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TRADITIONAL MEDICINE AND THE QUEST FOR NATIONAL IDENTITY IN ZIMBABWE

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Abstract

This article traces and analyses efforts by practitioners of traditional medicine to obtain official recognition of their sector in post-colonial Zimbabwe. Beginning with a brief historical background of the role of traditional medicine in the colonial period, during which traditional medical practice was marginalised and denigrated, while efforts were made to promote western medicine by the colonial settlers who benefited most from it, the article highlights the various post-colonial campaigns to get traditional medicine officially recognised as "a legitimate form of health care" and the struggles to "reshape traditional medicine into a health service parallel to western medicine". These campaigns are analysed within the broader context of Zimbabwe's search for national identity.

INTRODUCTION

When Rhodesia (formerly Southern Rhodesia) became Zimbabwe in 1980, its colonial legacy, an experience shared with practically all of Africa, was compounded by 90 years of white settler rule. The health service was white-run, white-staffed and practiced apartheid. It served the white minority and only incidentally ministered to the Africans, who comprised some 97% of the population. The white settlers, who controlled the colonial legislature, saw to it that they alone enjoyed posh medical attention. Thus Zimbabwe was challenged at independence to eliminate white privileges and restructure health care to provide services to the sections of the African population that had been the most deprived.

In addition, Zimbabwe became independent at a time when neighbouring countries were taking steps to officially recognize traditional health care providers and give them a role in national health service. This idea had been raised by the World Health Organization (WHO),

¹ I gratefully acknowledge the assistance of Michael West, who, while doing his own research on Zimbabwe, collected many of the primary materials used in this study and invited me to pursue the topic for a panel he organized at an academic conference. I also had the pleasure of directing the honours senior thesis of Madeline Frucht, now a medical doctor, whose study of traditional medicine in Zimbabwe gave me the rare pleasure to direct a subject in which I had an abiding interest, and acquainted me with developments up to the mid-1980s.

which called on member states to not only implement primary health care programmes based on preventive care, low-cost providers and decentralized facilities in order to achieve "health care for all by the year 2000", but also to evaluate the role traditional medicine might play in primary health care delivery. The recognition of traditional medicine was everywhere a controversial subject, given the reduction of its status under colonialism and the co-existence of a modern health care sector that remained convinced of its pre-eminence.

The story of traditional medicine in Zimbabwe in the first ten years of independence is told here, against the background of two related developments. One is the impact of colonialism on traditional medicine, and the other is the work neighbouring countries were doing by 1980 to "collaborate" with traditional medicine and its practitioners. After presenting this background, the Zimbabwean experience is told in two parts. The first part concerns the campaign to gain government recognition of traditional medicine as a legitimate form of health care, while the second part pursues the subsequent struggle to reshape traditional medicine into a health service parallel to western medicine. These efforts, coming as they did within Zimbabwe's first ten years of independence, spoke to the heart of Zimbabwe's search for national identity, both in terms of its professed socialist policy and its nationalist imperative.

THE COLONIAL BACKGROUND

In colonial Zimbabwe, as elsewhere on the continent, western medicine was introduced by missionaries. The missionaries, who had brought along medicines for their own use, quickly discovered that they could advance their evangelistic work by sharing the contents of their medicine chests. Soon the occasional treatment provided by missionaries led to a need for systematic services, especially when it became clear that evangelism was directly threatened by traditional medicine and its mysticism.

For instance, over three-quarters of a century after the London Missionary Society (LMS) established the first mission in 1857 in what would later become colonial Zimbabwe, one of its employees wrote the Society's Foreign Secretary about the problem of attracting African men to the mission. He lamented that "polygamy and beer-drinking seem to be the two great attractions, while witchcraft will never die out until some mission takes up medical work seriously". Arguing that the LMS mission in Botswana was successful precisely because it had a dispensary, he asserted that in colonial Zimbabwe the LMS "has depended too much upon (non-existent) Government doctors in South Africa and our work

has been starved in consequence", and urged the board to "realise what a terrible evil witchcraft is, . . . that bigger evil behind so much disease" (Anderson, 1936).

Similar, if less strident, sentiments were sent home by a locally-based Salvation Army officer who claimed the Army's one dispensary was not enough, "as the country is steeped in customs which centre around witchdoctors and other medicine men". He added that the Salvation Army workers in the Reserves, areas to which the majority of Africans were consigned under the system of territorial segregation, "have constantly to combat the evil practices of these people", noting how "Army Officers and Teachers have ever to be on the alert to prevent their people [African converts], when sick, being doctored by the heathen" (*Officers' Review*, 1934).

The health care offered by missions was devoid of mystical content because European medicine had already been secularized. Even so, many missionaries who offered care did not even have formal training in medicine and their facilities were primitive, with limited resources and sparse services. Under these circumstances, the vast majority of Africans remained unserved. Moreover, the African population experienced deterioration and stagnation in its living standards under the parasitical and parsimonious rule of imperialism (Chanaiwa, 1981). White settlers claimed half the country's land, including the most fertile areas, while Africans were restricted to Reserves where land quickly became overcrowded and overused. Consequently, men were forced to seek work on white farms and in the mining economy in Southern Rhodesia and South Africa, leaving the women and children behind in the Reserves to eke out an increasingly impoverished existence. Some women, many of them widows and divorcees, migrated to urban centres where they brewed and sold beer, cooked food and provided domestic and sexual services to male workers. Generally, these occupations, in addition to being low-paying, were also the source of many diseases.

Under the circumstances, the missionaries found themselves in a difficult situation. Finding their resources limited, though they had voluntarily taken on the task of providing education and health care, they called upon the government for assistance. Missionary pressure, along with the growing incidence of infectious diseases like smallpox, venereal diseases, tuberculosis and leprosy, finally forced the government to create a rudimentary public health system, build some hospitals and clinics for Africans in the urban centres, and subsidize the work of the missionaries in the rural areas. The Native Medical Services, as they were called, have been much praised (Webster, 1972, 1973a and b; Gelfand, 1976), but when compared to health care available to the white population, or even what was needed, they were minuscule (Gilmurray *et al.*, 1977).

Out of both choice and necessity, most Africans continued to use indigenous healers, even as these healers were being maligned and abused by the whites (Chavunduka, 1986a). Not only in the rural areas, but in urban centres as well, large numbers of people continued to consult traditional healers. Even as late as the 1970s, a study in one of the capital's African townships revealed that almost one-quarter of those surveyed used traditional medicine as a first choice and over half of the consumers of western medicine later consulted traditional healers (Chavunduka, 1978).

Opposition to traditional medicine was very strong among the missionaries, colonial officials, doctors and nurses who laid the foundation of western medical services in colonial Africa. The champions of western medicine took various measures against traditional medicine, such as seeking to undermine its legitimacy through the mission schools, organizing their own professional organizations which could censure colleagues who referred patients to traditional doctors, and insulting patients who used traditional medicine. People could be fired if they missed work while undertaking traditional medical treatment, but those who were treated by western doctors could submit certificates and letters attesting to this (Chavunduka, 1986a). Traditional medicine was also undermined by the Witchcraft Suppression Act of 1899, which criminalized both malpractice and legitimate practice since it subsumed most materials used by healers under the rubric of "witchcraft", even though many of their "charms" have nothing to do with witchcraft. The Act also removed control of witchcraft accusations from traditional courts, assuming "the whole practice of witchcraft as a pretense and a sham, [with] no real existence at all" (Chavunduka, 1982).

Even herbal medicines were considered "unscientific" and, with a few notable exceptions (Gelfand, *et al*, 1985; Harvey, 1962; Harvey and Armitage, 1961; Wild and Gelfand, 1959), elicited no interest among colonial doctors. Disinterest was especially acute among the colonial officials. For instance, in 1970 a short discussion was initiated in colonial Zimbabwe's Parliament on traditional medicine after an African member introduced a motion, "solely for the purpose of bringing certain matters to the attention of the House", urging the government to mobilize local scientific resources and personnel to study and create an independent supply of medicines using indigenous medicinal plants. An official from the Ministry of Health, after commenting that the mover of the motion was "very responsible" for not "dividing" the House by putting the motion to a vote, went on to say that while he did not object to the scientific study of native medicine as such, and understood that scientists like Dr. Michael Gelfand were at the time engaged in such study, he rejected the idea that the government

should "encourage the use of these primitive remedies . . . either in the local market or in an export market" (*Parliamentary Debates*, 1970).

With few exceptions, such as the mover of the above-mentioned motion, the members of the new African elite, almost all of whom were educated at mission schools, showed similar disinterest in traditional culture, and traditional medicine in particular. Despite such outward opposition, there were persistent rumors about elite Africans who visited traditional doctors. Still, there were always those committed Christians who would do no such thing but who also were little helped by western doctors, especially if they were barren, a condition that brought as much a grief to a Christian wife as it did to her non-Christian sister. An alternative appeared for such Christian women in colonial Zimbabwe in the 1950s, when the Methodist Mai Chaza founded a healing ministry especially for barren Christian women. One early member of her sect belonged to a prominent Zimbabwean family, the patriarch of which was a leading Methodist minister (Ranger, 1995).

THE ROAD TO COLLABORATION BETWEEN TRADITIONAL AND WESTERN MEDICINE

The advent of independence brought with it a reassessment of traditional medicine in some African countries. Governments wanted to reclaim traditions that had been debased during colonialism. However, the problem for the elites who came to power was their deep attachment to the European way of doing things and their uncertainty about what traditional elements should be revived. Consequently, it was a full decade after the "Year of Africa" in 1960, before most African countries turned their attention to the issue of traditional medicine, and only then for reasons other than an intrinsic interest in it.

The exception to this rule was Kwame Nkrumah's Ghana, where "a new awareness in Ghanaian culture" generated "a conscious quest for an African way of doing things to distinguish the African from the European". The "African way", of course, included indigenous medicine. Nkrumah commissioned a study of Ghana's traditional healers and followed this up in 1963 by organizing the Ghana Psychics and Traditional Healing Association, which included "spiritual and faith healers, herbalists and birth attendants". The Association's charter promised many things, such as clinics and improved practices. Traditional medicine, according to the charter, was to be "upheld, protected, promoted, helped, and encouraged". However, with the overthrow of Nkrumah's Government in 1966, the Association became moribund. Official Ghanaian interest in traditional medicine was revived in 1974 under the Acheampong Government, though without the psychics. Rather, now the government's attention was focused

on collecting and studying herbal medicines for possible commercial exploitation (Twumasi and Warren, 1986).

By 1974 other African countries were also beginning to support the study of traditional medicines, and for the same reason as Ghana, that is, a quest for commercial gain and self-sufficiency. Around the same time, traditional medicine as a whole began to receive widespread attention as various governments sought ways to expand services and increase personnel as cheaply as possible. In order to do this, they needed to depart from the western model of health care, which was altogether too expensive and a drain on health budgets. As plans were initiated for expanding services using low-cost health workers, such as medical assistants, technicians, and health educators, policy makers began to discuss the use of existing resources, namely traditional midwives and other traditional practitioners.

Maoist China's experience with the "barefoot doctor", its efforts to standardize Chinese medicine, and its success in checking famine and infectious diseases inspired progressive leaders in emerging African and Asian nations. China thus became the model for the historic set of resolutions passed by the World Health Organization (WHO) beginning in 1975, urging "primary health care for all by the year 2000". In 1977, WHO also issued a call for traditional medicine and its practitioners to be included in national health care, and with other international organizations began to make funds available for initiating "collaboration" programmes toward a goal of "integrating" traditional and western medicine (Oyebola, 1986).

Despite the persistent attacks, traditional and western medicine had long co-existed, and a majority of Africans were pluralistic consumers, using both services (Harrison and Dunlop, 1974). WHO's resolutions went beyond co-existence, however, and urged governments to intervene to integrate the two systems. As several African and Asian countries began to take steps in this direction, the issue of collaboration, to say nothing of integration, proved problematic. In the first place, studies by health planners questioned the success of the Chinese model in China itself (Croizier, 1973; Bibeau, 1978; Hillier and Jewell, 1983). Second, investigations of programmes begun after the WHO resolutions had been passed revealed that governments were either hindering collaboration or having no impact whatsoever (Elling, 1981). By the mid-1980s, international policy makers were conceding the failure of collaboration, but attributed this to vague national commitments and ill-planned programmes. Rather than scrap the idea, however, new guidelines were issued for re-evaluating those collaborative efforts funded by international organizations (Akerle, 1987).

Yet, ironically, at the same time that collaboration was being pronounced a failure by international organizations, some Zimbabweans were embarking on their own path of encouraging cooperation between traditional and western medicine, without funding from either external sources or the Zimbabwean government. Zimbabwe's programme came on line at independence in 1980, several years after other countries in Southern Africa had begun similar collaborative initiatives. While learning from the experiences of its neighbours, ultimately Zimbabwe's programme would prove unique and unprecedented.

COLLABORATION BETWEEN TRADITIONAL AND WESTERN MEDICINE IN SOUTHERN AFRICA

With the exception of Botswana (Staugard, 1986), countries throughout southern Africa had begun programmes of collaboration by 1980. Most programmes were inspired by the WHO resolutions but some antedated them. Those that antedated the WHO resolutions were concerned with herbal remedies, an interest the Organization of African Unity (OAU) had been encouraging since 1968, when it began to hold conferences on the subject (Sofowora, 1982).

Five countries neighbouring Zimbabwe have been selected for a brief look at what kinds of collaboration were taking place by the time of Zimbabwe's independence. These countries are Zaire (now Congo), Zambia, Malawi, Tanzania, and Mozambique, where the study of herbal remedies and the use of traditional birth attendants and midwives are the preferred areas for collaboration.

Tanzania, though generally situated in East, not Southern Africa, is included here since it was among the "Frontline States" assisting Zimbabwe's struggle to end white rule. It has led the way in medicinal plant research in the region, and of the five countries shows the best results so far in this work. Tanzania's Traditional Medicine Research Unit, established by the government in 1974, sponsors research expeditions to remote areas to collect medical material (Semali, 1986). The results of some chemical analyses have been published (Hedberg *et al.*, 1982; 1983; Chhabra *et al.*, 1984). Similarly, Zaire founded a Department of Traditional Healers in 1976 for the study of traditional medicine in selected regions (Janzan, 1976-77). The aim was commercial benefits, and two years later Zaire's Parliament passed resolutions to establish a local pharmaceutical industry and to give the Department of Health a central role in traditional medicine research (Republic du Zaire, 1978). By 1980, Mozambique was also sponsoring research in traditional medicine (Tomé, 1979; Jansen and Mendes, 1982; Mendes, 1981), as was Malawi, where considerable work has been done by the biochemist, Jerome Msonthi

(Msonthi, 1983b), co-founder of the government-sponsored Herbalists of Malawi. Zambia, unlike its neighbours, had shown little interest by the 1980s in herbal plant remedies, despite its extensive herbarium, which the author used for a study of verifiably efficacious common medicinal plants used historically in select districts in Zambia and Tanzania (Waite, 1988).

Another point of collaboration between traditional and western medicine was in the increasing use of traditional midwives, an area in which Zambia played a leading role. By 1980 hundreds of midwives were enrolled in Zambia's primary health care programme (Twumasi and Warren, 1986). Malawi also made considerable use of traditional midwives (Msonthi, 1983a). Training for them in both countries was funded by WHO and UNICEF. Some of these traditional midwives were already practising while others were inexperienced younger women. In Tanzania, data were being gathered on practising midwives toward including them in government-controlled health care (Semali, 1986).

Traditional midwifery and herbal remedies do not threaten western medicine as do practices that are based on mysticism and psychic powers. Training in hygiene, record keeping and recognition of birthing complications for referral to hospitals are all that the modern sector requires of traditional midwifery. Likewise, many herbal medicines are common enough that they need only be standardized, reproduced and distributed. Some traditional doctors are, however, reluctant to share their knowledge, for fear of giving away "trade secrets", or because they believe the medicines cannot be separated from the mystical and ritual contexts in which they are used. Yet one Zimbabwean scientist, Professor Norman Nyazema, has vowed to do just that: separate the pharmacology from the mystical-ritual, all the while challenging assertions that a particular practitioner or group of practitioners has a monopoly of designated herbs or remedies (*Herald*, Jan. 31, 1986). Nyazema, a pharmacologist at the University of Zimbabwe's School of Medicine, investigated the mystical claims made on behalf of some medicines, and found good, bad, and even underutilized qualities. Among the materials he has studied are crocodile bile (Nyazema, 1984), beetles, and a "magic formula" used by a doctor to diagnose his patients that made national news after one of his patients died from the medicine. Nyazema warns the public that "[t]raditional remedies are useful poisons, but if . . . not handled properly, people die and get unnecessary hospitalisation". He works to do away with "the cloak of secrecy and mysticism that surrounds [the medicines]", to prepare them for a role in primary health care (*Herald*, Jan. 31, 1986).

Throughout the region, the role of traditional doctors in government-sponsored primary health care has been limited to supplying medicines

to scientists. Otherwise, traditional doctors continue to supply health care as they have always done, although in a few countries dialogue has been initiated with government officials, such as a WHO-sponsored conference in Zambia in 1977. This meeting led to an increase in the number of registered traditional healers and began a process of consultation between health workers and traditional doctors (*Report*, 1977; Waite, 1981). No such mechanism for registering healers had been established in Tanzania at latest report, though the Ministry of Youth and National Culture was facilitating discussions between traditional and western practitioners (Feerman, 1986). In Malawi, conferences also were being held between traditional doctors, western scientists and doctors (Msonthi, 1986).

On the other hand, governments have taken steps against traditional practitioners, demonstrating their failure and unwillingness to understand the social context in which traditional medicine operates. For example, when the Machel Government in Mozambique, in the interest of socialism, banned private medicine, it effectively denied traditional doctors the customary right to collect fees for their services (Barker, 1983). Elsewhere governments continue to apply the old Suppression of Witchcraft Acts proclaimed by the British during colonialism. Zambia even went so far as to write a new anti-witchcraft law in 1967, just three years after independence (Twumasi and Warren, 1986). Though these laws are intended to suppress witchcraft, they have never been successful.

Upon attaining independence, Zimbabwe's government had no intention of including a role for traditional medicine, despite the several years of collaborative efforts already underway in other countries. Rather, the new authorities planned simply to use Village Health Workers (VHWs) as the "foundation" of the new National Health Service (so named to distinguish it from the old colonial Medical Service). VHWs, who are modeled after the "barefoot doctor", were already in service in Mozambique and Tanzania, two countries closely associated with the Zimbabwe nationalists who came to power in 1980, and had been proposed in a study undertaken on the colonial medical service just prior to independence (Gilmurray *et al*, 1979).

The VHWs were to be the "first level of contact between the community and health service", and each would serve 50 to 200 families in the rural areas, where the majority of people still lived (Republic of Zimbabwe, 1982b). The VHWs do preventive, not curative, work, mainly by providing health education, recording and transmitting vital statistics, and improving "the environmental health of the community members" (Republic of Zimbabwe, 1981) by organizing local communities to build toilet and other hygienic facilities, and to make bricks for clinics (Agere, 1987). Many VHWs are women, the popular myth being that they "are at home

more" and "feel freer to talk about health and related matters" (*Herald*, April 26, 1984). The VHWs are selected by the communities in which they work and are trained by another category of low-wage personnel, Medical and Health Assistants (Republic of Zimbabwe, 1981). Within the first year of independence, Zimbabwe had 334 VHWs, trained and outfitted with bicycles and medical kits by UNICEF. The numbers tripled thereafter, and so did problems in their selection and quality of work (Republic of Zimbabwe, 1982a). In addition to the VHWs, traditional midwives were mobilized by the new Zimbabwe health service.

A study undertaken in Zimbabwe soon after independence found that ante natal clinic attendance in urban and rural areas was high. Yet, despite this and available clinical birthing services, many women preferred their own midwives and continued to give birth at home. Thus, in an effort to incorporate the traditional midwives into the health service, the government launched a pilot programme in 1981, followed up by others, to instruct traditional midwives in hygienic practices (Chimbadzwa, 1985). Unlike traditional birth attendants in other African countries, who are frequently young village women selected for training with no previous experience or practice, Zimbabwe's midwives are what would elsewhere be called "independent" midwives. Many of these midwives were practising because they found midwifery a way to "gain extra income" (Blair Research, 1988).

TRADITIONAL MEDICINE IN ZIMBABWE: THE ROAD TO RECOGNITION AND CONTROL

Given the important historic role of spirit mediums in the liberation struggle, it seemed likely early on that traditional medicine would get a sympathetic hearing in the new Zimbabwe. Spirit mediums, the *mhondoro*, were national heroes in the first Chimurenga — the great battle waged against European colonialism in the 1890s (Ranger, 1967). Seventy years later, the *mhondoro* again became important, this time by forging an alliance with the guerrillas who won the battle for independence, the second Chimurenga (Lan, 1985).

During the election campaign and at independence celebrations, Zimbabwe African National Union (ZANU), the victorious party, acknowledged and celebrated some major "spirits of the nation", using songs, images on clothing, and a huge banner. Schools, a maternity hospital and streets were named after Mbuya Nehanda, "the grandmother of all ancestors". A revolutionary heroine of the first Chimurenga, Nehanda had prophesied that she would reappear to drive out the Europeans (Lan, 1985). There was thus strong symbolic support for the traditional medical culture in the new Zimbabwe (McDonald, 1981).

Symbolism did not necessarily translate into substance, however. Within months of assuming power, the new regime arrested Sophia Tsvatayi Jairos Muchini, a medium for the spirit of both the ancestress Mbuya Nehanda and of another ancestor hero, Chaminuka. Prior to independence, her activism on behalf of the guerrillas had landed her in jail, from which she had been released by the independent government. Within a few months of returning to her mediumship at Great Zimbabwe, Muchini was rearrested and charged with ordering the killing of several white farmers. Prior to being charged with murder, Muchini had been the target of harassment and threats by the whites in the area surrounding Great Zimbabwe, and the new government had been made aware of that. Some former guerrillas from the ruling party's army who were serving as her bodyguards admitted to the killings. In exchange for clemency, they blamed Muchini, claiming they were under the influence of her medicines when they committed the crimes, and that she ordered them to kill whites. Failing to find other adults to corroborate this account, the government took into custody two young teenagers from Muchini's home, including her own child, jailed, tortured and terrorized them for a year, and released them to bear witness against her (*Herald*, Oct. and Dec. 1981; Garlake, 1983).

What is interesting about this case is that Muchini was not the only prominent African arrested in this period for alleged complicity in killing whites over the land question. The Minister of Manpower, Edgar Tekere, had been arrested along with his bodyguards in August 1980, in advance of Muchini, accused of killing a white farmer, and put on trial. Tekere was released after a split decision, but it is said that "the affair unsettled the White community, caused bad feeling and did little to enhance the country's international image". The government's image was further damaged by the flaring "into open war", of the "traditional tribal conflict between the Matabele . . . and the Shona majority" (*Drum*, 1981). Muchini, seemingly, had to be sacrificed for the sake of the national image, meaning at that time allaying the fears of local whites and international capital.

Amilcar Cabral, the African revolutionary, had predicted such a scenario. Speaking at the Frantz Fanon Centre in Milan in 1964, Cabral warned that "[t]he moment national liberation comes and the petty bourgeoisie takes power we enter, or rather return to history, and thus the internal contradictions break out again". Asking rhetorically, "[w]hat attitude can the petty bourgeoisie adopt?" he answered, it could "either ally itself with imperialism, and the reactionary strata in its own country to try and preserve itself as a petty bourgeoisie or ally itself with the workers and peasants. . . ." (Handyside 1969). Muchini, needless to say, lacked the wherewithal to successfully or even effectively lead the peasants to possess the land of their ancestors. Her claims on traditional culture

were no match for the claims of the "assimilated" elites who were also in the process of betraying the workers (Astrow, 1983), breaking nearly 200 strikes undertaken in the first year of independence over wages, working conditions and labour relations (Sachikonye, 1987). Thus Muchini's case raised the dilemma over traditional culture and the issue of authority in the new Zimbabwe.

Rocked by "sectional conflict, lack of unity and sometimes of direction, serious economic difficulties, and a host of other problems" (*Drum*, 1981), the first year of independence was not an easy one for Zimbabwe. In spite of these problems, and even as Muchini's case was making its way through the courts, two supporters of traditional medicine emerged, both seeking to shape for the first time a positive relationship between traditional medicine and the modern government, and in the process update traditional medicine so that it could have a respected role in health service. The individuals in question were Drs. Gordon Chavunduka and the late Herbert Ushewokunze.

Chavunduka, then a Professor of Sociology and Dean of the Faculty of Social Studies at the University of Zimbabwe, was a recognized authority on traditional medicine and the author of several studies on the subject prior to independence. Many Zimbabwe healers knew and respected him. Chavunduka did not practise medicine, but had completed a course in traditional medicine at a well-known school in Pretoria (Chavunduka, 1986a; ZINATHA, 1986).

During the liberation war Ushewokunze had served as Commander of the Army Medical Corps of ZANU's Liberation Army. A member of ZANU's Central Committee, he was appointed ZANU's Secretary of Health in the waning years of white rule. When ZANU Patriotic Front (PF) swept the elections in 1980, Ushewokunze was elected to Parliament and brought into the Cabinet as Minister of Health. Hitherto, that is to say, in colonial Zimbabwe, the Secretary of Health, a civil servant, outlined policy and the Minister of Health generally deferred to him. Ushewokunze, however, refused to accept the role scripted for him, bringing to his new assignment the brashness and activism for which he was justly famous.

When, three months after independence, 1 500 traditional healers rallied in the capital, they were greeted by Ushewokunze, who, like other officials at independence, lauded the historic role played by traditional healers in the liberation struggle (British Broadcasting Corporation, 1980). Within days of this rally, the Zimbabwe National Traditional Healers' Association (ZINATHA) was founded at a meeting organized and attended by Ushewokunze and his Deputy, Dr. Simon Mazorodze (ZINATHA, 1986). The healers in attendance, some of whom represented smaller existing organizations, wrote and ratified a constitution, elected an interim

executive committee, with Chavunduka as Interim President, and laid plans for a future First Congress (Chavunduka, 1986a; ZINATHA, 1986).

ZINATHA was not the first organization of healers in the country, but it was the first to have the support of people in such high places. The first organization dates to 1957, when the African Nganga Association² was organized (Chavunduka, 1978). By 1980 there were eight associations, each claiming to be "the true medical association" and discrediting the others (Chavunduka, 1984). One of these associations held a conference the month before ZINATHA's founding and invited Ushewokunze and Chavunduka to speak, pointing out that its members wanted "to work hand in hand with modern doctors" and formulate "a code of ethics" to "discourage and root out any dishonourable practices among members" (*The Herald*, June 13, 1980). Many traditional doctors in Zimbabwe and elsewhere had long worked to disassociate themselves from "dishonourable practices", such as witchcraft, witch-finding, and the selling of bogus medicines (*Bantu Mirror*, 1956; *Mambo*, 1974).

With Ushewokunze, Mazorodze and Chavunduka representing a small but growing number of westernized African elites who supported traditional medicine, the founding of ZINATHA was no small matter. The medical establishment was alarmed (Carver, 1983). Chavunduka charged the white-dominated Medical Council and its members with trying to undermine ZINATHA, in an effort, he was convinced, to retain "full control of the field of medicine" (*Herald*, May 31, 1980).

In September 1980, again with the Minister of Health and his Deputy present, ZINATHA rallied 3,000 healers for its First Congress. The election of a permanent National Executive Committee was conducted by Dr. C. Mamvura, a medical doctor at the University of Zimbabwe (Chavunduka, 1984). Chavunduka remained President (Chavunduka, 1986a; ZINATHA, 1986) and continued in that capacity until the early 1990s when he was appointed Vice Chancellor of the University of Zimbabwe. The next step would be more difficult, namely gaining official recognition of ZINATHA, and therefore for traditional medicine as a whole.

The architect of this move was Ushewokunze, who in his brief 15 months as Minister of Health used the position to challenge the racist health service. With characteristic flair, Ushewokunze declared that "[s]ometimes a direct approach and shock tactics are needed to facilitate such a change", given the "entrenchment" of "racial attitudes" in the service. Using words like "revolutionary zeal", "duty" and "loyalty", he announced his desire to get "social justice" for the people. Ushewokunze also made liberal use of statistics and other evidence to demonstrate the

² The name for traditional practitioners was variously spelled until 1981, when it was standardized as *n'anga* (Shona).

"racial disparity in health care resources", including insights gained from on site inspections of hospitals, which some parliamentarians and newspaper editors disparaged as "disruptive tours". Ushewokunze acknowledged that many people found "the concept of direct ministerial involvement in the delivery of health services to the people of Zimbabwe a difficult and most drastic change" from the "accepted role of a Minister of Health playing the role of a rubber stamp". The growing chorus of detractors also accused Ushewokunze of destroying Zimbabwe's health services, an accusation he wore as a badge of honour, triumphantly proclaiming: "When I am accused of destroying the health services of this country I shall henceforth take it as a compliment, as the destruction of a discriminatory, archaic and undeniably unbalanced service would be an act of great service to the people of Zimbabwe." To charges that he was "causing turmoil and dissatisfaction, even embarrassment, amongst the employees of the Ministry of Health", he replied, "[t]o this accusation I must earnestly plead guilty" (Ushewokunze, 1984).

Ushewokunze undertook two other important activities while Minister of Health, which probably contributed to his being dismissed from the post in October 1981. In July of that year he placed family planning services under government control and pushed through a bill in Parliament to recognize traditional medicine. The contrast between the ensuing debates over family planning and traditional medicine is stark, and cast light on the priorities of the national government.

When Ushewokunze placed family planning under government control, he raised the heat in a longstanding debate between the white settlers and the Africans over population control. The African nationalists had firmly opposed western family planning services when they were introduced to the colony in 1957. By the 1970s the white, privately-run Family Planning Association had attracted considerable money from abroad but only offered African women Depo Provera, a contraceptive that by the late 1970s was known to have "serious known and suspected side effects" and had been banned in the US, its place of origin. In 1981, when Ushewokunze placed the activities of the Family Planning Association under the Ministry of Health, he simultaneously banned Depo Provera (Ushewokunze, 1984).

He was not ending family planning, however, for the post-independence nationalists were no longer demanding that. The new regime affirmed a woman's right to have access to "safe and effective methods of contraception". Ushewokunze and the director of the Family Planning Association, who was determined to continue distributing Depo Provera, engaged in a "nasty war of words", and "when the dust finally settled most of the Family Planning Association's white senior staff, many of whom were expatriates, had resigned and left the country". After their

departure, the Africans themselves took up the debate over family planning. Some members of the ruling party still firmly opposed western family planning. However, the executive branch steered the debate in favour of family planning, in tandem with the government-controlled national press. Thereafter considerable foreign money came to Zimbabwe for its programme, and by the late 1980s Zimbabwe had become a leader in family planning in the developing world. The Prime Minister-turned-President, Robert Mugabe, was frequently featured as a speaker at international conferences on population control (West, 1994).

In the same month in which his ministry took control of family planning, Ushewokunze introduced a bill in Parliament to regulate and register traditional practitioners of all kinds. Known as the Traditional Medical Practitioners Act, its central feature is the Traditional Medical Practitioners Council, which has the same authority the Medical Practitioners Council does for western medicine. The key words used to describe the work of the Traditional Practitioners Council are "supervise and control, promote, foster research, develop, hold inquiries, and make grants or loans". The Act requires the Ministry of Health, after consultation with the Council, to appoint a Registrar. Under the Act, registration is voluntary, but traditional healers who claim to be registered and are not can be fined. ZINATHA is officially recognized in this Act as "the legal body to which traditional healers should belong" (ZINATHA, 1986). In its capacity as the legally-constituted organization for traditional medicine, ZINATHA was given the authority, in conjunction with the Council, to discipline members who violate regulations that define their practice in ZINATHA's Constitution.

The introduction in Parliament of the bill that became the Practitioners Act of 1981 bears some attention. The national debate it inaugurated continues to the present day, and represents a struggle over culture and authority in the new Zimbabwe. Ushewokunze, who could personally attest for some of the claims of traditional medicine (Frucht, 1987), presented the bill with the standard descriptions of traditional medicine as "an immediate, existing source of health care" that should "work together with western medicine". He spoke of it being "holistic", familiar, and effective, "cheaper", and a source of "self-reliance". Nor did he fail to mention that traditional medicine is "people's culture" that could "redress a balance too long tipped by arrogance and ignorance". Explaining that the Council created by the bill would be able to "upgrade and integrate traditional midwives", Ushewokunze noted it would substitute for the "controls of a traditional community" that no longer exists to protect people from "charlatans" (Ushewokunze, 1984), and would be able to monitor unhygienic practices and instruments and standardized substances (*Herald*, July 1, 1981).

Many hopes and fears were stirred by the bill, and both houses of Parliament discussed it at great length, often revealing the cultural gaps among Africans as well as between them and white representatives. In the House of Assembly, where the bill got its first and most important hearing, many spoke in favour, even with distinct pride in their Africanness and indigenous culture. Some asked questions about the operation of the bill, such as who would be covered and what role the Council would have. There was opposition, however, and not just from white members. One African representative declared she did "not know of any *nganga* who has actually helped a patient", and demanded to know how an educated person could "sit with a *nganga* who never went to school, who does not even clean his teeth". This brought inaudible remarks, so she continued, "No, this is very serious. Most of the *ngangas* I know are people who are psychological. If he has failed in life then he goes to be an *nganga*" (*Parliamentary Debates*, 1981).

Another African representative, this one also a church Bishop, wanted to know how the bill would deal with traditional healers who are "said not only to know of the techniques of healing people, but also to know of ways to get people sick" (*Parliamentary Debates*, 1981). He was referring to witchcraft, a subject making news at that moment after a Senator tracked down, gathered and burnt the paraphernalia of an alleged witch-hunter who was scheduled to be arrested, and would probably be tried under the Suppression of Witchcraft Act of 1899. The issue was not, then, whether or not witch-hunting activities would be controlled by the Traditional Medical Practitioners Act, since the Suppression of Witchcraft Act ostensibly did that. Even Ushewokunze emphasized that the bill before Parliament had nothing to do with witchcraft (*Herald*, July 22, 1981). Still, witchcraft, witch-finding, and traditional doctors were associated in the public mind, and would continue to haunt the issue of traditional medicine in the new Zimbabwe.

In the Senate, an appointed body with much less power than the House, there was a barrage of what Ushewokunze identified as "colonial arrogance" and "cultural chauvinism" (*Herald*, July 17, 1981). One white Senator described the debate as "one of the worst we have ever had in this House" (*Herald*, July 22, 1981). Another one complained that the information provided by Ushewokunze was "scanty" and "an affront to our intelligence", and referred to the bill as "a macabre practical joke" and a "confidence trick". He accused Ushewokunze of seeking "to clothe in a professional mantle a group of individuals who have no recognised standards of learning and skill". Other white Senators demanded that the words "medicine" and "Council" be stricken from the bill, insisting that these terms were the exclusive preserve of western medicine. One Senator admitted that neither he nor the other whites knew anything about the

subject of traditional medicine, and expressed doubt that the black Senators knew any more, "with the exception of the Senator Chiefs". One of these Senators, a Chief for 40 years, who until then had apparently stayed out of the debate, agreed that "chiefs knew more about the practice of traditional medicine than anyone else", and pronounced, "there is nothing bad about this Bill" (*Herald*, July 15, 22, 1981).

Within days of the enactment of the Traditional Medical Practitioners Act of 1981, Ushewokunze was sent an effigy of himself with needles stuck through the head and heart. Displaying the macabre gift to the press, Ushewokunze declared that if he "preach[ed] the gospel of maintaining the status quo, the reactionary fringe would not be ganging up against me and instead of effigies, I would be receiving gold bars" (*Herald*, July 29, 1981). Two months later Ushewokunze was dismissed from his position as Minister of Health. He had used his 15 months in the post to challenge the monopolies of western medicine and private family planning. One of his last speeches, given in Parliament just before his dismissal, concerned family planning. Some Senators had raised a motion in support of the Family Planning Association and its recently resigned director. Commenting on the resignation, Ushewokunze said "good riddance to bad rubbish". Explaining to the movers of the motion why he banned Depo Provera, he first rhetorically demanded to know "who has said women in the Third World countries should act as experimental animals?" And he concluded, "I could go on on this issue, but I do not want to cast pearls before swine" (Ushewokunze, 1984).

Replaced by his deputy, Dr. Simon Mazorodze, who died suddenly in office a few months later, Ushewokunze was rehabilitated the next year and went on to hold the portfolios of several other ministries. Without him at the helm of the health ministry, however, traditional medicine went its way. Like the ruins at Great Zimbabwe (Garlake, 1983), ZINATHA was ignored by the government until the mid-1980s, when the issue of authority over traditional medicine was raised again.

TRADITIONAL MEDICINE IN ZIMBABWE: AFTER RECOGNITION

Speaking to members of ZINATHA right after Ushewokunze had been sacked, Chavunduka noted "the Government had done all it could to recognise the traditional healers", asserting that "now it is up to us to organise ourselves and remain strong". Chavunduka reminded his audience that "Today's n'anga" faced "a new war of liberation aimed at changing people's mentality". Their job, he explained, was "to teach people to respect their own customs, their own medicines and their own leaders" (*Herald*, Oct. 19, 1981).

The Registrar and the Traditional Practitioners' Council created by the Traditional Medical Practitioners Act were not appointed until 1986, a full five years after its passage. Until then the Ministry of Health neither appointed its seven members to the Council nor made appointments to ZINATHA's Executive Committee, where seats were reserved for it under ZINATHA's Constitution. Chavunduka would later attribute these delays to the "continuing debate over traditional medicine in the country" and "[a] number of leaders" arguing that "the Government was wrong in granting traditional healers legal recognition" (Chavunduka, 1986a). Some of this opposition made an early appearance in public statements by government officials shortly after the Traditional Medical Practitioners Act was passed.

For instance, Simon Muzenda, the Deputy Prime Minister, and Senator Joseph Culverwell, the Deputy Minister of Education and Culture, jointly addressed a state technical college graduation where they launched a tirade against traditional medicine. Culverwell dismissed the healers as a "drawback to Zimbabwe's educational system and its development", chiding them for regarding themselves as "workers of wonder" when in fact "their claims are worthless". Muzenda concurred, sarcastically asking "why were hundreds of people dying when n'angas who claim to perform miracles are here?" (*Herald*, Sept. 11, 1981). The point, however, is not whether or not healers make great claims for themselves; western-trained doctors often do the same. What is revealed by these comments are the mixed signals on traditional medicine coming from the government; the legislative branch had legitimized it and the executive branch was denigrating it.

The government-controlled press also was inclined to take a jaundiced view of traditional medicine. One columnist satirically wrote about the recent recognition and rising popularity of traditional doctors, mocking them as con artists living in comfortable homes paid for with fees from greedy people who hoped the medicines they purchased would help them get jobs or public offices (*Herald*, October 3, 17, 1981). To be sure, the press occasionally reported favourably on ZINATHA and traditional healers, but this was not the norm (*Herald*, Sept. 10; Nov. 6, 1981).

Where the government and the press may have equivocated, the church came out fully against ZINATHA. Singling out the Catholic hierarchy, Chavunduka accused the church of embarking on a campaign to discredit ZINATHA, hostilities he attributed to its fear of losing members and income. While denying the existence of a campaign, the Archbishop and chairman of the Catholic Bishops' Conference admitted that the Catholic Church objected to the use "of superstitious beliefs in seeking curatives" (*Herald*, Oct. 19, 1981).

Attacks on ZINATHA and traditional medicine in general subsided soon after the granting of official recognition. Instead, new dissension surfaced among traditional practitioners. In late 1981, the press reported the existence of an organization —variously called the Spirit Mediums' and True N'angas' Association of Central Africa (*Herald*, Nov. 16, 1981) and the True African N'angas' and Spirit Mediums' Association (*Herald*, Dec. 10, 1981) — whose president, a certain Dr. Mucheka Gombera, claimed to be the authentic, elected leader of healers in Zimbabwe, and had been for decades. Gombera also objected to Chavunduka's presidency of ZINATHA on the grounds that Chavunduka was not a traditional practitioner, and criticized ZINATHA for not displaying pictures of Mbuya Nehanda, the senior ancestress of the nation, in its offices (*Herald*, Nov. 16, 1981). Gombera's criticism was not directed solely at ZINATHA. He also lashed out at the government for compelling spirit mediums, like other traditional medical practitioners, to pay fees to join ZINATHA. This, Gombera objected, was contrary to the tradition of "young men and women [giving] presents to the spirits[,] but now we have a situation where the Government, which is full of young men, compels its elders to pay money" (*Herald*, Dec. 10, 1981).

By late 1982, leadership of the anti-ZINATHA True N'angas had apparently passed from Gombera to one Dr. Kenneth Ntopa (*Herald*, Nov. 2; Nov. 26; Dec. 7, 1982; Frucht, 1987). The True N'angas were then holding meetings in several Zimbabwean towns, where spirit mediums from several Central African countries competed with each other to drive out evil spirits and heal people in order to see which country had the best healers (*Herald*, Nov. 2, 26, 1982). They held a mass meeting, too, to pray for rain to end the drought that year, which they blamed on the armed unrest in Zimbabwe (*Herald*, Dec. 7, 1982).

ZINATHA, however, spurned such activities, determined as it was to demonstrate that traditional medicine was not contrary to the official ideology of "scientific socialism" but was, in fact, "a system based on science . . . waiting to be developed into a more powerful science" (*Herald*, Nov. 1, 1982). Over the next several years, ZINATHA contributed to this process by instituting a number of programmes aimed at professionalizing the healers and creating the outlines of a parallel health care service based on traditional medicine. The True N'angas also began to professionalize themselves but had their own distinct way of doing things (Frucht, 1987). Some healers (Sibanda, 1992) belonged to both ZINATHA and the True African N'anga Herbalist Association (TANHA), as the organized True N'anga tendency was now called. ZINATHA, however, was the organization upon which recognition had been conferred. Solely for this reason, some healers joined ZINATHA, even though they did not

accept its claims to be the only legitimate representative of healers in Zimbabwe (Frucht, 1987).

Besides distinctions in the operations of ZINATHA and TANHA, differences in the orientation and practice of urban and rural healers also began to appear (Frucht, 1987), though undoubtedly such sifting had been going on for some time. These issues certainly deserve a study in their own right. Here, the focus is restricted to what ZINATHA did after recognition and how it served as the lightning rod for public grievances against traditional medicine.

Immediately upon obtaining government recognition, ZINATHA opened a research centre, a department of education, and two medical colleges. The colleges taught hygiene, uses of traditional medicine and account keeping, but not spirit possession (Chavunduka, 1986a). In addition, ZINATHA operated four clinics in Harare and one in Bulawayo for training and treatment (*Herald*, Jan. 11, 1983). All of these projects floundered for lack of money (*Herald*, Feb. 23, 1983; Chavunduka, 1984; 1986a; ZINATHA, 1986), with the exception of the education department, which was quite active (Chavunduka, 1986a).

An early issue for the healers was continuous access to traditional medicines. Some healers were beginning to travel outside the country for medicines, and others were thought to be possibly hoarding medicines made from species that had become extinct (*Herald*, Feb. 2, 7, 1983). To address these concerns, ZINATHA began to grow herbs and trees on a small plot at its research centre. The space was insufficient, however, and the idea was raised of purchasing a farm (*Herald*, Feb. 2, 1983). Lacking the money for this, ZINATHA began planting trees throughout the country, starting in 1985 on the same day each year, to ensure indefinite supplies of some medicines (*Herald*, Dec. 11, 1990).

Other issues surfaced and challenged ZINATHA to find solutions. More than once traditional doctors complained that they needed financial help to build larger facilities for their growing practices (*Herald*, Sept. 10, 1981; Oct. 18, 1990). Others complained about patients not paying all their fees after treatment (*Herald*, Oct. 18, 1990). On the reverse side were patients not satisfied with their treatment, who wanted their money back (*Herald*, July 23, 1990). There was also the problem of employers not recognizing certificates of sickness from traditional doctors, nor could traditional healers submit treatment bills to medical aid societies (Frucht, 1987). One particular category of practitioners, traditional midwives, wanted to receive "the same treatment as village health workers and clinic midwives" and be compensated for their services by the government (Blair Research, 1988). Then there were the herbalists who were giving local scientists their herbal medicines and complained that after five years of collaboration they "had never had any feedback on what was

discovered", and feared "they might be robbed of their knowledge" (*Herald*, Jan. 9, 1992). Other herbalists wanted the opportunity to sell their medicines in pharmacies (*Herald*, Jan. 8, 1992). There was also the issue of increasing dialogue between western and traditional doctors, and of making clear to traditional doctors the terms under which they were practising in the new Zimbabwe.

In his capacity as president of ZINATHA, Chavunduka was especially attuned to the question of compensating healers for their services. He noted that since a very large number of people, perhaps upward to 80 and 90%, used traditional medicine at some point in their lives, some of the medical budget should be allocated to traditional healers (*Herald*, Jan. 11, 1983). His argument fell on deaf ears, of course, as even the midwives being trained by the government were told in no uncertain terms that they "were still not being employed and would not be paid by the Ministry of Health", and were to continue charging "according to traditional customs" (*Herald*, April 26, 1984). Nevertheless, ZINATHA appealed to the public on the matter of compensation, encouraging people who belonged to medical aid societies to find ways to be reimbursed for their use of traditional medicine (*Herald*, July 12, 1990). Of course, members of the medical aid societies were generally people of means (Agere, 1987), who were not the most likely to consult traditional doctors. Pursuing the subject further, however, ZINATHA proposed launching a medical aid scheme of its own, complete with a register of specialists (*Herald*, July 23, 1990).

As a means of making certain common medicines more widely and easily available, ZINATHA unveiled plans for a company to manufacture already-tested medicines, and proposed opening shops throughout the country where people could go without first consulting traditional doctors (*Herald*, Jan. 14, 1992). Around the same time these plans were revealed, ZINATHA herbalists decided they would protect their products in the future by only providing research scientists with powdered forms of medicines, labeled with the contributor's name and address, and the diseases treated with the medicine. They also agreed to form a committee of ZINATHA members and scientists to oversee the issuing of receipts to collaborating herbalists to ensure that they receive payments, and gave ZINATHA more oversight over the research. The herbalists were adamant about keeping these controls within the hands of ZINATHA and out of the reach of the Ministry of Health (*Herald*, Jan. 9, 1992).

While it was not difficult to convince research scientists about the value of traditional medicines, western doctors were far more skeptical, believing as they did that their system of medicine was the only true one because it was scientific and the traditional one was not (*Herald*, Nov. 1, 1982). ZINATHA's efforts to bring about greater co-operation between

western and traditional medicine began with a series of meetings organized by its department of education after 1982 (Chavunduka, 1986a). By 1983 and 1984, Chavunduka was able to report considerable progress in getting western practitioners to overcome their reluctance to recognize traditional healers as colleagues (*Herald*, Jan. 11, 1983; Dec. 19, 1984). Further work in this direction came in 1984, when first and second year medical students were required to take a Behavioural Science Course taught by a medical anthropologist, who instructed them on traditional family values, traditional medicine and its referral systems, the expertise of traditional healers in mental disorders and maternal and child care, and the attitudes of modern professionals toward traditional healers. A similar course had been taught jointly from 1978 to 1981 by Chavunduka and the late Dr Michael Gelfand, but was canceled after opposition by faculty and students (Frucht, 1987).

On the other side, the budding traditional medical service needed to "rationalise where possible traditional medical procedures, to eliminate incompetent healers and to prevent as far as possible abuse and quackery" (Chavunduka, 1986a). A series of seminars organized by ZINATHA informed traditional doctors about the regulations and laws affecting their practice, such as the Traditional Medical Practitioners Act, the Drugs Control Act, the Witchcraft Suppression Act, hygiene and ethics (Chavunduka, 1984). Local and regional meetings of ZINATHA were used to press the case against "abuse and quackery", activities forbidden under ZINATHA's Constitution, and to remind practitioners about the laws. Another avenue for bringing "discipline" to the profession was through registration.

The Traditional Practitioners Council, which was to appoint a Registrar, according to the terms of the Traditional Medical Practitioners Act of 1981, itself had never been appointed. Therefore, ZINATHA performed the work of registering practitioners. ZINATHA also compiled and distributed Registers in which healers were listed by district, branch of traditional medicine, and specialties. Registration and the Registers were underwritten entirely by the joining and annual fees of ZINATHA members, the number of which went from 5,000 in 1981 (*Herald*, Sept. 10, 1981) to 20,000 in 1984 (Chavunduka, 1984). Most active members were herbalists, although in the general population of traditional practitioners they represented only 16% (Chavunduka, 1986b).

"Discipline" was always a concern of ZINATHA, as it was of earlier organizations that wanted to "drive away fake herbalists who go about selling their herbs in the streets just for gain" (*Bantu Mirror*, 1956), or whose constitutions prohibited accusing anyone of witchcraft or helping the public "trace stolen goods" (*Mambo*, 1974). While its Constitution made no mention of witchcraft and witch-hunting, a booklet published by ZINATHA in 1981 emphasized that "No healer may attempt to try a case of

witchcraft" (Chavunduka, 1984; 1986a). Perhaps the existing Witchcraft Suppression Act should have been sufficient, but given the government's chronic inability to enforce this law, officials began to hold ZINATHA responsible for stopping the practice of witch-finding.

The government was pushed in this direction in early 1986, after persistent and numerous complaints in the media about traditional practitioners whose witch-finding activities allegedly posed a danger to the public. Prior to the recognition of ZINATHA several individuals had been arrested for witch-finding (*Herald*, Jan. 27, 1983). Then, a year after the passage of the Traditional Medical Practitioners Act, a registered ZINATHA member entered the news for his witch-finding activities, and concerns were raised about ZINATHA's role in curbing this practice.

When, in late 1982, the above-mentioned ZINATHA member began to "smell out" witches, people began to complain to their local officials about the turmoil witchcraft accusations were causing their families. Some of those who had hired him wanted their money back for this reason. When officials investigated, they discovered that the witch-finder was registered with ZINATHA and concluded that he was "protected by official papers of ZINATHA". No charges were filed and his activities continued. Months later, when Chavunduka was asked by the press to comment on the case, he revealed that he had personally registered the healer and questioned him about his background, since it had been said that the man was a witch-finder before independence. Appraising him "of the rules of the association which clearly forbid such activities", Chavunduka claimed to have warned the witch-finder that "strong disciplinary action would be taken against him" for any violations, since ZINATHA's primary role was to accredit healers "in their capacity as medical practitioners, but not for witch-hunting" (*Herald*, Jan. 27, 1983).

The problem, of course, was that there was a demand for witch-finding ceremonies (*Herald*, Jan. 27, 1983). Reporters pursuing this particular story interviewed several people, including the healer himself. His healing abilities were not in question and it was also clear that people came to him of their own free will to seek his help in uncovering witches. One chief, asked by a reporter why he had come the distance he had, and if there were no medical practitioners in his area, replied that he had "heard about the work this man performs and [had] come in search of him". The chief needed to take the witch-finder back to his village that night because it "is full of sick people and I want it cleansed", but unfortunately for him, there were already several other chiefs waiting for the healer to return with them to "cleanse" their villages. Taking a hint from the complaints being raised against him, the witch-finder agreed to stop receiving payments in advance. The local Senator, when asked what he thought of all this, expressed concern that "now that the rains have

fallen people should be in the fields ploughing and planting. But everybody is moving around following this man." He added, "[i]f he medically cures them, it's all right", but he detested the way in which witch-finding "leaves families divided" (*Herald*, Jan. 31, 1983). Numerous other cases of witch-finding were reported in subsequent years.

Chavunduka called reports of witch-hunting "very disturbing". He noted that ZINATHA members frequently reported cases to the police, and errant members would be suspended or expelled (*Herald*, April 26, 1984). At ZINATHA meetings members were reminded that it was illegal to name people as witches or to instigate witch-hunts, and they were urged to exercise greater discipline (*Herald*, June 11, 1984). Yet, local authorities, including ZANU party chairmen, were known to ask ZINATHA to send witch-finders to their area (*Herald*, Feb. 10, 1986). Some whites also used witch-finders. For instance, one white farmer reportedly hired a witch-finder when workers "failed to turn up for duties, allegedly because they were bewitched" (*Herald*, Nov. 28, 1985). Other whites, one a farmer and the other a garage-owner, engaged witch-finders to smell out suspected thieves among their employees, which included white workers at the garage (*Herald*, Nov. 25, 1986; May 7, 1990).

The government's frustration with witch-finding activities was revealed in a comment made by the Home Affairs Minister, Enos Nkala, who noted the difficulty of arresting witch-hunters "because people involved were reluctant to report to the police" (*Herald*, April 26, 1984). But, after a number of cases in 1985 that involved deaths of alleged witches, the authorities began to demand action from ZINATHA, especially after one of its members was arrested in early 1986 for conducting witch-hunts (*Sunday Mail*, Jan. 26, 1986).

The late 1985, early 1986 witch-finding activities of Size Chikanga, a member of ZINATHA, raised the issue of authority over traditional medicine, and led the government to take steps to gain control over ZINATHA. Speaking in early 1986, in the communal area where Chikanga was practising, the Minister of Information, Nathan Shamuyarira, asserted that while the government supports "traditional culture, chieftainship, [and] spirit mediums who used traditional herbs", it "does not support what some members of ZINATHA are doing". Shamuyarira attacked Chavunduka directly, stating that "[s]ome members of ZINATHA are not qualified medicine men by African tradition — their president, for example, is not a qualified herbalist: he is university professor". After assuring the audience that Chikanga would be arrested and charged, Shamuyarira announced that the government "would be looking more closely into the activities of ZINATHA" (*Herald*, Jan. 3, 1986).

Joining the issue was the Minister of Home Affairs, Nkala, who, having earlier mentioned the government's inability to crack down on witch-

finding, now placed the blame squarely on ZINATHA, which he assailed as an organization of "undisciplined people". Nkala threatened that "If the leadership does not discipline its people, then the Government will have to step in and do it for them." He claimed that "ZINATHA has been given the wrong impression of its powers" and suggested the government "should look again into [its] activities" (*Herald*, 20 Jan. 1986).

Subsequently, Prime Minister Robert Mugabe backed up his ministers. Declaring that the government's determination to "clamp down on witch-hunters and bogus spirit mediums was demonstrated by the recent arrest" of Size Chikanga, Mugabe attacked "bogus spirit mediums and witch-hunters" as a "retrogressive development". The Prime Minister demanded that ZINATHA "get its house in order" and reorientate its membership "towards more scientific and therefore more positive approaches to herbal practice" (*Sunday Mail*, 26 Jan. 1986).

Chavunduka was dismayed. "[A] few culprits", he lamented, were placing ZINATHA's name in "great disrespect and embarrassment", while admitting that the organization lacked the power to curtail witch-hunting, having neither the power to fine, suspend or imprison errant members (*Herald*, Feb. 10, 1986). Some power resided in the Traditional Medical Practitioners Council created by the Traditional Medical Practitioners Act of 1981, but previously ZINATHA had been unable to activate it because of the stalling tactics of the government (*Herald*, Jan. 11, 1983; Dec. 19, 1984).

The government, however, could no longer ignore ZINATHA, given the vengeance people were unleashing on suspected witches. For the first time since the Traditional Medical Practitioners Act was passed, the Ministry of Health in 1986 activated the Traditional Practitioners Council by appointing its seven members while ZINATHA elected five more from its ranks. The 12-member Council, which was to serve as the "high court" for the discipline of traditional practitioners (*Herald*, 10 Feb. 1986), was by 1990 licensing healers on an annual basis (*Herald*, May 21, 1990). Yet one problem, the appointment of a Registrar by the Minister of Health to run the affairs of the Council, remained stalled over the issue of who would pay his salary (*Herald*, 10 Feb. 1986).

ZINATHA also now took additional steps to control traditional practitioners, by setting up a disciplinary committee to suspend members (*Herald*, Feb. 10, 1986). Still, lack of real power and authority over practitioners continued to haunt the organization. For instance, after the disciplinary committee fined an unregistered midwife whose activities had generated negative publicity, it could not compel her to pay the fine (*Herald*, June 26, 1990). By the end of 1990, however, ZINATHA was compiling lists of unregistered practitioners and circulating them throughout the country, calling unregistered practitioners before the

disciplinary committee and fining them (*Herald*, Dec. 19, 1990). ZINATHA's success in collecting fines was another matter entirely.

By the late 1980s, ZINATHA was experiencing additional stress with the appearance of healers, or individuals claiming to be healers, alleging they could cure Acquired Immunity Deficiency Syndrome (AIDS). One man asserted that "he had been sent to cure all the 'incurable' ills that afflict mankind and defy modern medical science". Reporting that people, "some of them high-office holders, flock to him seeking salvation", an editorial noted that such "charlatans" had "tarnished the reputation of authentic healers in the eyes of the public and fuelled scepticism towards genuine traditional and faith healers". The editors called on ZINATHA, "with the help of the police", to "end the reign of charlatans among their midst", wisely adding that no legislation could put these healers out of business "because it is the naivete and desperation of the patients which give rise to this breed of dubious traditional and faith healers", whose increasing numbers were "largely the result of soaring unemployment" (*Herald*, Nov. 14, 1989).

A few months after these comments were made, another case was reported of a man who claimed that the ancestors had instructed him in a dream to "take up the Aids healing mission", showing him "the herbs for both its prevention and cure". Reporters wrote of seeing "scores of people" at his home, though his neighbours "remained sceptical about his alleged healing powers and said they were surprised to see people coming to him for Aids treatment 'of all the diseases'". This man owned several general stores and had a license to market and sell, which he admitted "suited well his new-found occupation as Aids healer" (*Herald*, May 18, 1990).

Editorializing about this latest case, the press pointed out that such cases were not limited to rural areas, for individuals in the urban centres trumpeted their abilities to cure AIDS, and recalled a recent report of a "self-styled 'prophet' who claimed he could 'heal' by the laying on of hands while in a self-induced trance". While the editors admitted that "a cure, if and when it is found, could well come from traditional medicine", they cautioned that such a cure would receive "the closest scientific scrutiny, something the charlatans avoid at all costs". Concerned about the danger of spreading the disease by people who believed they were no longer infected, the editorial warned that the public was demanding "tougher action" by the police, the courts and the legislature, adding that "ZINATHA, too, has been urged to take a tough line with members who overstep the mark" (*Herald*, May 19, 1990).

ZINATHA initially responded by warning the public about AIDS-cure claims and reminding them that traditional healers had to be licensed. It pointed out that some traditional medicines were known to relieve

symptoms, and advised people to consult ZINATHA for referrals to healers who were specially trained to deal with AIDS (*Herald*, May 21, 1990). The press was not satisfied with these comments, however. The editors of the government-owned paper, *The Herald*, demanded to know why ZINATHA did not condemn outright the aforementioned "healer" and others. ZINATHA's reaction to the stories, they argued, was "lukewarm". The editors then asked rhetorically, "when has ZINATHA issued more than the warning put out in this latest Aids cure case or at most administered a slap on the wrist?" (*Herald*, May 22, 1990). Actually, besides conducting its own research on AIDS and launching an awareness campaign among its members, there was little ZINATHA could do other than summon errant healers before its disciplinary committee (*Herald*, May 23, 1990).

CONCLUSION

It is typical of Zimbabwe that the debate over the place of traditional medicine in post-colonial society should so centrally involve the press, a forum that colonial Zimbabweans had long used to air their grievances and aspirations (West, 1990). Zimbabwe is also a country "rich in intellectual and analytic skills in the field of social science research" (Mandaza, 1987), a scholarly tradition well represented by the likes of Chavunduka and Ushewokunze, two dominant voices in the debate on traditional medicine. The quest for national identity in Zimbabwe involved the recognition, as one writer put it, that "traditional medicine is part and parcel of [the country's] culture" (Agere, 1987). But this, as we have seen, is a highly charged and controversial matter. Not only do the debates concern the place of traditional medicine, but also who should control it and toward what end. The formation of ZINATHA and its recognition by the government were attempts to control the practice of traditional medicine. It is, however, not easily controlled, as ZINATHA and the government discovered, to their chagrin.

Nevertheless, the work done by ZINATHA, Ushewokunze and others bears fruit. Take Dr Barbara Sibanda, a traditional practitioner in Bulawayo, Zimbabwe's second largest city, who seeks to combine the best of both worlds — traditional and western medicine — not to integrate them but rather to let them complement each other. I met Dr Sibanda in the early 1990s, and spent some time interviewing her and her staff, visiting her immaculately clean facilities, and taking pictures of newborn babies, buildings already in use and others undergoing extension.

Sibanda's mother had been a respected midwife and spirit medium in one of Bulawayo's African townships, where Sibanda herself was born. After training as a nurse, Sibanda was inspired by the spirit of her deceased mother to undertake service on behalf of babies and their mothers. One

of her business cards shows a baby being held by a nearly invisible hand, and another has a mother nursing her infant.

In 1980, Sibanda began the Zimbabwe Traditional and Medical Clinic in Bulawayo to bring together traditional and western medicine under the same roof. It was the first of its kind in Zimbabwe. In 1981, Ushewokunze, while still Minister of Health, facilitated the registration of her clinic, like any other medical facility. Sibanda recalled the early days of the clinic and how the "Medical doctors were so much against this concept", believing that working in the same physical setting with traditional healers would "jeopardise their ethics and dignity in society" (Zimbabwe Traditional and Medical Clinic, 1991). Yet, this was an idea whose time had come.

The main herbalist was Dr Dumezweni Sidambe, whose membership in healers' associations dates to the 1950s, and who had known Sibanda's mother. He was impressed by Sibanda's "love in this field of healing and [her] helping the needy" (Zimbabwe Traditional and Medical Clinic, 1991). Another early staff member was a practicing western doctor, T. Harvey, who qualified as a physician in England and in the 1940s entered foreign service in Asia, where he developed an interest in indigenous cultures and their medical systems. Dr Harvey had written extensively on these subjects relative to India and Zimbabwe, and in the 1950s helped to organize an association of traditional healers that included himself and Zimbabwe's first African medical doctor, Samuel Parirenyatwa. After retiring to England, his birthplace, Harvey realized his home was Zimbabwe, so he returned and joined the staff at Sibanda's Clinic (Harvey, 1992; Zimbabwe Traditional and Medical Clinic, 1991). In the Clinic's "functional structure and methods", he sees the opportunity to promote what he calls the "active and practical dualism of Traditional Medicine combined with the Allopathic discipline", a combination he believes is "ideally suited to the holistic approach of healing rather than the empirical reductionist system on its own" (Zimbabwe Traditional and Medical Clinic, 1991).

The Traditional and Medical Clinic is supported by an organization called "Friends of the Clinic", located in Bulawayo and headed by the regional manager of a government ministry. Hundreds of local families belong to it and receive free health care at the Clinic as part of their membership. From 2,000 patients seen at the Clinic the first year, the numbers had grown to 20,000 by 1990. In addition to the services given by the herbal and western doctors, dental advice, family planning services and free immunizations were available (Sibanda, 1992; Zimbabwe Traditional and Medical Clinic, 1991).

In addition to this clinic, Dr Sibanda opened Kings Maternity Home in 1990 in another part of Bulawayo, with support from the Ministry of

Health, Bulawayo's City Health Department, and donations from the US, Canadian and Netherlands Embassies. The Home includes a maternity ward staffed by nurse-midwives who practise natural childbirthing. It offers ante and post natal services, immunizations of children and natural family planning. Dr Sibanda trains local midwives and maintains contact with others, whom she encourages to use the Home, something she said the government should be promoting in clinics throughout the country but was not (Zimbabwe Traditional and Medical Clinic, 1991).

Besides these facilities, Sibanda has, since the late 1970s, operated a smaller clinic, her first, in a village 20 kilometres outside the city centre. When I visited, this clinic was scheduled to move into a community centre Sibanda was then building. Sibanda hoped to increase the clinic's work by getting a full-time medical staff person. Like the larger clinics, but on a part-time basis, this clinic also offers free care to the indigent, immunizations, and preventive-health education (Kings Maternity Home, 1994; Sibanda, 1992; Zimbabwe Traditional and Medical Clinic, 1991).

We should think, with an impressive array of services like these, that Dr Sibanda would be content. But she is not. If she could, Dr Sibanda, would create state of the art facilities for birthing services, where western and traditional medicine would be brought under the same roof (Sibanda, 1992). She is held back only by lack of money and the advanced technology it could buy, a common experience in Africa, and obstacles her resourcefulness, unfortunately, cannot overcome.

Despite the heights to which she cannot soar, Dr Sibanda has put into practice a vision of traditional and western medicine working side by side. She also shares her organizational abilities and her "love in this field of healing" with healers outside Zimbabwe. In 1986 she was instrumental in the founding of the International Organisation of Traditional Medical Practitioners and Researchers, which by 1990 had branches in over 12 countries on three continents. Its president was a Nigerian, while the Secretary General and Director of Research were both Zambian. For her work in traditional medicine, Sibanda has received honours from fellow Africans outside Zimbabwe (Sibanda, 1992; Zimbabwe Traditional and Medical Clinic, 1991).

Within Zimbabwe, her work is also esteemed. In 1991, the Tenth Anniversary celebration of the Traditional and Medical Clinic was attended by the Minister of Health, Timothy Stamps, Herbert Ushewokunze, then Minister of Energy and Water Development and an Honorary Member of the Clinic, the Governors of Matabeleland South and North, and the Mayor of Bulawayo. Fraternal greetings were sent by traditional practitioners' organizations in West, East, Central and Southern Africa, and even by the Prime Minister of Swaziland. Healers in Europe, North America and Australia, who practise alternative therapies and have visited

the Clinic over the years, sent congratulations or brought them in person (Sibanda, 1992; Zimbabwe Traditional and Medical Clinic, 1991).

The year after the anniversary celebration, the Zimbabwean Women in Contemporary Culture Trust, formed in 1991 to encourage women's creative work and local and regional networks, selected 54 women, including Dr Sibanda, for its first Diary-Notebook (Zimbabwean Women, 1992). Interestingly enough, Dr Sibanda was not featured for her medical work, but rather for having organized the Zimbabwe Traditional Music and Cultural Dancers Association in 1987. By 1992 this Association, located in Bulawayo, comprised almost 40 groups; it organized workshops and festivals, and encouraged women artists to be "members and decision-makers" (Zimbabwean Women, 1992). After summarizing the cultural work of each woman, the Diary-Notebook ended with a quote from each. Dr Sibanda's said: "I have always been rooted in tradition. My mother was a healer and a gifted dancer. I feel privileged to carry on her work." Actually, in continuing a family tradition of healing and dancing — activities in which she brings together the old and the new, the traditional and the modern — Dr Sibanda has quite unwittingly earned herself a place in the front ranks of the quest for national identity in contemporary Zimbabwe.

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