is referred to either as *Olorun* (the owner of heaven), or *Olodumare* (the king who holds the sceptre, wields authority and has the quality which is superlative in worth), is the core and cohesive factor of their religion. The Yoruba also believe in divinities, spirits and the living dead. The Yoruba have a pantheon of divinities through which God manifests Godself. These are associated with natural phenomena and objects, as well as with human activities and experiences. The 'living dead,' who are the ancestral spirits, are the closest links that humans have with the spirit world. They are the best group of intermediaries between humanity and God.

The Yoruba woman and her male counterpart are born in an atmosphere that is thoroughly soaked in religion. The Yoruba woman finds herself exposed to the same religious influences as the man—the place of the Supreme deity in her life, the divinities, spirits and the ancestors. In this religious atmosphere she cannot be passive, but she is expected to take an active part in religion. There are instances when she is expected to be religious, such as during pregnancy when she sees that her chances for safe delivery are remote if she is not on good terms with the divinities and the ancestors. The Yoruba woman does all within her means to live up to the demands of the religious environment in which she is born.

In spite of these general belief systems, there are also specific belief systems that have to do with women's reproductive health (that is, concerning pregnancy and child bearing). This forms the core of this study.

Perception of Women among the Yoruba

According to Mercy Oduyoye, women's experience of being persons primarily in relation to others—as mother or as wife—predominates in Africa. A woman's social status depends on these relationships and not on any qualities or achievements of her own (Oduyoye 1990:122). She is also

of the opinion that, the colonial rule reinforces patriarchal systems and compounds the woes of African women by augmenting their ordinary burdens with those of their western sisters (Oduyoye 1995:18). Bolanle Awe (1992:v), is also of the opinion that the colonial administration paid scant attention to the role of women. She observes that though our culture (the Yoruba) remains dynamic and is ever changing, like most other cultures, it has a firm foundation in tradition. These traditions continue to shape women's lives, both directly and covertly (Oduyoye 1995b:18). Most times this shaping starts from birth when a pregnant woman has preference for a son. This, in some parts of the world puts the baby girl at risk of infanticide or with advanced ultrasound scans technology at risk of sex selective abortion. The female child, if she escapes termination at pregnancy, may be subjected to genital mutilation as is done in some states in Nigeria-Ondo, Oyo, and Edo to mention a few. Throughout adolescence, the female child may receive no formal education (including sex education). She is also more likely than boys to be sexually abused by family members, friends, teachers or other male authority figures. Severe abuse may leave the girl with long-lasting psychological problems and predispose her to risky sexual behaviours later in life. The adolescent girl may be pressured into having sex at an early age by an arranged marriage to an older male offering money/gifts or with adolescent boys trying to fulfil masculine roles. After marriage, the female's low status continues to limit the ability of women to control their lives, including their fertility and their access to health care. Among the Yoruba, having a large family is a woman's way to improve her social status.

Double standards on sexuality deny women the ability to refuse sex or negotiate condom use and at the same time encourage men to have multiple sex partners.

The Yoruba, as a patriarchal society gives men primary authority over sex and reproductive health. Double standards on sexuality deny women the ability to refuse sex or negotiate condom use and at the same time encourage men to have multiple sex partners. As a result, women cannot protect themselves against unwanted pregnancies and sexually transmitted infections (STIs). As Oduyoye can state:

The female is to be a 'monotheist' while the male acts as a 'polytheist,' arrogating to him the freedom to worship the bodies of several women (1995b:22).

Oduyoye (1995a:80) goes further to mention how among the Ibibio of southern Nigeria, a woman is culture-bound to her father, in that while she

remains unmarried her sexuality is considered to be his property. She can however have children with secretive men. The children are then claimed as children of her father. Once she is past childbearing age she can freely leave her father's compound. Such a woman has no control over her reproductive health.

According to Oduyoye, the characteristics and roles of women as experienced in society are not necessarily related to their biological makeup. Rather, they are the dictates of society and women learn to live with them. Both girls and boys grow up with sayings that portray women in a negative light. Oduyoye (1995a:58.) gives some of the proverbs that portray women negatively as follows: "all women are the same," "what you would not have repeated in the streets, do not tell your wife in the bed chamber"—meaning women cannot keep secrets and they are fickle, restless and thus prone to unfaithfulness, "women love where wealth is"—meaning they are here today and there tomorrow, depending on how much they can find for themselves. The assumption is that women prefer to seek out wealthy men. With women viewed in this way, it means they can be trusted with nothing, let alone their reproductive health.

Women's Reproductive Health

The most important stages—which are physically self-evident and constant for the majority of women in all cultures—are as follows: birth and childhood, puberty, the onset of menstruation, marriage, pregnancy and childbirth. In most African cultures, marriage is the acceptable social institution in which sexual experience and pregnancy are supposed to occur. Pregnancy, childbirth, nursing and childcare occupy the greater part of most women's lives. In all cultures, it is generally accepted that the crown and joy of a woman's life is motherhood. It is made clear to her that the natural vocation for every woman is that of being a wife and mother. She is not expected to step out of this boundary, because when she does, she is faced with problems from men and women of her community.

The most important role of women in Yoruba patriarchal society is that of childbearing. Oduyoye bears witness to this in her 1992 autobiographical article, "Coming home to myself." A woman must be able to bear children because it is after this that she is accorded respect within the society. The value of women is thus determined by their biological reproductive capability. According to Mason (August 15, 2004), women of all economic levels, no matter the social position they hold, share one overwhelming and pervasive role and responsibility: that of being a child-bearer. This role supersedes all. As in most African countries, some girls among the Yoruba

are given in marriage by the time they are twelve years of age. Sometimes they are even younger, as among the Hausa, found in the Northern part of Nigeria. These girls are drafted to be mothers when they are still emotionally unprepared. Physically, their bodies are not mature enough to bear children. Such early marriages end up interrupting their education and consequently they drop out of school, have birth difficulties, psychological trauma, birth injuries such as Vesico-vagina Fistula (VVF) where they become incontinent after delivery. This malady, common among young mothers whose pelvic girdles are still immature, causes severe injury to the bladder and vagina by the descending head of the baby. The birth outcomes are also poor. The majority of young mothers lose their babies and still find it difficult to be admitted back into school. What is of great concern is that their husbands either neglect or desert such girl-children when the problem of VVF emerges.

The laws that prohibit pregnant schoolgirls from continuing their education are not applied to male students. Women are expected to have as many babies as they can (mainly boy-children) because this is what ensures their security within the home. Husbands want male children to carry on their family name and lineage and also to help work on the land. Men therefore expect their wives to be perpetually pregnant. These husbands are not mindful of the health risks linked to pregnancy; even the women do not seem to understand the risks involved for themselves or their foetuses. In a situation where they might be aware of these risks, a woman does not have a choice between having and not having children. Furthermore, she cannot overrule her husband if he chooses to have more children. If she does, her husband will bring in another woman.

Status and Power

In Yoruba society, women are valued only in relation to men. The same is true in Kenyan society. As Nasimiyu-Wasike (1995:102) has pointed out, “woman’s procreative power is important not for her own sake, but for strengthening the husband’s power or immortality and for giving him a privileged and prestigious status in the society.” It is for this reason argues Nasimiyu-Wasike that a woman’s virginity is important as a type of insurance that the “field” is whole and intact and should therefore give maximum yield. She goes further to state that a barren woman is considered to be dead and useless to the community. In spite of other qualified gifts and talents a woman might possess, the inability to procreate reduces her to the status of a non-person. African women still see themselves as lacking identity when they are without children or unmarried. Hence, in a society where continuation of lineage is a central

dynamic and the individual is subordinated to the group, the importance of a woman lies in her ability to bear children.

As far as power dynamics are concerned, pregnancy and childbirth are two areas where women still command power and status. Oduyoye mentions that in most communities a woman is expected to be stoical during pregnancy and childbirth. In Oduyoye's community, a woman who has given birth is described as one who has returned safely from the battlefield (1995a:13). Great premium is thus placed on procreation, children being seen as 'the heritage of the Lord.' If this is so, how then do we treat such a heritage? What value do we place on it?

As far as power dynamics are concerned, pregnancy and childbirth are two areas where women still command power and status.

The Yoruba Belief System on the Issues of Pregnancy and Childbearing

The reproductive health of women encompasses virtually their entire life cycle, including the health of the girl-child, adolescent sexuality, contraception, menopause and sexually transmitted infections (STIs). The belief systems discussed in this section were gathered through the focus group discussion and interviews with some of the women of child-bearing age (25-46 years) who attended the post-natal/family planning clinic of the University of Ibadan Health Centre (Jaja Clinic) as well as some social health officers/workers.

According to all the women, the essence of marriage is to have children, and the more male children, the better. They also affirmed that the man determines the size of the family, whereas the woman has no say at all. Most of the women confirmed that once they have 'taken in' (become pregnant), they cease having sexual relationships with their husbands, resuming only after three years have passed and the baby is weaned. This practice is particularly common among traditional Yoruba women who have no western education. Through the focus groups, it was interesting to discover that this practice still persists among women today, but mostly within Islamic society. The reason for this practice centres on the belief that if after conception, a woman continues to have sex with her husband, the pregnancy might be aborted; additionally, some respondents even held that the man's penis might put a dent or a hole in the baby's head! Some respondents even claimed that babies who did not cry at birth were

prevented from doing so by the semen ejaculated into their mother's vagina during coitus in pregnancy.

Traditionally, it is believed that if a woman engages in sexual relationships with her husband while breastfeeding the man's sperm would migrate into the breast milk causing harm to the baby. It would no longer be milk, but sperm. While these women used such methods to control their reproductive health, they also believed that it gave room for the promiscuity of their husbands. This might lead to polygamy, since their husband's sexual needs would be met one way or another. Most of the women interviewed were made to believe that they must accept the situation as it is. Such stoicism is enhanced through the women having gone through clitoridectomy (FGM), hence their libido is relatively low. When asked how they cope with sexual inactivity, they responded by saying, 'Is it food?' Most of the women agreed that they did not possess absolute control over their reproductive health. They adhere to whatever their husbands say or want. Their husbands claim there are plenty of children in their loins and if they do not bring them forth, it will make them sick to the point of death. It was also interesting to note that some of the women claimed that they must also have all the children in them less they too would 'die' or go 'mad.'

There are some traditional forms of family planning which the women wear on their person to stop pregnancy. These include, *Igbadi* (worn around the waist); *Onde* (worn round the arm); and *Oruka* (a ring worn on the finger). There are also some herbal concoctions that are taken orally. For example, *Kaun*, (potash) and *Osan wewe* (lime). According to Mrs. Yinka Adekoya (2005), a public health officer at the University Teaching Hospital, Ibadan, these items are injurious to health and most times cause death. When asked why these women still use these old methods rather than new ones, she said their husbands would not allow their use. Besides, these women cannot attend a family planning clinic without the consent of their husbands. According to Adekoya, she had to visit and educate some of the husbands as to why it was important for their wives to use modern family planning methods.

The women were also asked during health talks at the clinic if they had discussions on the issue of pregnancy and HIV and AIDS. On the issue of pregnancy, they reported they were taught how to care for themselves during pregnancy and what food to eat so that both mother and baby could be strong and healthy. The women stated that there were some recommended food items which for religious and cultural reasons they could not eat. These included snails. Although a rich source of protein, snails were thought to cause the baby to salivate excessively, producing

mental impairment or slow development in speech. A pregnant woman is also not expected to take milk. Regarded as 'sweet food,' the baby may turn out to be weak and turn to stealing later in life. A pregnant woman must also not eat eggs, as the baby may also grow up to be a thief. Surprisingly, most of the women agreed to these traditional food taboos, in spite of the fact that there were educated women among them. On the issue of HIV and AIDS, they did confirm that they are aware of *Eedi* the Yoruba word for AIDS but that they could do little or nothing about it, since they were not in control of their husbands' sexual relationships. Some of the women said they were happy and grateful to God when their husbands demanded sex. Indeed, they dared not advise their husbands to use a condom since that would be indirectly telling him that he was promiscuous. Some resorted to providing excuses for their husbands by utilising arguments from religion and culture. Men would always be men. This they claimed was part of Yoruba traditional culture and that it is only God who could protect them from HIV and AIDS.

From the aforesaid study, it is obvious that most of the women interviewed had no absolute control over their reproductive health.

Woman's Reproductive Health and Violence

Most violence against women is carried out by their husbands/partners (e.g., domestic violence). Domestic violence is a learned pattern of behaviour used by one person in a relationship (usually the man), and includes physical, sexual, psychological and economic abuse. In developing countries like Nigeria, poor and uneducated women have few ways to support themselves. Economic needs drive women to become sex workers. These sex workers have a high risk of contracting sexually transmitted diseases. The social stigma associated with the trade limits their access to adequate health care. Commercial sex workers often suffer from male violence as they have to obey the dictates of the brothel managers. They are in no position to negotiate safe sex with their clients or require the use of condoms. There are situations where a small number of women decide to take control of their reproductive health. This has sadly led to their being beaten by their husbands and partners. This consequence is clear in Mrs X story:

Question: Oh! What happened? How did you get these bruises?
Were you involved in a car accident?

Answer: Well you can call it that, I actually got the bruises from my husband. I refused to have sex with him and he did this to me.

Question: Did you not try to make him understand your health situation?

Answer: I did but he just was not ready to listen.

Although this is the experience of but one woman, most experience physical violence when they refuse their husbands/partners sex. Men understand marriage as granting them the right to unconditional sexual access to their wives and the power to enforce this through force if necessary. Abused women are less able to discuss reproductive health needs. As has already been noted, suggesting the use of a condom could imply the partner has been unfaithful and risks a violent response.

In many developing countries, very few women have access to resources to meet their basic needs such as, food, potable water, housing, employment and basic healthcare (Ram 1988:308). Male and community control over women hinders women from having a say in their reproductive health. They are oppressed by both the male (husband, brother and fathers) and community (religion, culture and traditions). Spouses are hindrances to women's reproductive health rights because most men's understanding of women's reproductive health is limited.

Men understand marriage as granting them the right to unconditional sexual access to their wives and the power to enforce this through force if necessary.

Daisy Nwachukwu has rightly pointed out that when a religious custom jeopardises the full human development of a total person and impedes progress, as exemplified in normative ritual prescriptions for the widow, a continuation of this is questionable in modern times (Nwachuku 1995:63). Such practices compel a woman into procreation against her will so as to give her dead husband more sons. This amounts to cultural oppression through which psychological and spiritual violence is metered out towards her. According to Nwachukwu, if African women are considered as 'people' they must be given opportunity to express their satisfaction or dissatisfaction even in the cultic aspects of tradition that often dramatically affect their lives and that of their children.

Another factor that causes women to keep on procreating and not consider their reproductive health is the desire to have male children. In patriarchal societies, male children are more valued than female children. A woman,

who bore only female children, was held in low esteem.¹ On this issue, during the author's interview with Mercy Oduyoye, she expressed the opinion that having children who are all girls is not a curse. In fact, she pointed out that science has shown that it is the father (his sperm that determines the sex of the child, not the mother. This biomedical evidence flies in the face of the traditionally held belief that the woman is to blame for failing to bear sons. By bearing females the woman is considered a failure by her community and shame and abuse are heaped on her. Unfortunately, women's worth and dignity is oft-times grounded in their marriage and procreative capacity. It was and still is assumed that this is the only way a woman can find meaning, happiness and fulfilment in life.

Gender Analysis of Men and Women's Relationship Concerning Reproductive Rights

The health situation of women is still pitiable, most particularly in the area of nutrition. Women often lack the needed nutrients essential to maintain their overall health. The consequences of this are that women are ill-prepared to conceive, give birth or nurse babies and to carry out their responsibilities both within and outside their family homes. Logical reasoning dictates that there is need to space, postpone or limit childbearing. Most often however, these important suggestions are brushed aside because of a large proportion of men who do not assume equal responsibility for family planning or disease prevention.

Most women lack the freedom to decide where, when and how to engage in sexual intercourse with their partners. This inevitably leads to untimely pregnancies and naturally-induced abortions. All these are largely borne out of men's non-involvement and lack of understanding of their women, partners or wives.

In many spheres of life, women's needs and issues are neglected or at best receive little recognition. One of the areas in which women suffer inequalities is in the area of health, despite their multiple roles as mothers, wives, producers and community organisers. Women are often assumed not to have specific health needs apart from mothering roles. Many believe that women's reproductive roles have become predominant criteria upon which their social, cultural, economic and political status is defined. All other health needs—gynaecological, mental and emotional are marginalised. Consequently, women handle difficult health situations by self-medication

¹ The author has personal experience of being victimised for only having borne female children.

or simply deciding to live with pain. It can be said that women all over the world have been deprived of holistic healthcare when they suffer deprivation in any form and are not allowed to function as a total person. Women do not enjoy full healthcare facilities, which normally would ensure their physical, mental, emotional and social well-being.

In Nigeria, families are slow to recognise when girls have health problems, delay seeking treatment for them and spend less on their medicines. Healthcare providers often treat female patients with disrespect. Physicians view female bodies and reproductive processes as potential problems. Researchers often exclude female subjects from clinical studies and focus more on male complainants. There are fewer role models for the girl child and fewer females are involved in making health policy and planning.

According to Andersen (1997:203), men control reproduction. Traditional social theories have also largely ignored the question of reproduction, as if assuming it is irrelevant in analyses of human experience and social organisation. The medical profession is unresponsive to women's needs. It treats women's bodies as objects for medical manipulation. It is also true that men (either in medicine or in politics) make decisions about reproductive issues (Ruzek 1978). This is a clear indication that women are accorded little or no respect within society. The place of the woman has thus been stereotyped. Society, culture and religion have already had their mind set on what the place of women should be. These views portray women as better prepared for private life (not public life, as man) and as the 'weaker sex' not because of a 'deficit of reason' but as a consequence of the greater sexual saturation of their bodies.

A Case for Gender Balance in Reproductive Health

Martin Luther King never got tired of emphasising the inter-dependence of all humanity. We are all related and whatever affects one affects all. Men must begin to see that whatever affects women, affects them too. Once they begin to see this, and accept it, then the problem of women's reproductive health, to a reasonable extent, could be solved (Ram 1988:308). This can only be achieved when men are educated from a human rights perspective on the issue of the reproductive rights of women.

This study has shown that most often reproductive health is seen as a woman's responsibility. Therefore, services are directed at women, thereby reducing men's participation. It is as a result of this that most men lack detailed information about reproductive health, do not use a condom, and are also unaware of the benefits of a vasectomy. Use of male contraceptive

methods requires male cooperation, which may only take place when men understand their own sexuality as well as that of women.

Men's sexual behaviour is an important factor in women's reproductive health. Therefore, reproductive health services must be directed at men as well. The women's role within the family must be valued in order to encourage men to also take equal responsibility for their children. Women cannot do it all alone. They need the help of men just as men, too, need women's help for both to stand on their feet so that together they can realise their health potential and enjoy the fullness of life together. Men should be made to witness the birth of their children. Through this, men would gain from exposure and information given during pre-natal care visits. This in turn would influence their partners and the ways in which they treat them. According to Akingbola (2004), for men to be there through delivery is best. Oduyoye advocates that, it is important to enlist men of stature, including the clergy, to spread the message that preying on young women is immoral (CBS News 2004) and that this damages their reproductive system and exposes them to sexually transmitted diseases and HIV and AIDS.

The women's role within the family must be valued in order to encourage men to also take equal responsibility for their children. Women cannot do it all alone.

Empowerment of Women in Reproductive Health

While it is necessary for engendering reproductive health, there is still room for women to learn about their reproductive health on their own. As observed by contemporary feminists (Andersen 1997:203), women's right to control their own bodies is essential to the realisation of other rights and opportunities in society. Unless women make the decision for themselves whether and when to have children it is difficult for them either to control their lives or participate in society (Boston Women's Health Book Collective 1984). Furthermore, responsibility for health ought to be placed upon the individual. People, particularly women, must take personal responsibility for their own well-being. Women must be made to participate in and contribute towards decisions which affect them personally. There is also need to ensure equality in meeting the healthcare requirements of everyone.

Until women are empowered to make and implement decisions, they will not be able to achieve anything worthwhile as far as their reproductive health is concerned. Women need therefore to be educated with respect to

their reproductive health and rights. A forum needs to be established where they can air their views, ask questions and be heard regarding matters of health and reproductive health.

Oduyoye (2004) is certainly right when she said that women should be allowed to tell their stories since they are the ones experiencing pregnancy, childbirth and marital rape. If they do not let people know what they are experiencing, there might never be a solution to their problems

Bibliography

- Adekoya, Yinka. 2005. Interview by author. Tape recording. August. Ibadan.
- Akingbola, Femi. 2004. Tape recording. Ibadan.
- Andersen, Margaret L. 1997. *Thinking about Women: Sociological Perspectives on Sex and Gender*. Boston: Allyn and Bacon.
- Awe, Bolanle. ed. 1992. *Nigerian Women in Historical Perspective*. Lagos: Sankore Publishers.
- Boston Women's Health Book Collective. 1984. *The New, Our Bodies, Ourselves*. New York: Simon and Schuster.
- CBS News. 2004. "Sugar Daddies" Give Teens AIDS: Wealthy Older Men behind Rise of HIV in Southern African Girls. July 14. <<http://www.cbsnews.com/stories/2004/07/14/health/main629744.shtml/>>. (Accessed August 15, 2004).
- Correa, Sonia. 1997. From Reproductive Health to Sexual Rights: Achievements and Future Challenges. *Reproductive Health Matters* 5/10, 107-116.
- Crane, S. C. and P. E. Kaye, 1988. The American Health Care System: Conflicts in Medicine, Economics and Human Values. Pages 24-119 in *Health Care and its Cost: A Challenge for the Church*. New York: University Press of America.
- Davis, W. T. 1972. Image of God and Image of Women. *ORITA Ibadan Journal of Religion Studies* 122-146.
- Harris, K. 1984. *Sex, Ideology and Religion: The Representation of Women in the Bible*. New Jersey: Barnes and Noble.
- Kanyoro, Musimbi R. A., 1995. Interpreting Old Testament Polygamy. Pages 87-100 in *The Will To Arise: Women, Tradition and the Church in Africa*. Edited by Mercy Amba Oduyoye and Musimbi R. A. Kanyoro. Maryknoll: Orbis.
- Kemdrim, P. O. 1996. Women, Health Development and Theological Education. Pages 116-129 in *Women, Culture and Theological*

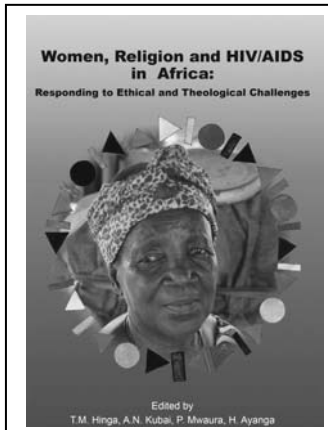
- Education*. Edited by P. O. Kemdrim and Mercy Amba Oduyoye. Enugu: SNAAP Press.
- Mason, Moya. K. Ancient Roman Women: A Look at their Lives. <http://www.moyak.com/researcher/resume/papers/roman_women.html>. (Accessed August 15, 2004).
- Morton, Nelle. 1972. The rising woman consciousness in a male language structure. *Andover Newton Quarterly* 12/4, 171-190.
- Nasimiyu-Wasike. Anne. 1995. Polygamy: A Feminist Critique. Pages 101-118 in *The Will To Arise: Women, Tradition and the Church in Africa*. Edited by Mercy Amba Oduyoye and Musimbi R. A. Kanyoro. Maryknoll: Orbis..
- Nwachuku, Daisy N. 1995. The Christian Widow in African Culture. Pages 55-70 in *The Will To Arise: Women, Tradition and the Church in Africa*. Edited by Mercy Amba Oduyoye and Musimbi R. A. Kanyoro. Maryknoll: Orbis.
- Oduyoye, Mercy Amba. 2004. Interview by author. Tape recording.
- . 1999. A Coming Home to Myself: The Childless Woman in the West African Space. Pages 105-122 in *Liberating Eschatology: Essays in Honour of Letty M. Russell*. Edited by Margaret A. Farley and Serene Jones. Louisville: Westminster John Knox Press.
- . 1995a. *Daughters of Anowa: African Women and Patriarchy*. New York: Orbis.
- . 1995b. Women and Ritual in Africa. Pages 9-24 in *The Will To Arise: Women, Tradition and the Church in Africa*. Edited by Mercy Amba Oduyoye and Musimbi R. A. Kanyoro. Maryknoll: Orbis.
- . 1990. *Hearing and Knowing: Theological Reflections on Christianity in Africa*. Maryknoll: Orbis.
- . 1976. Women from the Perspective of the Bible. *Orita* 10/2, 161-171.
- Ram, E. B. 1988. Churches' Pursuit of Health, Healing and Wholeness in an Interdependence World. Pages 308-319 in *Health Care and Its Costs: A Challenge for the Church*. Edited by Walter E. Wiest. New York: University Press of America.
- Ritchie, Ian D. 2001. African Theology and the Status of Women in Africa. Unpublished Paper Presented to the Canada Theological Society. Kingston.
- Ruzek, Sheryl Burt. 1984. *The Women's Health Movement: Feminist Alternatives to Medical Control*. New York: Praeger Publishers.
- Stanton, Elizabeth Cady. 1974. *The Original Feminist Attack on the Bible*. New York: Arno Press.

- United Nations. 1995. Beijing Declaration and Platform for Action.
<<http://www.un.org/womenwatch/daw/beijing/platform/>>.
(Accessed August 15, 2004).
- UNICEF, WHO, UNFPA. 1993. *Facts for Life: A Communication Challenge*. New York: UNICEF.

**A NEW PUBLICATION OF THE
CIRCLE OF CONCERNED AFRICAN
WOMEN THEOLOGIANS**

**Women, Religion and HIV/AIDS in Africa
Responding to Ethical and Theological Challenges**

**Edited by
Teresia M. Hinga, Anne Nkirete Kubai,
Philomena Mwaura and Hazel Ayanga**



"...a stunning assembly of essays that testify to the desperate tragedy, compounded by senseless violence and wilful prejudice, condemning millions of Africans, especially women and girl-children to social-death, even before they are taken by physical death."

ISBN: 9781 875053 69 8
Price: US\$ 15.00 or ZAR 75.00
Format: 210 x 148mm; 214 pages Paperback
Publication Date: 2008
Publisher: Cluster Publications

Order your copy today from:

Cluster Publications Box 2400 Pietermaritzburg, 3200
 or sales@clusterpublications.co.za Online orders:
<http://www.clusterpublications.co.za>

“AN ACT OF GOD?” THE EXPERIENCES OF GIRL-CHILDREN AND WOMEN LIVING WITH VESICO-VAGINAL FISTULA IN NORTHERN NIGERIA

Margaret Azuka Umeagudosu

Margaret Umeagudosu, a Nigerian, is a member of the Circle of Concerned African Women Theologians. She is currently working with the Raw Materials and Research Council, Abuja Federal Capital Territory, Nigeria <umeagudosu2000@yahoo.com>

Introduction

Gender issues have become a global concern in recent times especially with regard to health. The HIV and AIDS pandemic is being tackled worldwide, and has become a serious ailment holding back not only women but men as well. Vesico-vaginal Fistula (*hereafter*, VVF), although non-infectious is peculiar to women. It consists of an abnormal fistulous tract that extends between a woman's bladder and vagina, allowing the continuous and involuntary discharge of urine into the vaginal vault. It is a major health problem, very often found in adolescent girls who have been subjected to early marriage, pregnancy and delivery. Caused by obstructed and prolonged labour, prolonged pressure of the baby's head against the mother's pelvis cuts off the blood supply to the surrounding soft tissue of the bladder, rectum and vagina. The injured tissue soon rots away leaving a hole or fistula. As a result, the patient loses control over her urinary and bowel movements (UNFPA 2005:1). It should be noted that most VVF patients are young, illiterate, and poor, whose pelvic girdles are insufficiently mature to allow the normal passage of a baby. Because of poverty, no antenatal care is received, particularly during first pregnancies, and because of the long distances incurred in searching for medical assistance, a cure is often elusive.

It should be noted that most VVF patients are young, illiterate, and poor, whose pelvic girdles are insufficiently mature to allow the normal passage of a baby.

Africa, as Justin Ukpong describes, is “a land of poverty, hunger, malnutrition, starvation and disease (1984:1). As poverty increases throughout the continent as a result of unequal global markets, bad and

corrupt governance, civil wars and the like, so the feminisation of poverty becomes more and more obvious.

In some parts of Nigeria, girl-children are culturally regarded as chattels to be sold off for early marriage. Monies raised in this way are utilised to educate boy-children who will ultimately continue the family line. Education eludes the majority of girl-children because they are sent out to work as hawkers on behalf of their mothers and in the process fall victim to unwanted and early pregnancies when their pelvic girdles are not yet fully developed. While some end up becoming VVF patients, most are stigmatised, abandoned, or sent out of their family homes.

There are many socio-cultural beliefs, attitudes, religious practices, norms and taboos imposed on women by patriarchy which probably account for a large percentage of women's health problems. Early marriage by girl-children is one of the causes of women's health problems, even though most would attribute this to poverty. In some cultures, women are expected to give birth at home, which in Northern Nigeria is called '*Kunya*'—sometimes without any assistance, including that of traditional birth attendants (Sambo 1994:4). Given their situations of poverty, husbands or mothers-in-law often decide the level of care a pregnant woman receives. Under this rubric, prolonged and obstructed labour may set-in, placing the pregnant woman at risk of fistula and other serious injury, including death of both mother and child.

The experiences of the young girl-children who have their babies in the privacy of their homes are enormous especially as they often undergo a traditional practice called 'gishiri.'¹ Since their pelvic girdles are not yet fully developed to allow the normal passage of a baby, the traditional birth attendants use razor blades to cut the birth canal in order to widen it. This may cause damage to the bladder resulting in VVF, or the rectum resulting in Rectal-vaginal Fistula (RVF). VVF is experienced in almost all the parts of Nigeria, particularly among the rural poor. It is predominant in the upper part of Northern Nigeria where Muslims are in the majority. In these areas, some girl-children in the throes of labour travel for many hours or even days—by bus, donkey cart or on foot—in order to receive medical care, by which time, the baby has died. It is on the strength of these experiences that Sambo (1994) identified the causes of VVF as the consequences of delay in gaining access to medical care; the delay in deciding to seek help; and more directly, the delay in getting help when the facility has been reached.

¹ Traditional episiotomy which can expose the girls to HIV and AIDS, if the instruments used are not sterilised.

In this context, it is also important to note the traditional practice of female genital mutilation (FGM), which, if done in a crude way, may result in urinary problems and obstetric complication. In certain cultures, it is done during the infancy stage while in others, at the adult stage. Adults of a certain age group are brought together for the ceremony, where the custom is to prepare the girl-child for motherhood and ensure her virginity before marriage. As Mercy Oduyoye asserts, “the passage from childhood to adulthood is marked by rites; in some cultures they include circumcision of either male or female, or both” (1986:122). Oduyoye goes on to explain that when this rite is performed, a young person becomes a member not only of his or her family but of the whole community. It can be appreciated that health analysts have discouraged FGM, for the very obvious reason that it goes against a woman’s fundamental human rights.

Motivation and Method of Study

Given the foregoing problems, this study is aimed at examining the causes of VVF in Northern Nigeria and to analyse the experiences of some patients living with VVF. I was also interested in finding the views of the women and girls about their HIV-status in relation to God’s role in it. Furthermore, I wanted to find out the patient’s views about their role in the prevention of HIV infection.

The motivation to undertake this research came from the radio commercials on VVF by the Government of Nigeria Ministry of Health, stressing the need for proper education of girl-children up to university level before they can be given out for marriage. Emphasis was placed on early marriage syndrome (EMS) and the subsequent effect of teenage girls becoming VVF patients. Moreover, having observed some young girl-children begging along the streets, looking tattered, smelling badly and abandoned, I began researching the causes and cure of VVF in order to find out how best to prevent the ailment.

The methods adopted for this present study included oral interviews and visits to the Gesse VVF Rehabilitation Centre and Hospital in Birnin-Kebbi in Kebbi State, Northern Nigeria. Oral interviews conducted with VVF patients were used as a source of information and validation. Written reports of various workshops on VVF carried out in Northern Nigeria were used to buttress the oral information, and thereby analyse the steps taken thus far to affect a cure, as well as create awareness and prevention. In total, fifteen teenage girls were interviewed. Ten respondents were in the hospital wards awaiting surgery, while a further five had already been discharged, but were staying in the crafts section of the Hospital.

Conducted February 15-16, 2005, participants were each interviewed for half an hour. Six were interviewed on the first day and nine on the second. All interviews were conducted through an interpreter, who was well-versed in the Hausa language. Although fifteen women were interviewed, only four case studies will be shared here because they represent basically what was contained in the other interviews.

Experiences of Girl-children and Women Patients from Gesse VVF Rehabilitation Centre

The Gesse VVF Rehabilitation Centre had around 165 registered patients at the time of the research. The 15 interviewees were purposely chosen because they were willing to volunteer their information. The smallness of the sample does not make their views to represent the registered patients. Nevertheless, the sample is good enough for in-depth discussion. The fact that analysis of the 15 interviews showed that there were repetitions indicate that if all 165 had been interviewed, the stories could have been the same.

Through the interviews, it was established that the primary causes of VVF were prolonged labour and early marriage.

Through the interviews, it was established that the primary causes of VVF were prolonged labour and early marriage. The respondents however, did not see early marriage as part of their culture, but as a result of poverty. Although they did not attribute their problems to culture it was noted that in a particular family of seven, only boy-children were allowed to attend school. This was obviously a construction of culture emanating from particular perceptions of gender that deemed it more important for boy-children to receive an education than girl-children. In this respect, girl-children obviously became a burden to their parents hence the decision to marry them off early. The case studies below will illustrate some of these issues.²

Anita (14 years old) developed fistula during her first pregnancy. She recounted how she secretly told an elderly woman about her body leaking urine. The elderly woman went and told her mother-in-law who in turn enjoined her son to re-marry and throw his young wife out of the house. The husband however showed concern and took his young wife to the village maternity clinic; there he spoke to the nurse who had earlier helped

² It is important to note that the names used in the interviews are fictitious, in order to respect the confidentiality of the respondents.

her to deliver a dead baby. The nurse directed them to the Gesse VVF Rehabilitation Centre. At the time of the interview she was still in the hospital ward awaiting her turn for surgery. When asked whether she intended to re-marry after going through such an experience, her answer was positive. She was quite optimistic that her husband will receive her back since he occasionally visited her in the ward to bring her some food items. When asked why she had married early, she replied that her parents were very poor and could not even send her to primary school. As a result she sold 'dawa'³ for her mother. When asked whether she saw her condition as an 'act of God' she replied that God loves her that is why she did not die. When asked whether she knew about HIV and AIDS, she replied that she did not perceive herself to be at risk because she had never had sex with any other man except her husband, even though she does not know her husband's status.

Aisha (13½ years old) developed fistula during her first pregnancy. Her parents had sent her to school where a man impregnated and subsequently married her. Aisha recounted that when her husband smelled on her the odour of urine he beat her up, threw her belongings away and chased her out of the house. As a result, she went back to live with her parents. Her mother borrowed money to transport her to the Gesse VVF Rehabilitation Centre. Two weeks went by without anyone visiting her and she felt abandoned. She regretted her losing the chance of going to school, and intended to re-marry when she was well again. She thanked God for keeping her alive and giving her the type of mother that cared so much that she brought her to the hospital. She eats at the centre and occasionally goes to the crafts section to learn how to weave cloth. Regarding contracting HIV and AIDS, she vowed never to have sex with any man until she re-married. Here too, she did not show awareness that without knowing the HIV-status of the person she would re-marry she would still run the risk of becoming infected.

Zainab (15 years old) developed fistula during her second pregnancy. Her first child died because there was no money to take her child to the maternity clinic when the child became sick. She saw her suffering from fistula as an 'act of God.' She blamed her suffering also on the poverty of her husband, because, she had to travel long distances with her mother before they could get a bus to the Gesse VVF rehabilitation Centre. Even on the bus, both were standing. She recounted that her husband and mother-in-law visited her two times, bringing food items and some of her

³ Dawa is a traditional food that uses beans of the African locust (*Parkia biglobosa*) as its basis.

clothing. Regarding HIV and AIDS, she said that in their culture no married woman has sex with another man. However, she did not mention whether married men having sex with other women could equally put her at risk of becoming infected with HIV. She was convinced that she would go back to her husband after receiving surgery. She did not say whether her husband was having sex with other women during the period of her sickness.

Fatima (15 years old) was disowned by the man who impregnated her. She was badly beaten by her father for becoming pregnant, but her mother pleaded for her life. She did not attend school, but instead sold groundnuts for her mother. When labour set in no-one cared. After two days, when her condition becoming worse, her parents took her to a small private maternity home, where a patient suggested that they go to the Gesse VVF Rehabilitation Centre. Her mother managed to take her to Gesse, but as they were travelling her daughter gave birth to a dead child. The buses to the hospital were all full but because she was bleeding they managed to squeeze her into one of the buses to get her to the hospital. At the hospital they learned that she had VVF. At the time of the interview she had stayed at the Centre for only four days. The mother had returned home and promised to come back after one week. She recounted that her condition was her own mistake and that God would provide a husband for her. Regarding HIV and AIDS, she vowed never to have sex with any man until God provided her with a husband. This response was like that of the other girls who only thought of HIV as preventable by women and not by both men and women. She said that if she survives she will still go back to sell groundnuts for her mother.

Discussion of the Findings

It is helpful to note that the majority of the fifteen VVF respondents took the view that their condition could happen to any individual and was neither an 'act of God,' or due to their culture. Instead, they gave glory to God who they believed has helped them to be alive. Only two respondents saw their condition as an 'act of God.' They understood God as the architect of all that happens on earth, arguing that if God did not allow their sufferings, fistula could not have happened to them. Nevertheless, they thanked God who made it possible for them to be alive. One respondent said that no-one could blame her for marrying when her own peers were also getting married. This goes to support the assertion of Oduyoye, that "women's experiences of being persons primarily in relation to others—as a mother or as a wife, predominates in Africa. A woman's social status depends on these relationships" (1986:122).

It was clear from the responses, that these girl-children had internalised their culture to such an extent that they could not see it as oppressive. Early marriages were a norm in their culture and were not linked to fistula. It became a matter for conjecture how women who have been enjoined by God “be fruitful and multiply, and fill the earth and subdue it...” (Gen. 1:28 NRSV), could suffer hardship and death in their attempt to bear children.

To curb fistula in the developing world, the United Nations Population Fund (*hereafter*, UNFPA) has embarked on an important campaign to end FVV (UNFPA 1980:1-2).⁴ Importantly, the campaign has encouraged communication and networking among fistula centres throughout the world. In Bangladesh, a National Fistula Centre has been established at Dhaka Medical College Hospital. In Sudan, the Dr Abbo Fistula Centre has received funding for the establishment of a new operating theatre. In Chad, two fistula treatment centres have been established. In Mali, a new operating theatre has been established at the University Hospital at Point-G in Bamako. In Benin Republic, two major treatment centres have been established. In Niger Republic, UNFPA has supported a local NGO who organised a concert to raise awareness about VVF and funding for the construction of a fistula centre in Tahoua. In Zambia, the UNFPA provided the Monze Mission Hospital with medical supplies and equipment. Other countries where important initiatives are being supported by the UNFPA include Uganda, Sudan, Tanzania, Eritrea, Nigeria, Ethiopia, Sierra Leone and Kenya.

...the stigma associated with FVV causes many women to hide their condition. The pain, loneliness, and social stigma associated with FVV is often compounded by a sense of shame and humiliation...

While some live with FVV, others utilise traditional treatments. These are similar to what Isabel Phiri describes when, “women go out of their way to use herbs that cause the vagina to be dry, tight and warm” (2003:10). They believe that tightening the vagina will cure their condition. Due to high rates of illiteracy, many rural women do not know that they may do permanent damage to bodies. However, the stigma associated with FVV causes many women to hide their condition. The pain, loneliness, and social stigma associated with FVV is often compounded by a sense of shame and humiliation, hence, in the Gesse FVV Rehabilitation Centre

⁴ See also, <<http://www.endfistula.org/>>.

some young women decided to undergo skills training at the craft centre instead of returning home after treatment.

It is worrisome that all the girls connected their own abstinence from sex during their period of sickness or up to the time they remarried as a guarantee that they would not be infected with HIV. They did not question the fidelity of their spouses during their marriage or after their long separation following becoming sick. They did not mention the need to be tested for HIV if and when then go back to their husbands or remarry someone else. These results indicate that there is urgent need for HIV education while they are at the Gesse VVF Rehabilitation Centre so that they can make wiser decisions once they return to their homes.

Prevention

The widespread nature of VVF in the developing world has shown that it is neither caused by cultural practices or religion. The UNFPA has established VVF Centres which have special sections where survivors are taught income generating skills such as sewing, weaving and soap-making. They are also taught how to read and write. However, not all patients of VVF that came to the Gesse VVF Rehabilitation Centre agreed to undergo surgery. Indeed, of the 168 patients registered for treatment, 103 had been operated upon since the inauguration of the centre, while a further nine were treated without surgery. Given individual differences, as well as cultural and religious backgrounds, high poverty levels and other circumstances, some 47 patients were reported to have absconded without receiving treatment.

Although VVF work in Nigeria dates back to the 1960s (*cf.* Sambo 1994:1), prevention was inadequately addressed. Some 18 VVF treatment centres are spread throughout Nigeria, with some 14 being in Northern Nigeria alone, where the incidence of VVF is higher. Whether the religious and cultural milieu which sanctions the practice of early marriage in Northern Nigeria is responsible for this higher rate or the deeper degree of poverty in the area, is an important question worthy of further research.

VVF prevention should start from the family where the disorder begins. As Sambo (1990) points out, it was only in 1990 that an International Safe Motherhood Conference was held in Abuja, with the help of the Ford Foundation in collaboration with the National Council of Women to prevent VVF. As a result, the National Task Force on VVF was formed to draw up an agenda towards the prevention of the disease, In February 2005, the Federal Ministry of Health in collaboration with the UNFPA,

brought the campaign to Katsina, Kano, Kebbi and Sokoto. On the whole, proper antenatal care, alleviation of poverty, access to modern health facilities, provision of quality health services including family planning are essential if VVF is to be prevented.

It is disappointing to note that none of the religious institutions have thus far taken any action to either help girl-children and women with VVF, or incorporate messages of VVF prevention in their services of worship or sermons. There is also no intervention from religious leaders when husbands abandon their wives due to VVF, indeed it remains a taboo subject in religious circles. To some extent it can be argued that while some religious leaders in Nigeria have begun addressing the issue of HIV and AIDS, this is not the case with VVF. This is made worse by the fact that it affects women only, thereby adding to the many issues that consign women to being viewed impure and therefore not human enough for marriage, let alone service in the house of God.

It is disappointing to note that none of the religious institutions have thus far taken any action to either help girl-children and women with VVF, or incorporate messages of VVF prevention in their services of worship or sermons.

Conclusion

This study has shown that VVF is caused by “necrosis and not by infection” (Waalwijk 1995:35). Although affecting pregnant women of any age, it is mostly teenage girls who suffer the most, due to their pelvic girdles being immature. There is a clear cultural practice that allows for the early marriages of girl-children, placing them at high risk for VVF. As has been noted, at VVF centres such as at VVF Rehabilitation Centre, Birnin-Kebbi, Kebbi State, Northern Nigeria, skills training and literacy education is offered to assist recovering patients to learn a trade that will help them in the future. Skills training may be seen as a confirmation that poverty plays a big role in making families marry off their daughters at an early age. Poverty also accounts for the girl-child’s inability to receive medical treatment quickly when they are about to deliver their babies. From the respondents in the research, it became obvious that if they had received medical attention quickly, the chances are high that they could have averted VVF. Although their sufferings were great, the majority of the respondents did not see their plight as an ‘act of God’; instead, they thanked God for their survival. More research is needed to establish why religious communities are failing to speak out against the causes of VVF. Poverty, although not the only cause of the problem, certainly exacerbates

it, as the teenage girls are unable to raise money for both antenatal and hospital bills, not to mention adequate health care. Although the target audience for the study were the patients in the Gesse VVF Rehabilitation Centre, other data has shown that the problem cuts across Nigeria, as well as other parts of Africa where the situation is the same. It is therefore suggested that further research on VVF will go a long way to help eradicate it from Nigeria, Africa and the developing world. More research is also needed on HIV education to young girls who get married early. There is an assumption that HIV prevention messages are for single teenagers. As this study has shown, married teenagers need awareness messages on how the HI-virus is spread and how one can prevent it, especially when the couple has been separated for long periods of time due to illness.

Bibliography

- Agboola, A. 1988. *Text Book for Obstetrics and Gynaecology for Medical Students*. Vol. 2. Lagos: University Services Education Publishers.
- Atoyeyi, W. and E. Oriakhi. eds. 1993. *The National Medical Directory*. Lagos: Nigerian Medical Association and Healthy Living Communications.
- Ejembi, C. L. ed. 1995. *The Vesico-Vaginal-Fistula Scourge: A Preventable Social Tragedy*. Zaria: Ministry of Health.
- Mwanamke, Utu. ed. 2003. *Faces of Dignity: Seven Stories of Girls and Women with Fistula*. Dar es Salaam: Women dignity Project.
- National Foundation on Vesico-vaginal Fistula. 2005. *Facts on Vesico-Vaginal-Fistula in Nigeria*.
- Oduyoye, Mercy Amba. 1986. *Hearing And Knowing: Theological Reflections on Christianity in Africa*. Maryknoll: Orbis.
- . and Musimbi R. A. Kanyoro. eds. 1992. *The Will to Arise: Women, Tradition and Culture in Africa*. Maryknoll: Orbis.
- Phiri, Isabel Apawo. 2003. African Women of Faith Speak Out in an HIV/AIDS Era. Pages 3-20 in *African Women, HIV/AIDS and Faith Communities*. Edited by Isabel Apawo Phiri, Beverley Haddad and Madipoane Masenya. Pietermaritzburg: Cluster.
- Sambo, A. E. 2001. Vesico-Vaginal-Fistula in Northern Nigeria. *Grassroots Health News* 2/1, 7-8.
- . 1994. *Report on National Task Force on VVF 1991-1993*. Kano: El Rufu Publishers.
- Ukpong, Justin. 1984. *African Theologies: Now a Profile*. Eldoret: Gaba Publications.
- United National Population Fund (UNFPA). 2005. Annual Report: The Campaign to End Fistula.

<http://www.endfistula.org/docs/annual_report2005.pdf>.
(Accessed May 2, 2008).

- . 1980. *Campaign to End Fistula: Supporting Fistula Centre*. Zaria: Ministry of Health.
- Waldijk, Kees. 2004. The Immediate Management of Fresh Obstetric Fistulae according to Basic Surgical Principles. *American Journal of Obstetrics and Gynaecology* 191/3, 795-799.

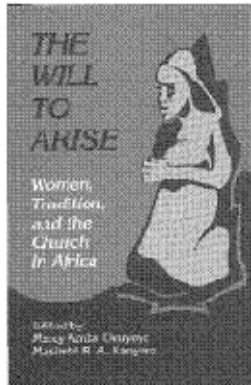
BACK IN PRINT!

THE WILL TO ARISE

Women, Tradition and the Church in Africa

Edited by

Mercy Amba Oduyoye & Musimbi R.A. Kanyoro



What is the reality of being African, woman, and Christian? In this collection of original essays, African women theologians write about the life and dreams, the sorrows and joys of African women in a continent where religion shapes the whole of life.

ISBN: 1-875053-58-1
Price: ZAR 80.00 (Incl. Postage & Packing)
Format: 210 x 148 mm; 230pp; Paperback
Publication Date: 2006 (reprint)
Publisher: Cluster Publications (First published by Orbis Books, 1992)

Order your copy today from:

Prof. Isabel Phiri
 School of Religion Theology, University of KwaZulu-Natal
 Private Bag X01 Scottsville 3209 South Africa
 Email: PhiriI@ukzn.ac.za

**CARE-GIVING IN TIMES OF HIV AND AIDS, WHEN
HOSPITALITY IS A THREAT TO AFRICAN
WOMEN'S LIVES: A GENDERED THEOLOGICAL
EXAMINATION OF THE THEOLOGY OF
HOSPITALITY**

Lilian Siwila

Lilian Siwila, a Zambian, is a member of the Circle of Concerned African Women Theologians. She is currently a PhD Candidate in the Gender and Religion Programme at the School of Religion and Theology, University of KwaZulu-Natal, South Africa <siwilach15@gmail.com>

The meaning of care is usually taken as given and often presented as comprehensive in its coverage of caring activity, when in fact the concepts of care employed are partial representations or segments of the totality of caring. Definitions of care are constructed such that, boundaries are differently drawn around what constitutes care with the effect of excluding or including sets of social relations. (Thomas 1993:649)

Introduction

**The task of offering hospitality in most African societies is
mainly assigned to women who in most cases have to risk their
own lives in the name of providing hospitality.**

Hospitality is one of the most common features of African society. Although practiced in different ways by different cultures, much of what Africans practice with regards to hospitality is held in common among them. The task of offering hospitality in most African societies is mainly assigned to women who in most cases have to risk their own lives in the name of providing hospitality. Although “hospitality is inherently and genuinely African” (Oduyoye 2001:94), meaning that Africans are born, live and die with the concept, most African women understand hospitality differently. To some, to be hospitable, means to be fully human, while to others, it is a gift from God that needs to be utilised if a person is to attain full spiritual maturity. This kind of teaching has often been adopted by the church in Africa. Women who fill the pews of the church are reminded of

the biblical importance of being hospitable to all who come their way, under the pretence of entertaining angels unawares!

Part of the title of this article is understanding hospitality as a threat to the well-being of African women's lives. In as much as hospitality is an African and Christian virtue that has a positive impact on people's lives, it will be argued that if not practiced properly, hospitality can cause serious harm, particularly to the lives of women. This article will thus aim at discussing the risks that African women encounter as they practice hospitality. Being aware that there are many risk factors incurred by African women practicing hospitality, this study is limited to the risk of care-giving in times of HIV and AIDS illness. This risk factor includes many others, including the danger of becoming HIV-infected and experiencing high levels of stress due to the burden of offering care to those suffering from full-blown AIDS. Both these factors are associated with African women's practice of providing hospitality.

In trying to address the problem of hospitality, of care-giving as a threat towards HIV-infection among most African women, I will use a narrative method in this case study. A feminist theory of care-giving as outlined by Isabel Phiri will be used to discuss the effects of care-giving in the time of HIV and AIDS. Finally, using a gendered theological examination of the theology of hospitality, it will be the intention of this present study to suggest a partnership model that will call for a theology of inclusiveness in care-giving in times of HIV and AIDS illness. Using this model, ways will be suggested in which the church can respond to the problem of hospitality as a risk factor to women care-givers to HIV and AIDS patients. While acknowledging that care-giving can be understood as a form of payment in kind or as voluntary work, this study will address the act of hospitality from the socio-cultural context because the concept as found in most African contexts is a constructed gendered role.

Hospitality: Some Definitions

Hospitality has posed a serious risk to most women in Africa. For Mercy Oduyoye, hospitality includes, welcoming/receiving; charity/almsgiving; boarding and lodging/hotel; protecting/sanctuary (2001:93). According to Pierre-Francois de Bethune, hospitality belongs to the realm of ethos which consists of letting others in, entering another's space, sheltering a stranger or offering food (2002:3). Finally, Brendan Byrne understands hospitality as conjuring up the context of guests, visitors, providing meals, boarding, lodging and making the stranger feel at home (2000:4). These three definitions are in some way related to the kind of hospitality that most

African women offer to those who come in to their lives. These three definitions will therefore be used simultaneously in showing how African women's hospitality as care-giving in times of HIV and AIDS illness has been abused.

The Biblical Concept of Hospitality

Although theologically, not much has been written on Christian hospitality, there are many biblical stories related to hospitality. The creation story in Genesis 1:1-31 speaks of God as a hospitable God. In this story, God shows hospitality by providing creation for the habitation and enjoyment of all God's creatures, God then offers hospitality to all humanity by establishing a home (*oikos*) for all. The other aspects of God's hospitality can be seen through the birth of Jesus. God, through the birth of Jesus offers hospitality, through which all humanity can receive salvation and everlasting life. From this New Testament perspective, hospitality has always been seen as being central to the teachings of the Christian gospel. The announcement of the birth of Jesus Christ (Luke 1:26-38) is thus viewed as the most important aspect of God's offering hospitality to all humanity. From a feminist and womanist perspective, Mary's role in the birth of Jesus stands out as one of the significant stories in the bible that depicts a woman's response to Gods' act of hospitality:

Then Mary said, 'Here am I, the servant of the Lord; let it be with me according to your word.' Then the angel departed from her (Luke 1:38 NRSV).

Mary allows herself to be the channel through which God demonstrates God's hospitality towards humanity by offering Jesus; Mary too is hospitable enough to allow this miracle to take place in her life for the salvation of all humanity.

Theoretical Framework

Gender roles are those socio-cultural roles that men and women are committed to do in their communities. Societies in most cases are shaped by such gender roles. Care-giving is one such gender role that has been associated with women especially when care is given to HIV and AIDS patients. Phiri (2003) in discussing the Circle of Concerned African Women Theologian's gender-based mainstreaming response to HIV and AIDS sees the idea of women caring for HIV and AIDS patients and projects as both a church and community phenomena. For her, women have traditionally been care providers for everyone in the home; the HIV and

AIDS epidemic increases women's workload as AIDS patients often require home-based care for long periods of time. Phiri sees this condition worsened by financial limitations and lack of knowledge on the side of the women, particularly with regard to how they can protect themselves from being infected with the virus. Phiri goes further to comment that young girl-children often have to drop out of school in order to take care of their sick parents or siblings and thereby lose out on their future in terms of education (2003:15). The theory of seeing women and girl-children as care-givers in times of HIV and AIDS as outlined by Phiri has serious implications on women's lives, calling for a partnership between women and men in deconstructing this idea.

Care-giving as a Form of Hospitality in Times of HIV and AIDS

In almost all African countries, care-giving towards the sick is usually undertaken by women and girl-children. Despite other forms of care, and social burdens such as poverty, structural adjustment programmes and globalisation, women and girl-children are still expected to care for the sick especially those dying of HIV and AIDS. As the incidence of HIV and AIDS increases in most African countries, so does the burden of care-giving on women and girls. Although this kind of care-giving is said to be compatible both with African and Christian values of women's expression of their God-given gift of hospitality, there is need for fresh examination of such socially and theologically imposed roles particularly as related to the ministry of care-giving and calling from God.

As the incidence of HIV and AIDS increases in most African countries, so does the burden of care-giving on women and girls.

The Challenges to Care-giving in Times of HIV and AIDS

Some of the challenges that these women and girl-children go through during this time are first, the risk of being infected with the virus in the process of care-giving. Most of these women and girls have to provide home-based care in their homes without proper training needed for this kind of care to AIDS patients, let alone the necessary equipment to be used during nursing. This is due to their economic and social location which affects access to the training facilities for home based care. There is also unavailability of the proper equipment for care. Even when training has been provided and the equipment made available to some of these care-givers, the affordability of these facilities due to financial setbacks becomes another hindrance to them.

Apart from the risk of becoming infected, women and girl-children also face the risk of losing their employment, as well as other eventualities. Some women risk their jobs because they have to spend more time taking care of their loved ones. In 1998, while working as a teacher in Zambia, the researcher came across a number of incidents of colleagues who received warning letters from their employers because of the time taken off work nursing their sick husbands. At the same time, pressure received from family members due to being unavailable each time at the hospital to take care of their sick husbands was also experienced. The climax was to visit a friend who was ill and see her crawling on all fours in the kitchen trying to prepare a meal for a sick, yet still mobile husband, who demanded it from her! Asked why she was doing this, she stated:

My parents and in-laws encouraged me to [be] more stronger than my husband in this illness and make sure that I take care of him well so that he can die a [decent] death as a man who had a caring wife. Besides this is my duty as a woman and that is what for better or for worse means...¹

Most African women who are care-givers cannot afford to stop work because they are often the sole-breadwinners in the home. At the same time, they cannot afford to let someone else nurse their husbands because of cultural demands. Hence, the church will always remind them of their wedding vows, expecting them to prove to the church that they have stood by their husbands in 'sickness and in health' at the expense of their own physical and mental well-being.

As has been seen above, many girl-children end-up dropping out of school due to their having to look after their sick parents at home. In many African societies, girl-children as young as ten years of age find themselves in the position of caring for their dying parents, denying them the opportunity of enjoying their childhood and forcing them to take on the responsibilities of adulthood at such a tender age. It is unfortunate to note that in most cases it is only when there is no girl-child in the home to take care of sick parents does this act of hospitality fall on a boy-child.

¹ I have decided to bring out this narration to show how hospitality can be a threat to most women in Africa especially when coupled with cultural and Christian traditions. This incident took place in March 1998. Mary (not her real name) died in October 1999, following the death of her husband six months earlier.

The question one must ask is what makes people think that to become a woman, it is necessary to care for the sick? Care-giving during the time of HIV and AIDS, as a form of African women's act of hospitality has been identified as one of the problems facing women and girl-children in the home and yet little has been written about other hazards related to care-giving such as stigma, depression, stress exhaustion, and burnout. As a result of these factors, some even die earlier than their patients or soon after their patients have died.

Care-giving as a Socio-cultural Construct

The idea of viewing women as the care-givers in times of illness is one of many socio-cultural constructs that make African women vulnerable to HIV-infection. In many African societies, care-giving and preparing food for the family is believed to be the duty of a woman. In discussing this concept, Phiri argues that:

The traditional upbringing of boys and girls runs on gender lines. Girls learn from their mothers that they were created to serve their brothers. Boys also grow up believing that they were born to be served by the girls and women. Such roles are further emphasised through traditional initiation ceremonies where girls are given sexual education to satisfy the sexual needs of their husbands (1998:143).

While it is important to appreciate the God-given talent of women as home-makers, it should be argued that African women's hospitability has been abused through the socio-cultural expectation of care-giving.

In as much as this concept seems to be slowly dying out due to gender awareness of having both boy and girl-children do chores around the house, much of what has been taught in the past still remains in the minds of many men and women who would find it a cultural taboo to let the boy-child do any housework previously associated with girl-children. These kinds of socio-constructed ideas have in many cultures been viewed as cultural norms used to govern society. A good example is a culture such as that of the Tonga ethnic group of Zambia. In this culture, most families still hold onto the idea that a woman's place is in the kitchen. This is demonstrated through songs and proverbs performed especially during marriage ceremonies, all of which point to women being the suppliers of hospitality in building the home.

While it is important to appreciate the God-given talent of women as home-makers, it should be argued that African women's hospitality has been abused through the socio-cultural expectation of care-giving. The story of Tamar (2 Sam. 13:1-22) is one such example of a socio-cultural construct theory where David requests Tamar to go and cook for her sick brother, thereby assuming that this is Tamar's responsibility as a woman. One respondent, during the launch of the 2007 Tamar Campaign in Zambia commented that:

In many ways most of us parents are like David, we have always exposed our girl children to the danger of being sexually abused by our male dependants by asking them to provide some form of hospitality to these male dependants. Tamar became a victim of rape in the process of providing hospitality to a sick brother.²

The other socio-cultural construct as discussed by Oduyoye is that of viewing women as the ones who offer hospitality, whether in the home, community or the church. As Oduyoye notes, "Women are expected to be available to all who claim attention and service" (2001:10). Oduyoye further observes that pre-marital counselling offered by the church to women on such topics as being in submission to their husbands, ensures that women continue to be viewed as sex-objects of men's desire and thereby making them vulnerable to HIV-infection. It is these kinds of socio-cultural constructs that bring into question the concept of hospitality as viewed by most African societies.

Factors that Influence African Women's Vulnerability as Care-givers during HIV and AIDS Illness

The first factor identified as influencing African women's vulnerability as care-givers in AIDS illness is the issue of male power and culture.

² The respondent in this story was one of the participants in the Contextual Bible Study that I conducted in Kitwe during the National launch of the Tamar Campaign, June 22, 2007. The woman was responding to the question on the role played by David in the rape of Tamar. This woman compared the act of David sending Tamar to cook for her brother to the African way of viewing a girl-child as the one who take care of her brothers in the home. The woman thus commented, "this is a good thing because we are teaching our children to be good wives in the future but what if Amnon had AIDS?...this is where I see that we should also teach our boys to do house duties so that we cannot over-danger our girl children..."

According to Karim (1998), the power imbalances between men and women and assigned gender roles are recognised as crucial contributing factors to women's vulnerability. Male power-relations can be associated with patriarchal rule, upon which most, if not all African societies are formulated. African women under such patriarchal structures have little or no power or control over their own bodies. The one who possesses the power is the man!

Musimbi Kanyoro is of the view that at this moment in the history of HIV and AIDS, we understand well that in Africa, poverty, ignorance and powerlessness compromise many women, incrementally increasing their risk and vulnerability to the virus. The issue of power in most African societies is closely associated with the culture and practice of power. Culture gives men the power to do what they want women to do. In most African societies, it is culture that prohibits men from taking care of sick people. Fear of breaking culture is one of the serious setbacks that have affected most African women who are care-givers during the HIV and AIDS epidemic. For most African women, the silencing aspects of culture have made it impossible for them to enjoy and appreciate the liberating spirit promised by Jesus Christ. Not until African women know and understand the true freedom they have in Christ, will they be able to break through the spirit of silence and fear. Calling on the spirit of resistance against such debilitating cultural practices, Kanyoro concludes by saying:

Resisting and challenging culture and cultural practices is one of our most urgent tasks in the face of HIV and AIDS, women's risk of HIV is increased by cultural and social subordination, the failure to recognise women's basic human rights and the growing levels of poverty, which expose many women to high risk. Women have to challenge gender norms, which legitimise the inferior status of women (2004:x).

While most African women look at deconstructing some of the gender constructs that dehumanise their lives, it is also important to view them with an African cultural lens, because it is through such culture that social constructs breed. As Diane Kimoto points out:

History has mistakenly considered women 'as carers' as a natural phenomenon rather than a social one. On the basis of this natural ability, the role of caring is overwhelmingly ascribed to women. Thus women's caring activities much like other biological activities such as child bearing are regarded as obligatory, unending and effortless. This antiquated manner of defining women as carers

imprisons them within highly prescriptive behaviours. It obliges them 'to assume responsibility for others' needs; confines them to the private sphere and constrains their access to resources and to independence (1998:157).

In reviewing such an understanding of care-giving, it is only natural to say that the issue of seeing women as care-givers during AIDS illness is something that can be revised by any community that is seriously seeking for the liberation of women. Instead of viewing care-giving as a joy, most women have done it out of a sense of duty, fearing victimisation because of the way culture has constructed their role as carers. In summarising this section, Kanyoro argues that just as no culture or religion can ever claim to be static, African ways of living and being are also not static. Hence, while bearing a direct link to the past, Kanyoro understands culture and religion in Africa today as having to adapt itself out of necessity to present realities (2002:1).

Instead of viewing care-giving as a joy, most women have done it out of a sense of duty, fearing victimisation because of the way culture has constructed their role as carers.

Methods

Study Site/Participants and Data Collection

This study took place in July 2004 at the Mindolo Ecumenical Foundation, Kitwe, Zambia. After conducting a Contextual Bible Study on the story of Tamar (2 Sam. 13:1-23) with the Mothers' Union, the researcher interviewed two sixty-eight-year-old women, and one thirty-eight-year-old woman from the same group, utilising an in-depth open-ended interview method. The reason for using this form of open-ended interview was to find out how these three women viewed the concept of women's hospitality in this time of HIV and AIDS. The interview took a more narrative approach method towards the problem. The reason for using this kind of approach was to allow a situation where respondents could relate their stories using their own lived-experiences. This kind of method proved very helpful to the study, knowing that most women's stories are rarely told or even written down, especially those related to their struggles in life. As a means of using the bible to open up discussion, the researcher prepared the questions in such a way that they moved from a group experiential approach to that of individual experiences of hospitality. In this way, women were able to narrate their experiences of hospitality and care-giving in story form.

Results

The interviews with the three women revealed a lot of issues, some of which were not mentioned in the bible study. One of the 68 year-old women, related a story of how she had nursed all six of her sick children single-handedly over a period of three years. Later, she was labelled a witch by the community and the relatives of her husband, who felt that she was behind the deaths of her children because she wanted to inherit their wealth. Asked why she allowed herself to go through all this alone, the woman told the present researcher that if she did not go to see her children, the same community would have called her a witch because only a witch has an inhospitable heart! In concluding her story she said these words:

If hospitality means that women should change hospitals and towns, nursing the sick and still be seen as witches, then there is nothing left of the word from the way I know it as an African Christian. What I have now are only my grandchildren and at my age I must learn the art of taking care of even the young children.

The other two women had similar stories. Both were widows who had nursed their sick husbands through until their death. The 38 year-old woman, in narrating her story, said that her in-laws told her to stop work and focus on her husband because this is the time she needed to prove her love to him. After much struggle, she resigned from her job and stayed home with her patient. Her resignation made the situation at home very difficult financially because they now had to depend on the husband's half salary which was managed by the in-laws. Asked how she viewed hospitality in such a situation, she remarked:

I found myself in a very difficult situation trying to question whether that is the kind of hospitality that God wants from us as women.

All three women interviewed lamented that hospitality—be it in the church or in the home—have become a threat to the well-being of women's lives. All the women said that they found themselves abused by the church, the home and the community. They saw HIV and AIDS as a fuelling factor to the abusive situations that they found themselves in. Asked whether they had received any help from the church, the women said that the church was no better than the home. It was the church that told them to submit to their husbands in everything, constantly reminding them that they needed to take care of the sick as part of their calling from God.

Analysis

The stories of these three women are just part of the hidden stories of most African women in Zambia and elsewhere. Care-giving in the time of HIV and AIDS has threatened hospitality among most women in Africa mainly due to the way in which society has structured the whole aspect of care-giving. The church has not made the situation any better, if anything it has contributed to the abuse. The women in particular cited the home-based care centres that are run by the church, which in most cases are managed by the women in the church. The three women all reported that the men in these centres are mainly managers, while the women are the ones who look after the sick. What was significant in this study was that most women in Zambia are care-givers to those dying of AIDS. Another aspect that was discovered is that culture has played a very important role in fuelling women's abuse in their practicing of hospitality. This was gained from the teachings they received while growing up from their parents, during initiation ceremonies, and finally through the teachings they receive through the church, including pre-marital guidance counselling sessions.

A Theological Analysis of the Concept of Care-giving using Mathew 25:31-46

As a woman theologian, growing up in a Methodist church where the Men's Christian Fellowship (MCF) was supposed to be as strong as the Mother's Union Group, the present researcher has always wondered why the MCF group could not be seen to provide care towards AIDS patients, be it at hospital or through home-based care units. Although both groups supposedly focus on answering the call of God through service towards the community, it is the women who in most cases act as sheep on the right-hand of God (*cf.* Matt. 25:34-36), providing an attentive and caring response to the call of God, even when no-one heeds or notices them. These are the ones who were able to give food to the hungry, drink to the thirsty, welcome to strangers, clothes to the naked, take care of the sick, and visit those in prison. The attributes listed above are demanding and can be risky, even to the point of death. In many ways, many women and girl-children risk their lives by going beyond their limits in providing care to those in need. Looking only for that blessed hope promised by the Lord at the final eschaton, one often hears Christian women in Zambia encouraging each other by the singing of this Bemba song:

*Nayo nayo (x 4) Nayo milimo ya Lesa
Nokupempula balwele Nayo milimo ya Lesa
Noku pempula balanda Nayo milimo ya Lesa*

Nokusambika ifitumbi Nayo milimo ya Lesa

This song simply tells women that any kind of care-giving and hospitality offered to the sick, the bereaved, the poor, is all the work of God. To such women, helping God's people is like hearing God saying:

And the king will answer them, "Truly I tell you, just as you did it to one of the least of these who are members of my family, you did it to me" (Matt. 25:40 NRSV).

Like goats, the church has decided to ignore the words of the Apostle Paul when he commands Christians:

Bear one another's burdens, and in this way you will fulfil the law of Christ (Gal 6:2 NRSV)

The only way this law will be fulfilled will be when the theology of inclusiveness stated by Oduyoye (2000) is initiated by the church, whereby all women and men work together towards a common goal. As members of the one Body of Christ, what affects women should also affect men (1 Cor. 12:12-30). Women should also be encouraged to support one another in times of illness. Instead of spending time condemning those women who nurse their loved ones, care and support should be given to the carers. Forming spiritual support groups will help enhance such a commitment to one another. The church, when dealing with women who are care-givers, should also introduce a theology of partnership for both women and men to help look after the dying.

The church, when dealing with women who are care-givers, should also introduce a theology of partnership for both women and men to help look after the dying.

One of the challenges the present researcher had in July 2007 while visiting the Zambian town of Mazabuka was to find a small post by the roadside with the words: *Men Making a Difference*. Inquiring further about the sign, it was found that it referred to a group of men who had formed this group aimed at fighting gender imbalance in the community. Some of these men go to hospitals to take care of the AIDS patients, while others have volunteered to work as home-based carers. If this kind of scenario is encouraged, then the burden upon women will be lessened.

Conclusion

HIV and AIDS is one of the worst epidemics to hit Africa in recent years. African women's experience of HIV and AIDS is different from that of men. HIV and AIDS is said to have a feminine face, meaning that women are more affected and infected with HIV and AIDS than their male counterparts. There are many factors that lead to this difference, one being the burden of caring for the sick and the dying. Women and girl-children as care-givers of HIV and AIDS patients have been affected in many ways by the disease. These include stigmatisation, stress and burnout, the danger of HIV-infection, increased workload and negligence by the community. The issue of cultural practices that make women vulnerable has also been addressed in order to help with the enculturation of the issue of HIV and AIDS. Those women who are voluntarily involved in projects such as home-based care should be encouraged to continue. At the same time, more men should also be encouraged to join these projects as carers, so that there is gender equity in care-giving. The church as the body of Christ should see itself as being infected and affected with HIV and AIDS. As a result, it should act as a catalyst to care-givers by providing them with the hope that they need to live longer and to nurse their dying friends and relatives with a positive mind.

Finally, the coming together of all humanity to look at the plight of the care-giver will help to give hope to some dying patients who sometimes wish that they could die sooner so as to relieve their carers of the burden of looking after them. African women who have sacrificed their time, energy, resources and jobs in order to take care of AIDS patients need the constructive response of the church if their care-giving is to be effective.

Bibliography

- Byrne, Brendan. 2004. *The Hospitality of God: A Reading of Luke's Gospel*. Minnesota: The Liturgical Press.
- de Bethune, Pierre-Francois. 2002. *By Faith and Hospitality: The Monastic Traditions as a Model for Interreligious Encounter*. Herefordshire: Grace Wing.
- Kanyoro, Musimbi R. A. 2004. Reading the Bible in the Face of HIV and AIDS. Pages viii-xiv in *Grant Me Justice! HIV/AIDS and Gender Readings of the Bible*. Edited by Musa W. Dube and Musimbi Kanyoro. Pietermaritzburg: Cluster Publications.
- . 2002. *Introducing Feminist Cultural Hermeneutics: An African Perspective*. Cleveland: The Pilgrim Press.

- Karim, Quarraisha A. 1998. Women and AIDS: The Imperative for a Gendered Prognosis and Prevention Policy. *Agenda* 39, 15-25.
- Kimoto, Diane M. 1998. Affirming the Role of Women as Carers: The Social Construction of AIDS through the Eyes of a Mother, Friend and Nurse. Pages 155-168 in *Women and AIDS Negotiating Safer Practices, Care and Presentation*. Edited by Nancy L. Roth and Linda K. Fuller. New York: The Harrington Park Press.
- Oduyoye, Mercy Amba. 2001. *Introducing African Women's Theology*. Introductions in Feminist Theology #6. Sheffield: Sheffield Academic Press.
- Phiri, Isabel Apawo. 2003. African Women of Faith Speak Out in an HIV/AIDS Era. Pages 3-20 in *African Women, HIV/AIDS and Faith Communities*. Edited by Isabel Apawo Phiri, Beverley Haddad and Madipoane Masenya (ngwana' Mphahlele). Pietermaritzburg: Cluster.
- . 1998a. Christianity and African Women: Liberation or Oppression? Pages 198-217 in *Faith at the Frontiers of Knowledge*. Edited by Kenneth R. Ross. Blantyre: CLAIM.
- . 1998b. The Initiation of Chewa Women of Malawi: A Presbyterian Women's Perspective. Pages 129-145 in *Rites of Passage in Contemporary Africa*. Edited by James L. Cox. Cardiff: Cardiff Academic Press.
- Thomas, Carol. 1993. De-constructing Concepts of Care. *Sociology* 27/3, 649-69.