Violence and Reclamation: Understanding HIV in Tanzania

By

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Abstract

This paper focuses on the dialogue between HIV, various forms of violence, and acts of reclamation based on ethnographic experience in Mufindi, Tanzania. Ethnographic examples in this paper are the product of ethnographic research methods, such as informal interviews, focus groups, and textual analysis. Symbolic violence produces a problematic understanding of African health, that then becomes internalized, and inhibits strategies to combat HIV in Tanzania. Structural violence is enacted through economic policies that drive poverty and impact quality of/accessibility to healthcare and treatments. Environmental degradation and pollutants sustained by structural policies that affect quality of life and well-being are examples of slow violence. Everyday violence in Mufindi appears in the shape of funerals and generational death. However, complicating how grief is understood in these contexts challenges the typical medicalization of emotions like grief showing how the western biomedical gaze dominates conversations about African health, and therefore impact what gets treatment. Analyzing the discourse around HIV, paired with ethnographic data, revealed other illnesses affecting the Mufindi population, that have been ignored in health scholarship. Acknowledging these other health issues contributes to a more dimensional understanding of African health and furthers understanding of everyday aspects of these diseases. This gives the potential for future studies to explore chronic illness in Africa, contributing to nuanced understanding of the illness experience.

Keywords: violence, health, HIV, Tanzania, ethnography

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Ningependa kushukuru walimu wangu, rafiki zangu, na familia yangu katika Mufindi na Dar es Salaam kwa kunisaidia. Asante sana, kwa sababu sikuwezi kufanya chochote bila ujuzi wao na uvumilivu wao. Asante kwa kunitambulisha kwa Kiswahili; ni lugha nzuri sana. Asante kwa kunitunza na kunifundisha vitu vingi.

Lastly, I would like to thank my wonderful family and partner for their continuous encouragement and love. Malo. Ofa atu.

Symantha

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Introduction

In early August, I left my host family's house in Mufindi, Tanzania, and walked to a grieving family's home with an American colleague working for an NGO in Mufindi. She said that when she had first arrived with the Peace Corps twelve years ago, there could be as many as five funerals in a day due to complications with HIV. That number had since decreased. I could not imagine what that meant for the families here and I thought about how these funerals must have disrupted their daily lives. When we reached the family's house, I learned that the funeral was for a young HIV-positive man, whose family had received support from the NGO. It was an all-day affair with people coming and going. This was the first funeral I had attended of someone my own age and it was only my third day in the country. I thought about how these community members watched those that they loved and grew up with disappear. I witnessed, in short, the everyday violence of disease, complicated by the symbolic and structural violence that already afflicts people in Tanzania.

However, I observed acts of reclamation even in a time of grief. At the end of my week in this community, a local HIV activist explained to me that while HIV was prevalent, it was not the only or most important health issue he saw facing his community. Other concerns, like diabetes, were often ignored. He was not just pointing out to me that there are different public health challenges in this context. He was asserting a critique of authority figures who he believes were neglecting these larger and more urgent problems. By challenging scholarly understandings about HIV, this thesis will show how acts of reclamation pave the way for more varied and complex notions of health in Tanzania. Specifically, this project highlights how Tanzanians experience and respond to diverse modes of violence in their communities, as well as how they

contend with comorbidity and chronic illnesses, which remain largely unrecognized in popular representations of Africa.

Women's health, marriage, and family planning are focal points of public health programs that address the HIV epidemic. Clinical and public health practitioners suggest that women's relationships and reproductive health decision-making are hampered by the disease, the causes of HIV transmission, or exacerbate the risk of contracting the virus (for example, Fuller, 2008; Hunter, 2010; Susser, 2009, Thomas, 2003). Linda Fuller's text, *African Women's Unique Vulnerabilities to HIV/AIDS: Communication Perspectives and Promises* problematically details the depiction of "the African woman" as the poor, rural, worked, and sick, void of ethnicity, religion, education, and more. Fuller attributes these traditional practices and "African culture," more broadly, to the continent's long history of gender inequalities (p 6). As a result of these traditions, women are expected to marry as soon as possible, farm, prepare food, give birth, care for children and the sick, and are vulnerable to men's attacks. Women's poverty, coupled with their singular identity as sexually reproductive beings, expose them to gender-based violence, which leads to HIV infection (p 6). More so, Fuller adds, "an African woman's 'social security' has been dependent on her ability to have as many children as possible, despite the many difficulties she might encounter […] And so, AIDS puts women "in 'triple jeopardy,' impacting them as individuals, as mothers, and as caregivers" (p 7). Africa is consumed with "alarming rates" of sexual assault and abuse, and unprotected sex is "a given" (p 7). Fuller's work mirrors the concerns of prevention and health programming efforts, but burdening women with prevention work ignores other factors contributing to the epidemic and illness experience.

This is only one example of many, but these statements are problematic because they primarily emphasize gendered behavior, largely removed from the structural forces that shape

women's risks of contracting HIV (see Higgins, Hoffman, and Dworkin, 2010). Women, for example, center their livelihoods and deploy agency within the context of pre-existing structures, which open them up to other vulnerabilities, as well as opportunities for protecting themselves (see Kandiyoti, 1988). By analyzing HIV through these cultural frames, public health practitioners too often neglect these structural forces that shape harm on an individual and collective level. As Farmer (1996) and Talal Asad (1975) explain, culturalist explanations are ways of perceiving and objectifying societies outside of one's own, without acknowledging the inequalities constructed and reproduced by powers outside of the society. More so, examples like Fuller's work conflate structural violence with cultural difference, getting lost in relativistic analysis (Farmer, 2004). Social inequities are exacerbated by structural and symbolic violence, dismissed as culture, and often overshadow an analysis of the ways in which local people exert their agency.

Invisible Monsters

The goal of this thesis is to explore community experiences of HIV, modes of violence, and resistance. In order to unpack my experiences in Mufindi, it is critical to understand the concept of violence, in its many forms, and to fit my experiences into the discourse of health and violence. Therefore, I take some of the social and theoretical concepts of violence and illustrate how they appeared in the field.

Nancy Scheper-Hughes and Phillipe Bourgois (2005) explain that the concept of violence is "slippery;" in all directions, able to make, break, and put back together just to do it all over again. They write:

> "[v]iolence itself […] defies easy categorization. It can be everything and nothing; legitimate or illegitimate; visible or invisible; necessary or useless; senseless and

> gratuitous or utterly rational and strategic. Revolutionary violence, community-based massacres, and state repression are often painfully graphic and transparent. The everyday violence of infant mortality, slow starvation, disease, despair, and humiliation that destroys socially marginalized humans with even greater frequency are usually invisible or misrecognized" (p 1).

Violence is commonly referred to as visible and physical. Scheper-Hughes and Bourgois, like other social scientists, are complicating the definition associated with violence by asserting that it can appear in many forms: invisible, slow, through symbols and institutions, in which harm is indirect. The authors are attempting to not only bring attention to different forms of violence, but to illustrate how these other forms can be enacted and reproduced over time. Scholarship like Fullers, then, miss the mark by assuming violence is mostly physical. Linda Fuller is not wrong in her assertion that traditions can lead to biological and physical harm. But, this means that texts and images like those Fuller employs neglect the fact that suffering becomes ingrained, making it easy to dismiss violence as natural or "just their culture." It is oversimplified, one-note imagery that is removed from dense historical influences and taken out of context.

However, the explanation of violence from Scheper-Hughes and Bourgois is not complete. It does well to expand our understanding of violence, but makes violence appear as anything and nothing. If violence is nothing and everything at the same time, then it is impossible to observe or stop. However, violence is bounded, even if scholars have not fleshed out all of the indirect forms. There are specific modes of invisible violence, such as symbolic, structural, slow, and everyday that have concrete definitions and examples.

In this thesis, I will apply different analytical frames to my ethnographic experience in Mufindi, which employ the concept of violence: symbolic violence, structural violence, slow

violence, and everyday violence. Symbolic violence, introduced by Pierre Bourdieu (1991), is a "gentle violence, imperceptible and invisible even to its victims, exerted for the most part through the purely symbolic channels of communication and cognition (more precisely misrecognition), recognition, or even feeling." Representations of the HIV epidemic in Africa offer a wide range of examples of symbolic violence. When articles like Donald McNeil's (2014) are printed with headlines indicated a simple theory and proposal on "H.I.V. in Africa," they communicate to readers and patients alike that HIV is a problem, Africa is a problem, and outsiders are needed to propose theories of solvency. It glances over the context of the disease (South Africa), painting it as the entire continent's issue. In summary, the article argues that there is a new reason why African women are more vulnerable to HIV and it could be genital schistosomiasis (a parasite), according to a team of Norwegians. This example, and many others, produce images rooted in racial tropes and the conceptual/problematization of Africa(ns): African women as victims, inherent sexual implications of brown and black women, brown and black bodies as dirty and poor, disease Africa, and only the expertise of those outside of Africa can solve such problems.

Bourdieu (1991) argues that symbolic violence can only be enacted through "collaboration of those who undergo it because they help to construct it as such." For example, Figure 1 depicts a setting in which women discuss family planning, contraceptives, and the idea of a variety of methods for any kind of family to use. Single women passing by this poster may interpret it as contraception and family planning are only useful for just that – families. This poster indicated what a family should look like and what she as the woman is responsible for. The implication is that a woman should have a relationship (with a man) in order to reproduce,

and that it is her role to be the one to make the plans and decisions about her family's construction and well-being.

This poster, meant to inspire the normalization of family planning and use of contraceptives (potentially to help monitor health status, test and treat HIV, and more) establish what family looks like and what a woman is. If a woman walks by this, and does not see herself in this poster, she may be left with the idea that without a family to plan for, she is failing at her role, or without children she is not a "real woman." She may disregard the message entirely, producing the opposite result intended, or she may put herself at risk for other harms to meet the images she sees for women around her. These women are left to replicate the stereotypes they are often associated with, despite the social and symbolic catalyst.

The translation (right to left) are as follows: 1. "You have heard about family planning." 2. "Yes, but I have not yet chosen a method to use." 3. "There is a method of family planning for every woman." 4. "It's true. For the benefit of your family, I advise you to plan."

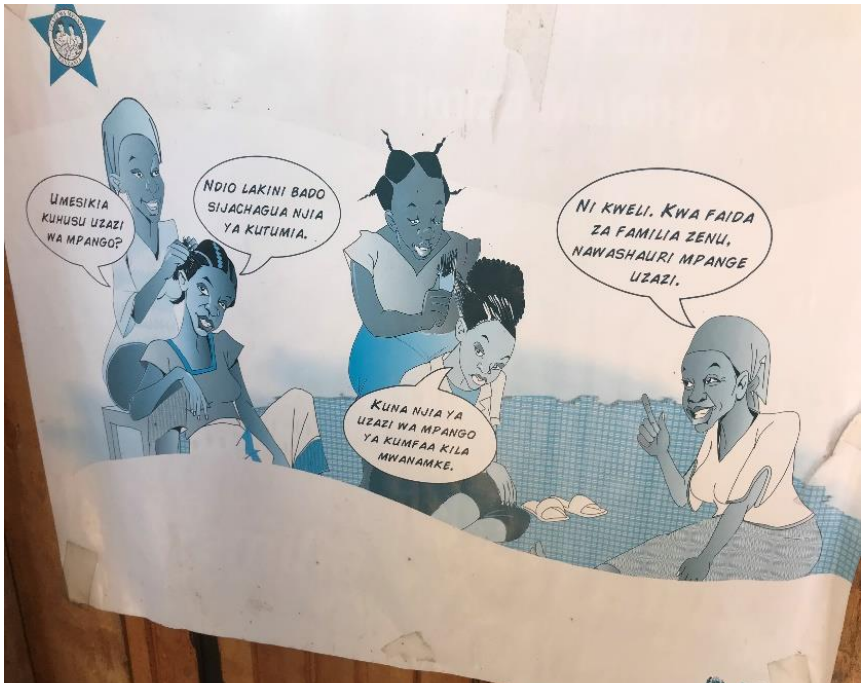

Figure 1. Clinic poster, 2018.

Frantz Fanon (1967) emphasizes a different dimension of symbolic violence, suggesting that colonial language is symbolically aggressive against the colonized. It reconfigures lives and histories in terms that are familiar to the colonizers,

with violent repercussions. Fanon explains that colonial agents (police officers or soldiers) bring violence into the minds of the colonized (pp 3-4). The colonized "[are] constantly on [their] guard: confused by the myriad signs of the colonial world […]. Confronted with the world configured by the colonizer, the colonized subject is always presumed guilty. The colonized does not accept his guilt, but rather considers it a kind of curse" (p 16). Fanon's argument emphasizes that it is not always a collaborative effort, unlike Bourdieu. In the case of Figure 1, Fanon's analysis allows me to question where the family framework pictured above came from. Historically, a heteronormative, nuclear family is abnormal and potentially unsustainable in African countries, a quality that is policed and critiqued (see Epstein and Ashburn, 2004 for examples).

In terms of gendered suffering, Gwendolyn Mikell (1997) mentions that in Africa, female subordination is complicatedly grounded in traditions, but unlike Fuller, argues that images of these relationships "[are] exaggerated by colonial, Western, and hegemonic contracts. Since culture is not static [...], inequalities have arisen that politicians and layperson alike sometimes present as customary when, in fact, they are distortions of the African reality." This would help explain how some of the characteristics of Figure 1, such as family construction and gender roles, may have changed over time. Colonial and western reframing of African traditions produces a caricature of reality, which is then consumed and reproduced.

Both Fanon's and Bourdieu's arguments align in the idea that representations can become internalized through feelings of fear and inferiority, especially when positioned against those in power. Structural harms and inequalities are normalized, justified, or perceived to be a "natural" occurrence. Mikell (1997) adds to this that political powers and leaders may view these harms as "externally generated," so that actions taken internally to make changes are interpreted by said

leaders as outsider manipulation. So, in the instance of a woman walking by this family planning poster, internalizing the messages of inferiority and that she is less of a woman for not having a family, she decides to marry the first person she can get to. However, once married, she realized her husband is not going to abide by the family planning guides or approve of contraception, because it may negate some of his expectations of marriage and social roles as a man and husband. If she complains or tries to incite action against him, she can be dismissed, or her claims delegitimize by local leaders under the guise of manipulation by western influence. Western influences may blame a woman's suffering on the broad understanding of culture and patriarchy, and local powers may blame suffering on the brainwashing done by westerners.

Structural violence, defined by Paul Farmer (2004), is "violence exerted systematically […] by everyone who belongs to a certain social order: hence the discomfort these ideas provoke in a moral economy still geared to pinning praise or blame on individual actors. [It] is intended to inform the study of the social machinery of oppression." For example, when Structural Adjustment Programs (SAPs) introduce economic policies that cut funds to social welfare programs in order to ensure countries can make debt repayments for loans given out by the World Bank or International Monetary Fund (IMF), it can contribute to disproportionate patterns of infectious diseases in participant countries. Structural violence, like symbolic violence, can play a role in reorienting history, by masking the political and economic conditions that decrease infrastructure, end investments in social services, and restrict humanitarian policies, and instead focus on individual or group blame. This, in turn, normalizes oppression and enables institutions to enact further violence. In the case of Figure 1, blame is indirectly placed on the individual, as it is up to each woman to take their health into their own hands, and if a woman gets sick or has issues with her family, then it is because she did not do enough and not that the resources were

not around to help her. The poster indicates that "there is a method for every woman" implying that there is no excuse to not have a plan in place. However, the lack of concrete examples of methods or information for methods, could indicate the lack of resources, political popularity, or access to information about the variety of methods to use.

Rob Nixon (2011) proposes the concept of "slow violence" as the "gradually, out of sight violence of delayed destruction that is dispersed across time and space and […] typically not viewed as violence at all." Health is holistic; not limited to one but a culmination of social, environmental, biological factors. People exist in and out of these different spaces that shape social relations, access to care, creation of livelihoods, and more. Villagers in Mufindi, for example, are born already set-up for suffering given the infrastructure, economic policies, corporate and contested accessibility of natural resources. Locals may not (at least in the foreseeable future) get land rights to valuable tea farms or the luscious acreage gifted to (not bought by) white, affluent, British families prior to independence. Symbolic, structural, and quotidian processes create the scenarios for slow violence's "calamitous repercussions playing out across a range of temporal scales" (Nixon, 2011).

Figure 2 shows a result of slow violence, embodied by the clinic. This type of violence, associated with environment, can be seen in the location of the clinic and others like it, and its architecture. Without access to land near a community, clinics may need to be built further away. The location of Figure 2 was away from any immediate communities, and to access it, one would need a vehicle to traverse difficult, bumpy roads, or walk a sizable distance. Changes in investment of property or disinvestment in an area lead to poor infrastructure or lack thereof. More so, the architecture of the clinic showed years of wear and tear, as if it had been built several years ago with little to no upkeep. The posters were faded, torn, and unreadable in most

places. Vital facts, contacts, and preventative information is lost on patients as posters like these are inaccessible. This kind of environment can have direct impacts on an individual's health.

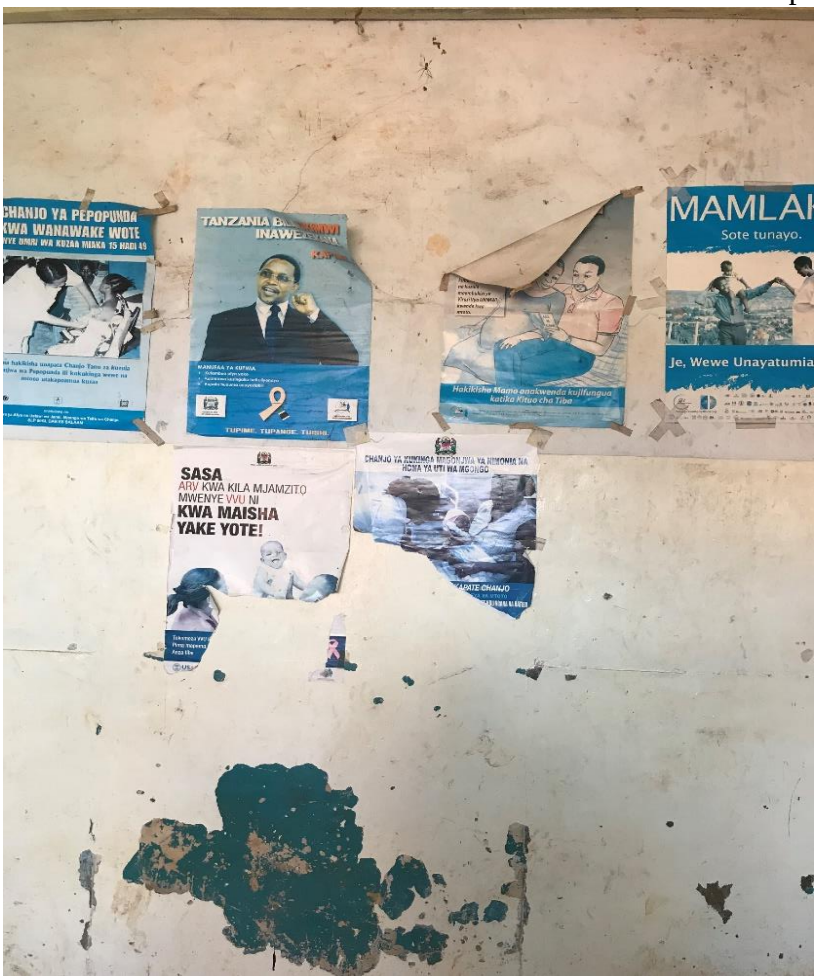

Figure 2. Taken at a clinic in Mufindi, 2018.

Lastly, everyday violence, is "situated at the 'capillary level' and focuses on the daily micro-level interactions that directly and indirectly impose violence on individuals" (Scheper-Hughes, 2004). This makes it the small infractions and microaggressions that reiterate the above concepts, but the proximity to the individual is overwhelming, making it difficult for the individual to acknowledge the aggression's place in broader contexts. This kind of violence can be indirect, such as westerners prompting only conversations about HIV or like social stigma. For example, in an *Atlantic* article, Stephan Faris (2010) describes an HIV-positive child's experience in a school so that if the child showed a symptom of any sickness, "a classmate would call out, "Remove your HIV from us!" "You didn't abstain well," a fellow student would sing." It can also be enacted overtly, in death and with funerals that take place, like the one I attended in Mufindi.

Images and language become internalized and broadcasted, structures are then put in place and replaced over time as reactions to these images. It is thoroughly pervasive, taking its time and becoming more naturalized as time goes on, making it difficult to see, but even harder to address or resist. However, while violence folded in on itself in layers around this small village in Mufindi, I was struck by both the clear evidence of it, and in much softer tones, the push back against it. From kangas to grassroots health initiatives, I found myself surrounded by counternarratives that contrasted sharply with the more dominant narrative about HIV/AIDS and violence that circulates in the press, which frequently blinds patients, providers, and foreigners to inequities.

In the vein of Ama Ata Aidoo (1998), African feminism is as much about women's rights as it is "[taking] charge of African land, African wealth, African lives and the burden of African development." Western feminist and progressive/social action are currently intertwined, and it plays out by Western-based or influenced health policy, programming, and implementation relying on the image of the "third world" person. As Mohanty (1988) argues, "Western feminism" creates an "ahistorical and stagnant" Third World, where power is binary and gendered. In the case of my study, violence, unlike other scholarly works, is not the defining factor of African health or the African lived experience. It is the acts of resistance to violence that help to define it. Using violence as the definition only creates a one-dimensional understanding, in which to be African means to be part of a catastrophe, to be a tragedy. Understanding the different types of invisible violence, such as how blame is shifted and oriented, or the historical contexts for contemporary problems, allowed me to locate my ethnographic experience within examples of resistance.

Mapping the Complexities

In this thesis, I begin by weaving my field experience into the different theoretical discourses of violence related to health and well-being. Following this, I will begin by describing the methods and context for this study. My fieldwork used a variety of ethnographic methods. I first break down what role autoethnographic processes serve in the field, illuminating lessons learned and how insight is gained by using myself as a tool of inquiry. This contains parts of my thoughts and feelings on my experience, as well as an analysis of those thoughts and feelings. This makes the autoethnographic data academically useful and creates a sophisticated discussion. After, I explain the other types of methods used: participant observation, interviews, and panel discussions. Next, I will give a brief overview of what HIV is and the statistical data of HIV in Africa, Tanzania, and Mufindi. I then discuss the types of violence previously mentioned, as they appeared to me in my research: symbolic, structural, slow, and every day. Each section contains examples from my experience and from literature of the violence occurring. With that, I argue the implications of my case in relation to other scholarly works. Following this, I discuss the usefulness of understanding violence typology and the potential contributions and limitations of this study. Lastly, I will give concluding remarks, tying together the various concepts and arguments of my thesis.

Context and Ethnography

On Being Human with Methods

The first full day of my visit to Mufindi was one riddled with anxiety, awkwardness, and exceeded what I considered to be my emotional limits. The trip to Mufindi took almost three days of traveling, first from Kansas City to Abu Dhabi and then to Dar es Salaam. Next, we

travelled another full day's journey from Dar es Salaam to Iringa. Later, we packed onto a bus, rumbling for hours on bumpy, jarring roads from Iringa to Mufindi, arriving late in the night, only to spend the next day walking around the village, touring the non-governmental organization, and then going straight to a home-stay with a local family later that afternoon. I was nervous about traveling abroad for the first time, being on my own, and my lack of Kiswahili skills.

Our student group had met with our host families on the NGO campus before following them into the villages. I spent the afternoon helping my host-sister carry huge buckets full of gallons of water from the well to our house on my head. Neighboring women visiting the well called out, making jokes about my attempts at helping and saying they were impressed by my efforts. My host-sister and I cooked dinner. I chopped cabbage, tomatoes and onions with the help of two children that used me to practice their English and were thrilled to answer my elementary Kiswahili questions. I found myself in the small building adjacent to the main house, coughing on smoke from the cooking fire for an hour or so that night, while my host-sisters and mother, children, and chickens bustled in and out preparing dinner. These were pivotal moments in relationship-building, which is at the core of the ethnographic methods I sought to employ over my week in this community. If I had not immersed myself in this family's life and helped them where I could, they would not have trusted me. These small acts of building rapport and making myself visible to the community, establishing my presence positively, made navigating conversation and space easier. While this was only a week-long visit and not a year-long ethnographic study, which is the norm in cultural anthropology, I was able to quickly access a sense of this family's routines and the common sense they apply to their different roles and concerns.

Nevertheless, the first night I felt out of place, unsure of how to interact with my host-family. I kept a smile on my face throughout the afternoon and meal. The same DVD of local performers from the church group singing hymns played over and over as we talked and ate, until I felt I could not keep my eyes open any longer. I thanked everyone for dinner and for taking care of me before closing the bedroom door and curling up under a heavy blanket. In ethnography, scholars' bodies become a research tool in participant observation. A researcher must use their body and their senses to experience the field beyond visual observation and notetaking. We carefully straddle the line between insider and outsider. Our bodies are used in attempts to position ourselves as insiders. We must watch closely to learn when to laugh, how to compose ourselves in social situations, and relearn habits like sleep patterns and meal times. However, the limits of our bodies (exhaustion, emotion, confusion), return us to outsiders. For our own selfcare, we must learn how to be okay with our bodily limits and the need to withdraw, despite how isolated we may feel in the process.

While we sat in the living room on plush, colorful couches, my host-father explained over a dinner of *ugali* (porridge) and beans that the next morning the family will attend church. He said we would all leave by nine. I was staying in a village primarily comprised of people who attend a Seventh Day Adventist church. Being in a culturally different space successfully means engaging in the performance with as much of my own, genuine experience as I could, even if it was not a common experience I associated with, like church-going or piety. These small acts of reflexivity in ethnography serve as reminders of positionality and our own cultural upbringings, and what aspects of my positionality influence me in different social settings. Understanding this allows us to flesh out how much of our personal lives to share and how much to hold back.

I spent the night wondering what kind of meaning I could take away from my upcoming church experience, especially when I still felt uncertain about how much I could understand in Kiswahili. I was made aware of how much I would need to infer meaning without language, given my restricted linguistic abilities. I imagined that the "data" would appear tangible like a fruit to pick from a vine and carry back with me, as I fully immersed myself in this new place. I expected that an event would happen and as it unraveled, it would come with red flags and flashing lights with "EXPERIENCE" on top, and that would be my moment. I struggled to read posters and signs from the minute I landed, looking for anything health-related and coming up empty-handed. I was fumbling through Kiswahili and Kihehe greetings and did not have the ability to ask HIV related questions to my host-mother and sisters.

I thought about sitting in church, taking notes in my tiny, yellow, crumpled notebook about the clothes people wore and what I thought the preacher might be saying. My mind ran through arguments about the ties between health and religion, women and religion, quotidian life and health, unaware that I would wake up the next morning and never step foot in the church. Instead, I went to a funeral for a neighbor a few paces down the dirt road. Ethnographic research means opening ourselves up to contingency. Our studies are not taking place under microscopes with petri dishes, complete with lab manuals. They are done in conversations on the sides of streets, in between the lines of mixing languages, and on living room floors. Flexibility and adaptability are non-negotiable, because life is dynamic and exposed to infinite variables.

The "moment," in other words, never came and it was not until back home in Kansas, almost a year later, that I could begin to unpack this day. Yet, it is these earliest encounters with my host-family and community that shaped my entire experience in Tanzania, giving me the most important insights and challenging me to adapt. I learned different lessons about being a

human in this space, being a researcher. and when it was appropriate to be which. There were serious obligations to my host-family and the community that I never imagined starting very early in this fieldwork, to which I was given tolerance and treated with kindness in return.

ColLAB and Other Methods

After spending the weekend with this family, I returned to the Mufindi NGO, where I rejoined the group of students with whom I travelled. I was one of seven student participants to join a university-based program called "ColLAB: Bridging East Africa's Health Divides," or simply "ColLAB." This program focused on an interdisciplinary approach to East African health issues with a new take on a laboratory. We traded white coats, goggles, and beakers for language learning, homestays, and squat toilets. Through our connection to two KU alums who co-directed the NGO in Tanzania, we selected Mufindi as the site of our field school. All of the participants had enrolled in Kiswahili classes and had research interests in African Studies. I took this opportunity to develop research questions about health and women's bodies, with a focus on HIV, given the high prevalence in this region. We spent several weeks prior to the trip preparing to approach these research topics through a critical lens, to address East Africa's colonial legacy and its implications for research, and to exist in different cultural spaces respectfully. Participants in the lab employed qualitative methods to get an idea of the lived experiences of the individuals with whom we interacted. By using these methods, we were able to get a better understanding of the interworking of everyday life in Mufindi.

Observations, Interviews, and Panels, Oh My!:

Ethnography is the craft of analyzing and synthesizing the quotidian experiences of life, in order to draw connections to critical themes (Susser, 2009). By using these methods, I was

able to access local informants and receive crucial information about the on-goings of life with and around HIV. Through participant observation, members of the lab were able to build rapport with the individuals in this area. By living and speaking with those in Mufindi, we were encouraged to try and understand what questions I can and cannot ask, which questions are considered appropriate as opposed to inappropriate, and gain a sense of how everyday violence plays out "on-the-ground." By learning the language, I felt as though I displayed respect and built a repertoire with the individuals I talked with, allowing me to understand cultural nuances in conversation for interviews, group discussions, and participate in co-production of knowledge (Robben and Sluka, 2012; Marcus, 1995; Geertz, 1973). Speaking Kiswahili and Kihehe at any possible opportunity created a comfortable space for those I talked with, particularly when dealing with health-based issues that can be emotional and may create tension. Language learning also seemed to create a differentiation between myself and "voluntourist" groups, which changes the dynamic of interactions. Several members of the community commented on the pleasure they took in seeing our group learning and speaking Kiswahili, as several of the groups that visited from the U.S. did not learn or try to learn Kiswahili or Kihehe regardless of their length of stay.

Outside of the homestay, our group was involved with the day-to-day work of the NGO. Most of our days were spent hoeing farmlands, helping students after school, working in the nursery or the elementary school, cooking, and learning about the work being done to make the NGO environmentally sustainable. More than once we ventured into the surrounding villages to meet with community members, to see groups of women running a basket weaving business in order pay school fees for local children or to watch how millet is grown and ground for cooking. We attempted to make these interactions worthwhile, not just for our own purposes, but for those

we were talking with. We all sat and talked with community members, which allowed us to make connections and later granted us opportunities for one-on-one interviews with said individuals. Through two interviews, I was able to ask more pointed questions and get a sense of individuals lived experience with HIV. This information was comparable to information given during focus groups and I was able to analyze instances of affirmation and contradiction. The interviews were semi-structured to allow for open-ended responses about relevant topics over the course of less than two hours. The conversations included a translator fluent in both Kiswahili and English. All answers were given in Kiswahili, as was the preference of the interviewees, and then translated into English. These questions covered several topics including: anecdotal information about HIV, experience, activism, community organization, challenges to these organizations, as well as everyday life.

The group sat in clinic meeting rooms and the community center of the NGO with hospital staff, nurses, home-based care volunteers, and activists. For two hours on two different days, we watched as presenters stood and relayed information to us about the facilities and services provided, HIV in the community, community organization, and more. All of the speakers spoke in Kiswahili, which was translated by individuals fluent in both English and Kiswahili. The students attempted to ask our questions in Kiswahili when we could or had the translators ask questions. The interactions with the translators and panel groups were critical to me. This was my first time working with a translator or trying to ask research questions in a different language. I could see how vital this may be in independent ethnographic researcher – to have someone well known work as a go-between for interaction. I had to learn to be comfortable with adjustment to questions or explaining context for my questions, as translations would never be exact, and to account for that in understanding the answers to said questions.

Through both the panel discussions and interview, I tried to ask specific questions and dig for pointed answers. I was met with apathy and, in some ways, dismissal until much later. The very first presenter was expected to talk about HIV in Mufindi and Iringa, he almost literally recited a history of HIV in Tanzania. "HIV started in 1983, reported in Northern Tanzania," he began. "Four years later, all regions reported it and the government started possibilities for treatment. It started with a seven-percent prevalence and is now down to four and a half percent. It is estimated that 2 million people in Tanzania have HIV and awareness increases every day. 26,000 people in Mufindi are on medications; 9,000 men and 16,000 women. Twice as many women as men are medicated. Forty-three percent have stopped medication, 3,000 were referred to outside of Mufindi, 3,000 have died, and 3,000 have lost contact for follow-up." I remember thinking that, while this was wonderful information to get about the disease, it felt entirely scripted, as many of the answers we received would. This was a performance; echoing the many similar moments in which this kind of interaction has occurred with the groups of visitors before us.

I had been curious about textual health messages, only to learn that even if the language is wrong or culturally removed, most people do not pay attention to flyers, posters, and written messages "unless they are already looking for that [kind of] information." I had to rethink the importance of exploring this avenue of interests. I can now, in the semi-distant future of that moment, come up with other questions that might have produced more information, but it is only with hind-sight. It took a semi-structured interview with the activist previously mentioned, for me to get the piece of this puzzle that connected everything, showing that, unlike other research methods, ethnographic methods are less about getting specific answers, checking off survey

boxes, or understanding "why." It is about interacting with people intimately and reading into the information given, regardless of the assumed relevance to the questions asked.

A Note on HIV

HIV is most prevalent across sub-Saharan Africa. As of 2017, almost twenty million people live with HIV in East in Southern Africa, which equates to almost seven percent of the entire population aged fifteen to forty-nine years old (avert.org, 2018). This makes East and Southern Africa the most heavily affect region in the world. Over eighty percent of the population in these countries report knowing their HIV status, and more than eighty percent of those infected are on ARTs (avert.org, 2018). In Tanzania, over a million individuals are living with HIV, making up almost five percent of the entire population. More than half of the adults that know their status access antiretroviral treatments (avert.org, 2018).

HIV is a sexually transmitted virus that attacks the immune system of those affected (cdc.gov, 2018; Heeney, Dalgleish, and Weiss, 2006; Sharp and Hahn, 2011). Per CDC guidelines, HIV is broken down into three stages: acute HIV infection, clinical latency, and acquired immunodeficiency syndrome. The last stage is the result of severely damaged immune systems, in which a person is diagnosed with AIDS. This stage is also one in which individuals are highly infectious and can spread the virus, due to increased viral reproduction in the body (cdc.gov, 2018). It is important to mention the distinction in stages and classifications, as HIV is often referenced without stages. It becomes synonymous with the AIDS stage, which is highly infectious and is related to irreparable damage to the immune system. By referring to HIV or AIDS without understanding the classifications, broad associations get made for those infected that have resulted in the understanding of a positive diagnosis as equal to a death sentence or a predatorial entity.

While infrastructure, transportation, and ramification of poverty may contribute to not adhering to treatment or knowing HIV status, these numbers have decreased in recent years and treatments are becoming more and more accessible over time. In fact, the "roll out" of medication has contributed to consistently reducing the impact of the epidemic (avert.org, 2018). Instead of sickly-looking individuals, most of those that are HIV-positive look and act as if they are not sick. As Arthur Kleinman (1981) mentions, diseases are pathological or biological phenomenon, while illnesses are lived and expressed conceptualizations of disease, therefore making it possible to experience disease without illness and vice versa.

HIV-positive patients often face the biological on-goings of disease (viral reproduction, change in CD4 counts), but lack the illness experience, particularly after ARTs and access to resources. HIV changes from life-ending, miasmic epidemic to invisible chronic condition, living dormant under the skin. More so, it means those with HIV are less infectious and living longer (as ARTs slow the progression). The goal of ARTs is to reduce viral load and promote longer, healthier lives for those infected (aids.info.nih.gov, 2019). Living longer can contribute to individuals developing other diseases.

In the section that follows, I will address the four types of violence in the order that they appeared in my preparation and research. I will touch first on symbolic violence and its role in the construction of "Africa" as a concept. Then, I will discuss how the problematization and conceptualization of HIV is fitted within the racial and colonial frameworks that have been created around the concept of Africa. Secondly, I will explain the processes of structural and symbolic violence in Tanzania that have occurred in response to or that have aided in the spread of HIV, impacting the epidemic and hindering treatment or prevention. Next, I will dive into examples of slow violence and everyday violence. Lastly, I will describe the acts of reclamation

in response to long-term violence. These acts pave the way for more nuanced understandings of African health and allow for more diverse discussions on prominent health issues in Tanzania.

Symbolic Violence and the Construction of Diseased Africa

"When they talk about Africa, they talk about Diseased Africa or Poor Africa" *– Mwalimu*, personal communication, 2018.

I remember preparing for my travels and getting the comments "you're going to Africa?" and "Tanzania? Where's that" when I was asked about the trip. After completing rigorous coursework to ensure the student participants understood how to be culturally considerate researchers, I offhandedly mentioned to a close friend how there are social media pages dedicated to promoting local photographers and artists in African countries, and was met with the startling response "oh, they have cameras in Africa?" When I checked my bag and printed my ticket at the airport, I stood with two others from our group and the airport employee asked if we were going on a church mission trip. These experiences are reminiscent of the fact that Africa is often washed of its diversity, modernity, many borders and complexities. It is so often less place and space, than concept and construct. The responses from those around me illuminated the image of Africa held in their heads, where technology would be unheard of and the only logical reason to go to Tanzania was to lead an evangelical mission.

Foucault (1977) emphasized the imaginary space of the metanarrative, "imagery" that took place in "the hushed precincts of the library." Edward Said (1978) added to this thinking of "geographical imagery" in which the "East" becomes a "cartography of identities," formulated by Western projections of understanding time, space and spatiality, which articulate

"constellations of power." These accounts of imaginative places, painted with large, observer-biased brushstrokes are to be read critically, picked apart from the colonial legacy and exigence of the author. More recently, these thoughts have become more nuanced as ways of thinking about space and time – spatial imaginaries – "reproduced in language and practice, rhetorically and materially (Koch, 2018). It is with colonial documents, the pages of books, and posts on social media that the image of Africa is made for the rest of the world to ingest: of the poor, of the sick, or both.

Previous scholarship and documentation produced an image of the "backwards" Africans. This is seen in images of the Maasai in traditional dress for credit card ads (Figure 3) or showing suffering children in need of Western help for NGOs (Figure 4) as the most dominant depiction of the continent. This creates a flat and static depiction of Africa and it is this image that produces action and reaction. Rooted in colonial understandings of Africans, these images are saturated with symbolic violence. These images stem from the ways colonial officers spoke about and redefined Africa in their own terms.

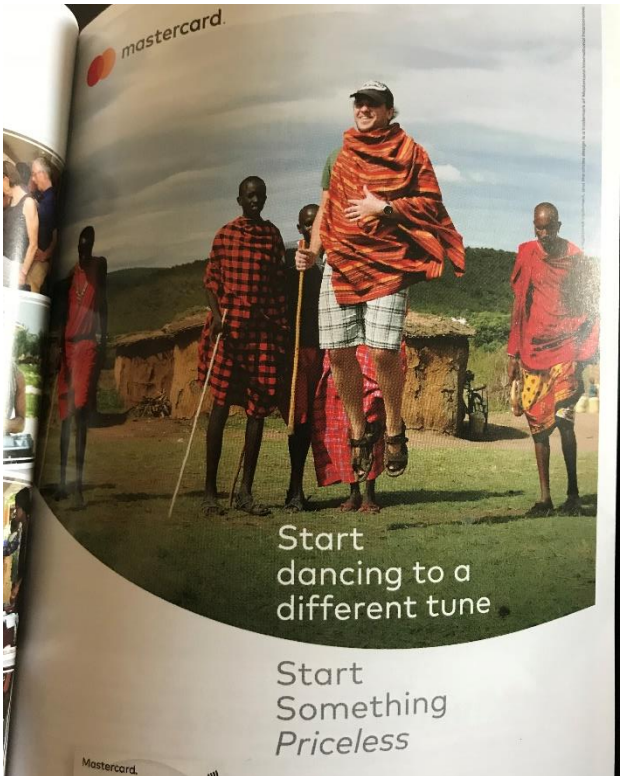

Figure 3. Mastercard ad, Dar Life magazine, 2018.

While geographic imaginaries are not unique to Africa, there is a uniqueness to the way synecdoche is performed. The geographic imaginary of Africa is, as my *mwalimu* pointed out, one of rampant disease or of the impoverished. John (2013) writes that the West has a perception problem when African countries are mentioned. This is so much of a problem that Africa Check, a non-profit organization, was established to fact check media information printed about Africa, needing to respond to *Time* articles that conflate and make sweeping generalizations about the entire continent (John, 2013; africacheck.org, 2012). Popular author Chimamanda Ngozi Adichie warned against the dangers of the "single story," in which she explains the reaction of a roommate that had never met pitied her, only knowing the "single story of catastrophe" in which Africa is swept up (2009). Koch (2018) argues that there are geographical politics leading to "synecdoche," in which small parts (such as a capital, modern city) are pulled out and displayed as the whole, "representative of an entire country's diversity." Ken Walibora (2006), Kenyan children's book author, writes a story of two boys dreaming of going to America, describing a luxurious New York hotel with all the food and drinks one could ever want:

Figure 4. NGO business card, front-facing, 2018.

> "*Ndani, mlikuwa na mabomba ya soda, chai, kahawa, na vinywaji vingine mbali mbali. Ukifungulia tu bomba hilo vinywaji hivyo vinabubujika kama maji katika mto. Utakunywa kiasi chochote utakacho/Inside, you had soda, tea, coffee, and*

many other drinks. Just open these drink pipes so the fluid flows like water in the river. You will drink whatever you want"* (pp 17-18).

*Seems to be depicting a soda fountain machine.

Instead of promoting the history of riches and innovation, or beautiful cityscapes of Dar es Salaam, Kampala, or Nairobi, we are exposed to a rural, impoverished mass of problems. The consequences of which are in responses to these images: those acting in order to solve problems and those reacting to images and internalizing them.

This depiction makes it easy to problematize Africa and Africans as something needing intervention or to be fixed. Rosebell Kagurime (2012), Ugandan blogger, exemplified this problem with her response video to the KONY2012 viral video campaign, arguing that this kind of reporting, among others, "simplifies the story of millions of people […]. And makes out a narrative that is often heard about Africa, about how […] hopeless people are […]." Kagurime's words reflect a long-standing issue, with a lengthy and heavy colonial legacy. As Foucault (1977) mentions, colonial legacy and these imagined geographies lend themselves to the creation of "docile bodies," in which the body becomes a codex for reading power, due to the separation of body and power. Colonial governments across the African continent exploited black bodies, for labor and otherwise, producing a narrative of bodies that reacted "not only so they may do as one wishes, but so that they may operate as one wishes" (Foucault, 1977). This stance is divorced from the discourse of autonomy, promoting the victim narrative, instead of allowing complications, "frictions" between local, state, and global forces, and the possibility of rejection and reaction to force (Tsing, 2015).

The power of the narrative creates an image of the helpless, the poor, the unable to care for themselves, implied by colonial documents and exacerbated by globalization. These images

become internalized, creating a cycle of codependency, met by (largely foreign) structures and institutions to fix what is assumed Africans cannot. For example, during one of our group's excursions through the villages, we met a group of women selling woven baskets. The profit made from the baskets goes towards paying school fees for local children. These women were well acquainted with our NGO host, who had worked in Tanzania for twelve years. Our host had clearly made this trip many times, either to buy baskets herself or to bring other NGO visitors. However, the family running the NGO had decided they were going to move back to America, planning to leave shortly after our visit with the village women. That afternoon, the women gathered around their baskets and tearfully expressed their affection for our host and loudly exclaimed that, without her, they could not do their business and keep funding children, going so far as to beg her not to leave.

This is not to say these women are incapable of solving their problems or finding other ways to fund the children. This is an example of internalization and reaction. These women have been exposed to the idea that they cannot solve their own problems and it takes foreigners to provide help, but these foreign institutions are temporary and unsustainable. Foreigners are exposed to the poor, sickly images of Africans and prompted to help solve the Africa problem. More so, NGOs are goal-oriented, so the women's fears are valid. The host had established a business co-op with these women during times of extreme illness when women were too sick to farm or leave their houses. Basket weaving was a way to income generate and fund the families. However, now the women had been treated and were able to move, farm, and go back to their lives prior to getting sick. The NGOs goal was to help sick women take care of themselves and that goal had been accomplished. The women can go back to farming and providing. The disconnect, however, is that the goal of the business is not necessarily met. It is true that the

women can now grow food, but they will not make money from farming, therefore they cannot afford school fees through farming. Volunteering abroad is temporary, therefore volunteer institutions become temporary fixes, causing harms during installment and exodus.

Nancy Rose Hunt's (1999) work in the Congo establishes a history of colonial violence on African bodies through medical research and health-related aspects. Aspects of African health have long been problematized under the hand of saviorism and racial tropes Africans themselves have been boxed in. I argue that, in many ways, HIV has become the new face of this colonial legacy and these same racial tropes. These colonial and racial tropes problematize Africa as helpless, catastrophic, and prompts reactions based on this geographic imaginary. The treatment of HIV in Africa has followed similar routes.

Guest (2001) describes the "tragedy" of AIDS, as Africa has been "struck the hardest" and there is a generation of children growing up without one or both parents, resulting in "AIDS orphans" (UNAIDS, 2018; Sherr et al., 2008). Guest's work sets the tone for the discourse on AIDS and Africa. This tone has been consistently reiterated by NGO work, medical policy and plan implementation across Africa, voluntourism, research funding, and media. As recently as last year, USAID administrators travelled to East Africa, UNAIDS policy frameworks are based around HIV prevention, and even local NGOs like MACAO in Arusha ask for and expect international volunteers to pay to work towards HIV/AIDS awareness (USAID, 2018; UNAIDS, 2014; https://www.macao-tz.org/mission.html, 2012).

"AIDS orphans" as a subcategory has gripped social science literature, as well as a general emphasis on life with HIV (Gebre, 2009; Mwiturubani, 2009). Stigma and HIV within African nations have also been the focus on a majority of HIV literature and African health literature (Deacon and Stephney, 2007; Walker, Reid, and Cornell, 2004; Rhine, 2016). African

sexuality, disease social etiology, and the role of children have been analyzed in the literature (Bhana, 2009; Wamoyi, Fenwick, Urassa, Zaba, and Stones, 2010). Sexual orientation, legality and morality have been examined in the literature surrounding HIV in African nations (Mantsios, Galai, Shembilu, Mbwambo, Likindikoki, Mwampashi, Beckham, Leddy, Davis, Sherman, Kennedy, and Kerrigan, 2018; Setel, 1996; Kyomya, Todyrs, and Amon, 2012; Moen, Aggleton, Leshabari, and Middlethon, 2014). More so, gender analyses complicate these discussions even more, where "African women" are "clearly" vulnerable (Fuller, 2008).

So many of the same racial tropes about the immoral, the poor, the sick, the ambiguous "other" of Africa appear in scholarship like this and global health organization calls to action, in which it is the Sub-Saharan African woman in need of help, and those rural, "poor women" are the ones "shouldering the burden" of the orphaned or sick, and risking infection, (Susser, 2009). Fuller's "African woman" is not like the Tanzanian women I met in Mufindi. These "African women" were not like Maria, with a degree in biology, or the nurses who used WhatsApp to communicate with other nurses in-country to solve patient health crises. The Tanzanian people I lived with and interacted with did not match the image I had been exposed to of "Africans" for so long. No one talked about the children that came back to the campus from school and did homework about computer function or the grassroots health movements.

Instead, Fuller's "woman" is unchanging; she is faceless and devoid of specifics, but familiar. She is needing to be saved –from HIV, from men, from her culture. Lila Abu-Lughod's "*Do Muslim Women Need Saving?*" mirrors my concern, albeit her critique is largely centered on accessibility and rights for Muslim women. Abu-Lughod (2013) questions what it means to be "a Muslim woman," particularly from a Western gaze, and how that image matches the Muslim women she knows. In this work and others, she goes on to question saviorism, given the political

violence and war happening in Muslim countries in order to "save" Muslim women from Islam's oppressive rule. She questions what it is that forces the assumption Muslim women need to be "saved," from what, and by whom, warning against homogeneous depictions of womanhood (Abu-Lughod, 2013). Muslim women get religious oppression, African women get cultural oppression and AIDS.

Geissler and Prince (2010) argue that AIDS "brings many tensions and conflicts in social relations to a head, but the situation of this sociality cannot be reduced to it or explained by it," and yet, Smith (2014) writes that classic accounts of Sontag and Treichler "teach us the ways people think and talk about AIDS […] as CD4 counts, seroprevalence, viral loads, and the number of dollars spent by the Global Fund for AIDS […]." Smith goes on to say that as long as there is an epidemic,

> "[…] there can be no doubt that there is still work to do to understands AIDS in […] Africa, whether it is because we have not learned enough to contribute to effective prevention and treatment or because the knowledge we have has not been properly communicated or implemented" (p 6).

These words are full of good intent, but still read as problematic. AIDS is the problem to be solved in Africa, and therefore Africans are also a problem, unable to solve things for themselves.

This list is not complete but shows the contemporary themes of research regarding HIV research in Africa. The scholarship relates to negotiation of boundaries, stigma, and limited agency for the affected individuals. These scholarly works, while informational, depict disease as a stagnant experience. As Susser (2009) argues, "to begin to explain the possibilities for agency […] in fighting the epidemic, we must also understand the political, social, and cultural

variations that underlie the impact of globalization." While HIV is a disease that needs treatment and acknowledging the different problems individuals face is critical and lifesaving, the immediate threat of disease has started to dissipate.

This depiction of Africa and the construction of "the problem" of HIV are acts of symbolic violence. They are placed on an individual with or without permission (Bourdieu and Wacquant, 1992). It becomes embedded in the narrative of African health. These symbols are connected to a specific place. They are broadcasted across the globe and result in action and structures, promoting harmful stereotypes and stagnated understandings of complex lives. HIV becomes the new face of racial and colonial tropes, resulting in decades worth of misinterpretation and erasure.

Exploring Mufindi and Iringa

Iringa is one of the central hubs of Tanzania. Located in the middle of the country, Iringa is divided into high-, middle-, and lowlands. As our group bused through the inner city, up and down a large mountain, I watched Montessori school children cross the streets. We passed small outside markets full of pottery and artwork. Motorcycles and *bajaji* zipped dangerously in and out of traffic, leaving us trailing steadily along behind. The city buzzed with life as people shopped, walked, ate, and talked with each other. Tall business buildings were scaffolded in construction and open markets sold anything from fruit to couches. Once outside of Iringa proper, the roads fell away, leaving cracked and jolting terrain. I remember thinking once or twice that we were dangerously close to losing a tire as Tanzanian hip hop videos played on the small display screen/DVD combo the bus had. The journey to Mufindi took something in the

range of five hours. I watched the sun set over beautiful rolling hills brimming with chai plants, bumpy as it may have been. We arrived late at the NGO campus late at night.

Structural Violence in Tanzania

Iringa is ranked as one of the top three districts in Tanzania for rates of HIV, where some areas, such as Mufindi, can have up to seventy percent of the population testing positive for HIV (mufindiorphan.org). During a panel discussion with Tanzanian health professionals, they acknowledged an overall decrease in HIV in Tanzania, but said there has been a rise of HIV rates in the Iringa region (personal communication, 2018). This makes Iringa particularly useful in understanding violence and reclamation, due to the statistical anomaly.

Several informants explained on multiple occasions that HIV took a toll on the community. Yet they emphasized what has been done to treat the issue including: foreign-aid work, local NGO educational programs, outreach, home-based care work, and quality of mother and infant treatment pre- and post-delivery. One movement in particular "*Furahi Yangu"* (My Happiness) is a locally led program targeting men to go and get tested for *ukimwi* (HIV), as women are twice as likely to be on medication for HIV than men in Mufindi (personal communication, 2018). One advocate involved with this program mentioned a ninety percent target range for population participation, and as of June 2018, the program was reaching ninety-one percent population participation (personal communication, 2018).

It is this village-to-village approach, home-based care volunteers, and "Mentor Mothers" working with villages that have promoted changes around stigma and disease prevention (personal communication, 2018). According to those I talked with, while these local operations have been incredibly successful in the past, recent cuts to funding have affected the reach and span of these movements. The reason for these cuts were not discussed directly but given the

history of economic crisis and action in Tanzania, structural adjustment programs, or SAPs, could be a major factor.

Following independence, Tanzania had a growing economic crisis that resulted in structural adjustments in the 1980s (Van Arkadie, 1995). The reform consisted of four parts: stabilization, liberalization, privatization, and enhancement of government capacity (Van Arkadie, 1995). The "Arusha Declaration," established in the late 1960s, led to increased radicalism in the 1970s, calling for SAP-based reform in the 1980s, to recover from instabilities. While the Arusha Declaration was ideally "utopian," blending "*ujamaa"* (collectiveness) and cooperation with localized development, the result was ill-fated (Van Arkadie, 1995). The processes through which IFIs (international financial institutions) work as a result of adopting these economic plans dictate health policies (Thomson, Kentikelenis, and Stubbs, 2017). Social policies that can produce good health or healthy lifestyles, education, and more are increasingly done away with in attempts to increase output. There are studies indicating that these macroeconomic policies have had positive outcomes on at least twenty-three countries' economic and social sector spending, but critical scholars have questioned what micro-harms are caused, particularly involving individual health and wellness (Bhutta, 2001; Thomson et al., 2017; Lugalla, 2007).

Lugalla (2007) proposes that SAPs lead to making the low, lower in Tanzania through increased workloads, migration, increased mortality, chronic malnutrition, and "rendering implementation of HIV intervention strategies difficult." These align with the difficulties mentioned while discussing current challenges with HIV. A woman that worked as one of the Home-Based Care Volunteers mentioned that without this program of volunteers going out to

check on patients, ensure they received medication, and make it to appointments, there was a problem with patient retention. Some would forego medication due to hardships.

SAPs, voluntourism, laws, and foreign aid funding creates a cycle of structural violence, in which large economic and social processes work to restrict agency and action (Farmer, 2004). Funding international projects may promote symbolic violence and old tropes about Africans, bringing in tourist to do volunteer work with little to no training. On the ground, these organizations enable paternalism and can be unsustainable long-term (Jesionka, 2014; Sullivan, 2018). As of 2014, eighty-eight percent of the Americans that volunteered abroad were white and from affluent homes (Biddle, 2014). Biddle (2014) writes in her *HuffPost* article about the images of children on the laps of volunteers from Tanzania are interchangeable from those in the DR, and that this is the experience of so many Westerners.

In this, symbolic violence creates opportunities for structural violence, which reiterates symbols that reproduce violence. By producing geographic imaginaries, this creates a concept of Africa, Tanzania, and Mufindi, as a problem to be solved, and this gets internalized over time. NGOs and foreign-aid groups come in under the guise of help and end up reproduce these images. Global forces use low economic growth as means to intervene, restrict, or control, which then makes the low, lower, and the cycle continues.

Slow Violence in Iringa

Nixon (2011) describes slow violence as "neither spectacular nor instantaneous," rather it is "incremental and accretive" in its calamity. Nixon's work focuses on understanding slow violence through environmental degradation and poverty. Unseen poverty is compounded by the invisibility of slow violence, and those who are poor are easily viewed as disposable to capitalist

ventures (Bales, 2012). This production of slow violence then has negative affects on health through access to care, improvements, infrastructure, and more. Some of these effects have already been discussed, but I will expand on how structural violence (like the examples of SAPs) is connected to the production of slow violence in Iringa through mining, and how this relates to health, environment, and HIV.

The Kliniki

As previously mentioned, Tanzania gained independence in the 1960s under *Mwalimu* Nyerere. While this doctrine was good in theory, the implication process has been critiqued for its idealism, explaining why *ujamaa* was unsustainable (Rodney, 1972). In 1986, the IMF stabilization program was accepted, but not without extreme social and environmental costs, due to policy and implementation failures (Reed, 2001). The focus of reform and investment fell on gold mining, which still contributes to around twenty percent of Tanzania's exports, as of 2015 (Reed, 2001; tanzaniainvestment.com, 2019).

According to Grosen and Coşkun, (2010):

> "Due to incentives and priorities favoring large-scale or middle-scale mining companies and merchants, significant inequalities occurred among people who are occupied in mining activities. Most […] small-scale miners lost their businesses because of the harsh competition with powerful large-scale companies who can easily manipulate the market prices and the official support. Moreover, many people who live in mining areas have lost their lands and the base of their livelihoods because of the policies in favor of mining companies (p 55)."

This continuation of poverty for local communities also means that locals lack the ability to move away from toxic environments, poor infrastructure, and more (Holterman, 2014). Poverty also makes it difficult for locals to get into positions to speak out against the harms that are occurring or getting help, particularly on the global stage (Holterman, 2014).

Environmental harms, such as toxic chemical exposure through drinking water, erosion, and loss of agriculturally capable land are coupled with "lack of official regulations and weak legislations" (Grosen and Coşkun, 2010). Chachage (1995) mentions that in Tanzania, resources are exploited as necessary for progress. This exploitation creates the framework for Bales' picture of "disposable people." Economic disruption, environmental degradation, and structural-based social inequities cannot be tied to one single event. Its influence traces back to before several of the villagers in Mufindi were born.

More so, Iringa is home to one of these gold mines: the Nyakavangala Gold Mine (allafrica.com, 2018). The presence of the mine fosters all of the long-term harms, while leading to increased populations in nearby villages, putting strain on local resources, housing, land, and more (Kangalawe & Lyimo, 2010). The Mining Act of 1998 in Tanzania makes this possible by allowing 100% ownership of mines to foreign corporations. These companies can employ any number of foreign workers (Magai, Márquez-Velázquez, 2011). There is little or no local wealth and gain (Magai, Márquez-Velázquez, 2011). Lack of local benefits and continuous poverty (produced by structural policies) has lasting impacts on health. Magai and Márquez-Velázquez go on to add that:

> "[d]espite the fact that the Tanzanian government is currently implementing the second phase of its poverty reduction strategy, […] "National Strategy for Growth and Poverty Reduction", […] mining activities and poverty reduction cannot be

> gauged; this is especially true with […] local employment creation, revenue generation, and public service delivery. […] settlements in the vicinity of mining sector operations are extremely poor. Living conditions in these areas are […] lacking […] basic necessities for human health. Social conditions are […] to deteriorate as unemployment among artisanal miners increases. Given the lengths the government has taken to appease large-scale mining operators, the lack of government attention paid to these conditions calls into question the priorities of public policy (p 16)."

It is also fair to say that The Mining Act could then contribute to higher risk of HIV and spread. Given the population increase in surrounding mine areas, Joane Nagel (2003) explains in her book that crossing ethnosexual boundaries underpins mobility. Mobile populations (like limitless foreign works introduced into these areas) create risks for contracting HIV due to sexual activities of workers abroad, crossing ethnosexual lines, globalization meeting reproduction, and more. Surrounding plots near mines become unusable for farming, given the environmental harms. Land that could be used for social services to meet local needs becomes limited. Deforestation and other environmental harms come from simply needing land to use and struggling for access.

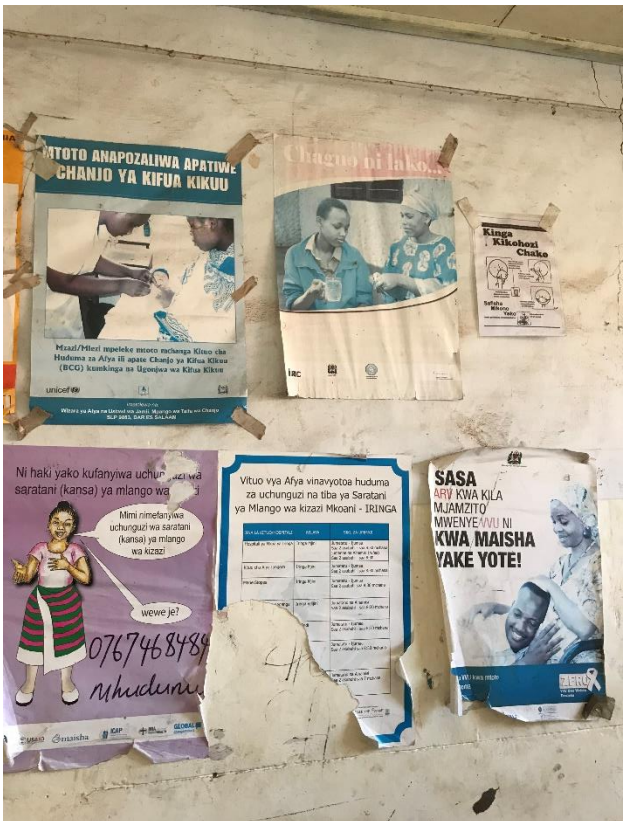

Figure 5. Posters from clinic in Mufindi, 2018.

All these factors have a trickle-down affect that lead to the images of the clinic.

Returning to the clinic pictured in Figure 2, poverty of the surrounding area takes its toll on the available resources, maintenance, the ability to update and improve, and architecture. Proximity to and use of mining areas are only some of the factors related to poverty and slow violence. Yet, this violence is evident in images of the clinic. Figure 5 and Figure 6 are of parts of the clinic and surrounding area.

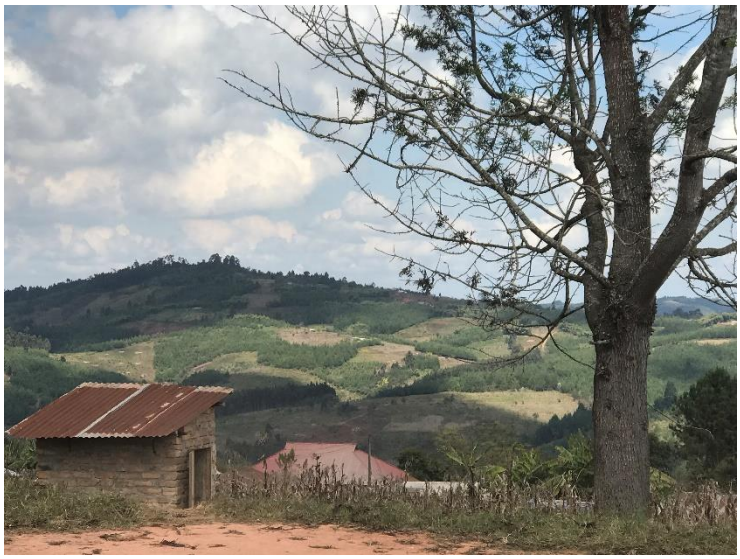

Figure 6. Surrounding area of clinic, 2018.

These two figures are embedded with the long-term repercussion of slow violence across Tanzania. The roads across Mufindi are not paved, as present in Figure 6. The paths are difficult to maneuver on foot and by vehicle, due to jarring, deep cracks in the earth and hills. The clinic was built outside of an immediate community, making it difficult to reach. The walls are old, warn and weathered. The posters displayed on them are faded, ripped, and falling apart. Parts of many walls were cracked and roughly patched. The presentation of a place can be representative of the experience of time in an area.

In the Life of…

I had originally dismissed the entire ordeal of a neighbor's death as irrelevant to my research. This dismissal was premised on my very American understanding of death (traumatic and private), as well as my position as an ethically motivated scholar, making me struggle with

associating what I felt was voyeuristic. With that, I choose to revisit this day, not by solely explaining the data I gained from the loss of a man's life, but rather explain how his life is connected to a long, complex history and how he and his community have worked to reclaim their lives from continuous violence.

Nancy Scheper-Hughes (1992), suggests that everyday violence is evident in slow starvation, disease, despair, and humiliation that destroys socially marginalized humans. I could see glimpses of this reflected in Mufindi. Some of it appeared indirectly, such as foreign visitors coming into the NGO's pre-school and disrupting classes. These tourists, perhaps investors in the NGO, pulled children away from the teachers or designated play areas. They gave out treats while taking pictures of the children without the children's or their family's permission. Not only would this never be allowed to happen in a school where I grew up, this encounter between tourists and children has a rippling effect on these students' education and presumably their development. Teachers complained that this interaction happened so often that the children started refusing to do school work or behave without treats. This was mirrored in my own interaction with the children during my day helping the pre-school.

Everyday Violence: A Day to Remember

There are more direct ways in which everyday violence occurs, as in death and deconstruction of an entire generation. While HIV is generally no longer a death sentence but treatable chronic condition, it is still, for some, a slow death. That morning, the house was empty, so I sat quietly on one of the couches in the living room. I felt more like a stranger in those few minutes than any other time of the trip. Everyone had left me alone in their house to do their daily business. *Mamangu* had made chai and cooked *maandazi*. I could hear voices

humming beyond the open front door, overlaying what I thought was distant singing. The cold drove me to stand and grab a cup off the table.

My host-father came inside, heavy jacket shuffling with his movements, as I poured chai. I greeted him in Kihehe (the only knowledge I had of the indigenous language), and he returned the greeting. In broken English mixed with Kiswahili, he explained that a neighbor, a young man of twenty-six who had been suffering from *ukimwi*-related complications, had passed away overnight. *Baba* told me that he would not be able to go to church, as he was to help with the funeral preparations. I offered my condolences and he thanked me. Shortly after, he left again. I learned later that the other members of the program had been shipped off to church for several hours of that morning with the children.

After being redressed by my host-mother and sister, they told me they were going to stop by the funeral. They asked if I was afraid to go. I was more afraid of being left behind or being rude, so I told them no, I was not afraid, and joined them. I followed host-sister up the small dirt road lined with elders, softly whispering "*poleni sana, pole, pole sana*" with handshakes and bows to everyone we passed. I was told that it was common to shake hands and bow to everyone. It was not just a brother or son that was lost. The community was now missing a piece.

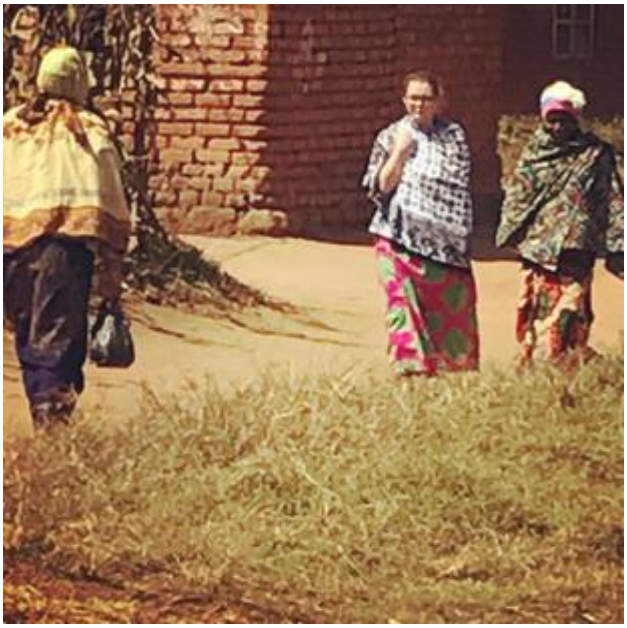

Figure 7. My host-sister and I walking, 2018.

We ducked into the house of the young man and walked through the unlit hallway to his bedroom where a crowd of women had gathered, sitting on the floor. The wailing was loud enough to hurt my ears as I huddled in between sisters and family members, packed together tightly with ten or so other women. The man's body remained on the bed as if he might still be sleeping. Someone had covered him with a red and green blanket. The moans and wails built, crashed, and lulled like waves while we sat, rocking gently. I could feel myself becoming more and more embarrassed, but I could not stop the tears from rolling down my cheeks. I still reeled, hours after, while I watched my host-family pick up right where they left off, taking a half hour here and there to finish tending to funeral on-goings throughout the day. In the mid-afternoon, once the burial plot was dug, villagers from all over joined a procession into the woods, following those carrying the casket. Three-hundred or so people gathered around as what I assumed was a preacher stood over the grave site, explaining the number of those in the community that had died to HIV and more about the man's life that I could not understand.

That day, I left my homestay assuming that normalizing and being able to seemingly "code-switch" in and out of a grieving state was a form of coping with long-term, massive pain and loss. HIV had afflicted life in Mufindi for years by sneaking through the villages and taking lives. This type of violence, as Scheper-Hughes (1992) describes, is consuming in a way that overshadows everything else. It is so close to, or in the homes of, everyone in the community that all the larger factors making violence possible disappear due to proximity.

Acts of Reclamation

For the rest of my time in Mufindi, I thought about how uncomfortable I was with the grief "code-switching" I thought I had seen, because all I could feel was my own emotional

interpretation of the funeral: anxious, out of place, heartbroken. This did not match up to the confident, hardworking individuals I had met and spoken with, nor did it fit the behavior of everyone throughout the day of the funeral. I had not bounded the grieving experience within the walls of the neighbor's small house, as it seemed my host-family did. When I had experienced grief in the past, it was a long-term affair, where for days (or months, or years), we would cry and hurt.

Reclamation is often discussed in literature in relation to environment or land (Giguère, Lalonde, Jonsson, 2012; Muscolino, 2010), in which land that has been bought or stolen, is then taken back by those living in the area or that lived in the area first. What I witnessed was more like a reclamation of life, material, and well-being against violence. I expected the community to be powerless or to see themselves as victims given the community's in-depth understanding of HIV, but I found the opposite. I assumed that the harmful structures, the images of HIV in Africa, the slow degradation of the environment, and the ultimate result of this disease would create a linear progression to desolation.

My assumption was contingent on my cultural understanding of grief as a state, which is often pathologized in the United States (see Mayo Clinic, 2017 for an example of "complicated grief" symptomology). I understood grief as the natural result of death or loss, as trauma follows violence, therefore seeing acts outside of or coinciding with grieving was off-putting. I was not seeing the behaviors associated with what I considered to be an extreme state. In Rosaldo's work about headhunters (2014), he writes about Ilongot headhunters expressing grief through rage. Instead of headhunting, I saw my host sisters doing their hair in between segments of funeral proceedings, chatting about boys and their phones. M*amangu* started dinner while sharing moments with her newborn grandson, smiling and cooing. Advocates explained the work they

are doing and their long-term goals, regardless of their HIV status or the loss of a community member. This showed dedication to improving their condition and quality of life. These are instances of reclamation: of time, of energy, of happiness.

Reclamation was in the minutiae of the day, as a way of grappling with violence. Seeing grief as a consuming, predictable or universal state (as westerners like myself might) leaves out critical parts of understanding emotions and health, which are unequivocally intertwined. This follows other critical social thoughts on medicine, as the body is not always the best or right unit for exploring health. If the medical lens of grief is removed, it can co-exist with a variety of emotions, including happiness and fear, which changes who individuals are experiencing death, illness, and violence. Looking at acts of reclamation in the everyday illuminates the hard work done to reshape life with violence and then we can consider violence as a non-stationary phenomenon.

Helga and Fuma: Rethinking African Health

On the last day of our stay in Mufindi, during the final panel discussion, an older woman named Helga stood up. She had waited patiently until the back-and-forth came to a lull before taking her turn to speak. Helga's eyes met each of our faces before she opened her mouth. To the students, she asked what it was we were doing in Tanzania and why we were interested in learning about HIV. In broken Kiswahili we attempted to explain our ideas, interests, and how these topics intersected with HIV. More so, we wanted to understand first-hand experiences with *ukimwi* and figure out what things were most appropriate to ask. Helga took in our answers one by one, and at the end of our explanation she asked, matter-of-factly, "why come to Tanzania for this information when there is HIV in America?"

The student group fell quiet. Several moments passed before the student with the most language training said the situation in America is different and, in general, we enjoyed being in East Africa and learning there. Helga nodded and seemed to accept this answer before sitting down, but once more I was uncomfortable. Helga's comment made me reevaluate my assumptions about the goal of my research. I, like most scholars interested in African health issues, read numerous articles about the various ways in which individuals experience *ukimwi* in Tanzania. My presumptions mirrored Smith (2014), assuming I would find stories of morality and crisis. Given how vocal some of those I talked with were about religion, and politics, I thought I would encounter the same grandiose ruminations about AIDS. Instead, I spent most of my time in Mufindi frustrated with my inability to hear anything like that. Outside of the funeral, HIV was not the center of attention.

Later that afternoon, with lunch in hand, sitting in the midday sun outside of House 6, I began the interview with the HIV activist named Fuma. I asked the series of questions I had prepared beforehand, but I could not shake Helga's comment. Finally, as we were getting ready to end the interview, I decided to ask if he believed *ukimwi* to still be a prominent issue in the area. Fuma then explained that while HIV is a problem, he believes he and those in his community face bigger issues. He added that the biggest health problems he had seen affecting the area were more like different types of cancer, diabetes, and high blood pressure, which have been relatively ignored in the African health discourse.

According to him, those in the community had been living longer, which contributed to developing more chronic diseases outside of HIV/AIDS. He also mentioned that he believed lack of access to "indigenous" ways of life (like family-sustainable farming) was contributing to these bigger health issues. "Junk foods," Fuma said, when asked what changes had happened. He

explained via translator that there was an increase of junk food intake, due to accessibility and affordability, as well as "new fertilizers with chemicals" in farming that contributed to cancer and diabetes rates. Fuma's insight is also backed by scholars claiming that pesticide use in Tanzania can have hazardous health affects due to overuse, exposure, and lack of education on proper use, storage, and disposal (Ngowi, Mbise, Ijani, London, and Ajaiy, 2007; Elibariki & Maguta, 2017). Some of these substances can be fatal if inhaled and contain carcinogens (Ngowi et al., 2007).

This alert to what Fuma called priority diseases in Tanzania made me question what I understood the be "African health." Given my experience with grief and reclamation, I can take Helga and Fuma's comments as a push to rethink African health beyond the body, HIV/AIDS, and to challenge western pathological assumptions. So much of African health scholarship, particularly anthropological and social science scholarship, hinges on HIV. Dilger and Luig (2010) open their book with the statement:

> "Over the last couple of years, anthropological studies on HIV/AIDS in […] Africa have taken an increasingly broad focus. While anthropological and social science publications […] tended to assume an applied and […] narrow approach to the disease by concentrating on risk behaviors, risk groups, and prevention […] more recent research has focused on the way HIV/AIDS as a social reality has become embedded in specific social and cultural contexts and how these contexts in turn are being modified, transformed and challenged by the presence of the disease" (p 1).

The authors call for a thick description of HIV, beyond the power of political, economic, and social means, as others before them have advocated (Geertz, 1973; Farmer, 1999; Schoepf, 2001; Dilger and Luig, 2010). In her study on risks and motherhood in Tanzania, Denise Roth Allen

(2004) uncovers the story of a "Mrs. X," a poor, sick, pregnant mother that died during labor, referenced over and over by those in the World Health Organization, Women's Health conferences, and more stemming from the late 80s. She writes that this narrative was used for a health initiative for safe motherhood, but she began to see it as one that "shapes and then freezes this unfortunate woman's experiences –and thus, by extrapolation, the experiences of all women she is supposed to represent – into a particular representation of facts" (2004). Locals in Mufindi have been victim to this same kind of extrapolation around HIV.

A brief overview of scholarship around cancer research in Tanzania yields a few epidemiological studies on cervical cancer and HPV screening models in Mwanza, Tanzania (Bernstein, Hari, Aggarwal, Lee, Farfel, Patel, … Ries, 2018), a nine year study of the pathological features of breast cancer in Northwestern Tanzania (Rambau, Chalya, Manyama, and Jackson, 2011), higher rates of esophageal cancer in Kilimanjaro men 55 years or older (Gabel, Chamberlain, Ngoma, Mwaiselage, Schmid, Kahesa, and Soliman, 2016); and the preliminary study from 2010 on inflammatory breast cancer (a lethal form of cancer) in Tanzania due the fact "little information" was available about breast cancer or IBC in native Sub-Saharan African populations" (Burson, Ngoma, Mwasielage, Oogweyo, Eissa, Dey, and Merajver, 2010).

Diabetes literature for Tanzanians is similarly limited, largely describing biological risks diabetics have for contracting tuberculosis (Faurholt-Jepsen, Range, Praygod, Jeremiah, Faurholt-Jepsen, Aabye, … Friis, 2011); diabetes symptoms seen as "witchcraft" (Metta, Bailey, Kessy, Geubbels, Hutter, and Haisma, 2015); and prevalence (Stanifer, Cleland, Makuka, Egger, Maro, … Philippin, 2016; Mwanri, Kinabo, Ramaiya, and Fesken, 2014).There are few ethnographic attempts to understand chronic disease in Tanzania. Dilger and Luig (2010) write about the critical role ethnography plays in "dismantling the various perspectives, practices, and

power relations that have come to shape the views, actions, and experiences of a broad range of actors in global, national, and local settings" regarding HIV, but this drive and enthusiasm seems to be lacking for other African health issues. Scholarship on morality, sex practices, relationship, population politics, development and reproduction involving HIV are readily available, but cancer and diabetes are negligible.

Hunter (2010) wrote that he "opposed claims […] that culture is static," a standing anthropological argument. Munn (1992) argued that anthropologists and other social scientists had long been plagued by the "problem of time," assuming static, pin-pointed pictures of peoples and cultures and refusing to allow for change. Indigenous scholars have critiqued this ten-fold, arguing that anthropologist compile in-depth knowledges of a people –referring to them as the "real"— and once they stop fitting the allotted profile these people are dismissed as not "real" (Deloria, 1969; Biolsi and Zimmerman, 1997). I argue that this is exactly how HIV and violence are talked about in scholarly works concerning Africa. Talking about either in these static ways creates a consecutive image, confined to a specific range of time, creating health imaginaries and erasing a critical portion of the human experience.

African health is continuously seen as relatively unchanged. In short: it is as it has been, from the 1980s to present, albeit we have a greater sense of what it might look like to live with the disease as an African. Instead of acknowledging aspects of health and identities related to health as fluid, flexible, and multifaceted (or, at the very least, working to understand comorbidity through ethnographic works) as others have for non-African health problems, HIV is still the heavily funded African "problem" to be solved. Health becomes located or placed with the people associated with them. Not accounting for "placedness" omits the ability to account for change in disease experience as well as changes amongst people, mostly attributed to global

flows and connections. Static depictions of African health are, then, a product and reproduction of symbolic and structural violence.

This research is important in addressing the static depiction of Africans and African health by understanding what violence can look like and reactions to it. This is not to say that research on HIV has not been useful. However, organizations that are solely continuing to focus and fund HIV research and outreach, particularly funding foreign efforts around HIV, may be doing a disservice to those in areas like Mufindi. Communities like this one are facing more immediate health threats that are underfunded and ignored. These other priority diseases create bigger, less manageable day-to-day risks than living with HIV/AIDS, given the consistent attention and work that has been done to combat HIV across the African continent for the last four decades.

Acknowledging African health as multifaceted and multidimensional allows for more nuanced understanding of health in Africa, complexity of health issues over time, comorbidity, and social adaptation. More so, awareness of reclamation occurring prevents paternalist, problematic depictions of African health. Tanzanians are active participants in their own health. Noting acts of reclamation, big and small, bring awareness to local action and understandings of health. Awareness can lead to better channeling of international funds that do not promote voluntourism, but the work of programs that are already on the ground instead.

Discussion

One discussion point to build on in the future is a more significant effort to understand the comorbidity. This is the time to focus on understanding chronic illness and African health, rather than the media and research focus on infectious diseases. Infectious diseases seem to come

with their own problematic imagery: poverty, bad sanitation, and no infrastructure. This perpetuates the stereotypes that have caused so many harms in African countries. I also think it is important to get a better understanding of local organizations and movements. Particularly, how those efforts are working with, against, or in place of foreign aid campaigns. I question why foreign aid is not directly funding local NGOs and how much more effective it would be to fund these programs instead of having large groups that devolve into voluntourism. I think ethnographic studies of these local organizations would illuminate their challenges and indicate where funds could be allocated.

Limitations

The limitations of this study are related to length of time for fieldwork. Due to the restraints and time table for my participation in ColLAB, data for analysis is limited to two weeks of participation. Given more time, it would be possible to establish more finite depictions of these concepts of violence and resistance in Tanzania, to produce more succinct counter-narratives of agency, and learn more about the local efforts and challenges. The second limitation is one of association. By working with an NGO that had established and oriented itself long-term in relation to HIV the conversation may have inherently floated around HIV and the location was one where the prevalence of HIV in the population was much higher than it would have been in other locations around Tanzania. More so, most of the time spent in Mufindi involved attempting to build rapport with the community distinct from other tourist and volunteer groups that had come into the area. We tried to combat the association with colonial legacies that had been (and still are) in this area and in relation to the NGO through language learning prior to travel, intensive cultural training, and conversation, but there is no way at this time to know how much

of our relationship with everyone was impacted by such a legacy. However, I believe being in a location with a community that was largely HIV positive made it a unique case study for discussions about violence and reclamation.

Conclusion

I began this project wondering how I would be able to have a new and engaging take on HIV in Africa, worried that I would be continuing the same type of projects I have read about over and over in preparation for this trip to Tanzania. Once in Mufindi, I quickly learned that all my preconceived notions, while fueled by scholarship and news on HIV in Africa did not entirely line up with what I was witnessing in the lives of the individuals with which I spoke. It made me uncomfortable to see the routine scripts and animosity towards conversations about HIV. Not because this conversation was taboo or stigmatized, but because the community was worn out over revisiting the topic.

Upon learning this, I made a point to ask those around me what they felt matter most and was the most important to discuss, and it surprised me to learn of the various other health issues affecting the community I was in that had been hidden or drowned out due to the focus on HIV. This made me realize the extent and variation of violence that have occurred in this area and what is being done to counter it. African health becomes synonymous with conversations about HIV. The discourse on HIV mirrors the same racial and colonial tropes that have been used for over two-hundred years to talk about Africa. Depictions of HIV and Africa are another form of symbolic violence.

Structural violence has, in some ways, become both a result of symbolic violence (perpetuated imagery and ideals) and of a complex, interconnected body of politics, moral

values, and economic ups and downs that have shaped and caused health problems. SAPs and funding cuts, voluntourism, and more have created institutions that affect accessibility, education, medication, and infrastructure. Slow violence, in relation to economic and environmental change, helps create a setting for structural violence to take place. Everyday violence, the creeping, pervasive harms that affect life throughout the country cause grief, loss, and disruption to social function. However, through acts of resistance, Tanzanians have made efforts to reconceptualize their image and their health: arguing for different priority diseases outside of HIV, creating grassroots movements and local NGOs. Complicating how grief is understood in these contexts challenges the typical medicalization of emotions like grief. This can bring to light how western medical gazes dominate conversations about African health, when Africans may have differing understandings of what to and to not medicalize, and therefore treat. This also raises questions about what other health issues affect Tanzanians and what can be done about them.

Acknowledging these other health issues contributes to a more dimensional understanding of African health. This could add to understanding everyday aspects of these diseases, potentially revealing the intricacies of structural causes of disease that may be otherwise unknown or ignored, contributing to nuanced understanding of the disease experience. Exploring these other diseases, patterns, trends in causes, and treatment of these diseases, and funding between HIV and other health problems are considerably worthwhile.

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