

# The Countersyndemic Potential of Medical Pluralism among People Living with HIV in Tanzania

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## ABSTRACT

HIV and emotional distress often co-occur and interact in syndemic clusters with social, political, and economic factors that amplify the 'syndemic suffering' of individuals. In this paper, I describe how HIV+ women seeking antiretroviral therapy (ART) at a hospital in northern Tanzania engaged with plural methods of healing to ease suffering and address the multiple dimensions of illness. I explain the case of a famous faith healer at the time of research from 2011–12, 'Babu wa Loliondo,' from whom a third of the women interviewed – 25 of 75 – sought care in addition to their ART. These women experienced significantly fewer symptoms of emotional distress compared with those women who did not, suggesting that either those who sought his care were already healthier, or one strategy for coping – engagement with medical pluralism – played a role in buffering against syndemic HIV and emotional distress.

## Introduction

In spring 2011, the Tanzanian faith healer Rev. Ambilikile Mwasupile, or 'Babu wa Loliondo,' sat at the front of a queue of buses and Land Cruisers stretching 26 kilometres long, pouring out his millionth or so cup of medicinal tea from a green plastic bucket (Vähäkangas, 2016). Patient believers waited, sometimes for days, to get a cup of his tea, brewed from roots of the black currant tree – known locally as *mugariga* (*Carissa spinarum*) – which people could buy for 500 Tanzanian Shillings (TSh), or about US\$ .20 cents (Malebo & Mbwambo, 2011). Reputed to heal a litany of illnesses, 'taking the cup' (*kikombe*) was believed to be particularly powerful in healing, and curing, five principal chronic afflictions: HIV, cancer, diabetes, asthma, and hypertension.

Lucia was one of several HIV+ women I interviewed who travelled to seek 'Babu' and his cure for HIV. Lucia was a 22-year-old unmarried mother of two, who lived nearby in town with her children. She was also actively seeking biomedical care at the same time through the HIV clinic at a large, rural hospital in northern Tanzania I call Nguzo Hospital. Lucia was part of a group of HIV+ mothers I interviewed from 2011–2012, who had participated in the clinic's Prevention of Mother to Child Transmission of HIV (PMTCT) programme. During this research, I was principally interested in better understanding how women coped with the decreasing HIV care services that were offered at Nguzo Hospital, in large part a consequence of the global recession and stagnating foreign aid (Marten, 2020). Like many women I interviewed, Lucia managed her health in the face of uncertain care by engaging multiple systems of healing: antiretroviral therapy (ART) from the hospital, and 'taking the cup' from Babu, the enormously popular faith healer. Interestingly, unlike approximately half of the HIV+ women I interviewed who reported experiencing

significant emotional distress, Lucia did not, nor did most other mothers who had also sought Babu's healing. 'I can't explain it, but I just feel okay' after seeing him, she told me.

HIV and emotional distress have been described as constituting a syndemic – a 'synergistic epidemic' – in which two or more diseases cluster within a population, made worse by the biological, psychological, and social dynamics of diseases interacting and amplifying the day-to-day 'syndemic suffering' of the patient (Mendenhall, 2012; Singer, 2009). Significant theoretical work has engaged syndemics recently: in special issues of the *Lancet* (2017), and *Current Opinion in HIV and AIDS* (2020), scholars extend and elaborate the work of Merrill Singer who first coined the term in the 1990s (Singer, 2009). Through their extensive work, several research gaps have been identified, including a lack of research among HIV+ populations in low- and middle-income countries (Bhardwaj & Khort, 2020). Several scholars highlight the importance of using a syndemics framework for identifying examples of vulnerability and resilience. For example, Slagboom et al. (2020, p. 1) encourage more research of syndemic vulnerability, what they define as 'a predisposition to the development of clustering and interacting diseases or health conditions that result from shared exposure to a set of adverse social conditions.' They advocate exploring ways in which people who are vulnerable to syndemic disease demonstrate resilience and experience better health than may be expected. Similarly, Bhardwaj and Khort (2020) lament the exclusion of comparative contexts in which syndemic HIV and mental illness, in particular, *do not* occur, which could highlight protective, 'countersyndemic' factors that could be harnessed to improve health (Singer et al., 2017).

In this article, I describe the syndemic context of HIV and emotional distress among women interviewed, and consider how medical pluralism may promote resilience, potentially buffering the emotional distress many experienced. I draw on Mendenhall's (2012; 2016) concept of syndemic suffering to highlight both the clustering of stressors alongside co-morbid chronic diseases, and the chronicity of a life-long disease burden that can shape both stressors and methods of coping (Weaver & Mendenhall, 2014). First, I outline how mothers described living a 'hard life' (*maisha magumu*), with the stressors of stigma, increasing poverty, and concern for their families and children complicating their experiences of living with HIV. Second, I describe how many of the HIV+ women I interviewed assembled a meaningful plural system of care: combining ART with Babu's healing. Women who did access Babu's *kikombe* reported suffering from significantly fewer symptoms of emotional distress (a composite measure of symptoms of anxiety and depression) compared with other women, despite reporting similar stressors. This suggests that these women were already healthier, or one strategy for coping – engagement with medical pluralism – possibly played a role in buffering against emotional distress.

## **Syndemics of medical insecurity, HIV, and emotional distress**

Globally, the prevalence of depression and anxiety is growing rapidly. Depression is expected to become the second-leading cause of morbidity worldwide after HIV by 2030 (Patel & Stein, 2015). In sub-Saharan Africa, depression is projected to be the third-leading cause of morbidity by 2030, behind HIV and respiratory disease (Mathers & Loncar, 2006; Pappin et al., 2012). For many, living with HIV is coupled with depression and/or anxiety, compounding the experience of suffering (Kulisewa et al., 2019). Depression and anxiety are twice as common among people living with HIV (PLHIV) compared with HIV-negative individuals, and the number of PLHIV who concurrently suffer from emotional distress is reported to be as high as 50 - 60% in sub-Saharan Africa (Antelman et al., 2007; Kaaya et al., 2013; Kaaya et al., 2002). Numerous social and physiological pathways account for this co-morbidity, including stigmatisation and feelings of hopelessness, as well as HIV's detrimental effects on neuronal function (Patel & Stein, 2015). Depression is linked with HIV disease progression as well, impacting immune function via multiple mechanisms, including reducing killer lymphocyte cells and altering serotonin and norepinephrine

function (Antelman et al., 2007). Finally, depression is also associated with reduced adherence to ART (Belenky et al., 2014; Singer, 2009; Thielman et al., 2014).

Understanding the frequent co-occurrence of HIV and emotional distress can be achieved through the framework of syndemics (Singer, 2009). Syndemic theory extends public health models of co-morbidity to include the dynamic and synergistic nature of concurrent disease suffering, and the social, political, and economic factors that undergird them (Mendenhall, 2016). At the individual level, stories of the lived experiences of PLHIV in sub-Saharan Africa illuminate factors that intersect over time, possibly contributing to emotional distress. For example, living with HIV includes the long-term management of symptoms, side effects, and the individual discipline to maintain ART (Mattes, 2012). Frequently, it also includes experiences of living in poverty (Patel & Stein, 2015), social isolation and stigmatisation (Parker & Aggleton, 2003), and treatment-related concerns (Moyer & Hardon, 2014).

More broadly, individuals' experiences of syndemic HIV and emotional distress is influenced by large-scale political and economic forces that fluctuate over time, including forces operating within donor-funded global health policy environments (Weaver & Mendenhall, 2014). During the period of research, for example, many PLHIV sought biomedical care amidst significant volatility in donor assistance for health post-global recession, resulting in the scale-down of HIV care services and turn toward more biomedical interventions (Kenworthy et al., 2018; Moyer & Igonya, 2014). In precarious donor-funded environments like Tanzania, vicissitudes in donor funding and health services over time – what Carruth calls 'medical insecurity' – can also contribute to experiences of suffering (Carruth, 2014; Carruth & Mendenhall, 2019).

Further, individuals' ability to access HIV services versus mental health services in many countries differs dramatically, which may affect the experience of suffering among those living with co-occurring HIV and emotional distress. As Charlson and colleagues (2017) note, in many low-income countries with weak public health sectors like Tanzania, mental health care is considered an 'unaffordable luxury' (p. 8). This is attributed in part to the longstanding unwillingness of donors to fund it (Izutsu et al., 2015). For example, while HIV garnered approximately 36% of total donor assistance for health (DAH) in 2015 (US\$11 billion), funds dedicated to mental health services attracted an estimated 0.4% of total DAH, or US\$132 million (Charlson et al., 2017; IHME, 2016). Inattention to the growing prevalence of emotional distress in sub-Saharan Africa may not only increase the burden of disease for the many people who lack access to necessary care, but because of its syndemic interactions with HIV, can also exacerbate HIV and advance disease progression. In cases such as these, limited mental health care availability may also hinder considerable progress already made in curtailing the global HIV epidemic.

Buffeted by these circulating spheres and scales, living with syndemic HIV and emotional distress changes over time. Mendenhall's concept of syndemic suffering, or 'the lived experience of a syndemic' (2016, p. 466), builds on syndemic theory to include the particular concerns and coping strategies involved in living with chronic illness, a focus of chronicity theory. Chronicity theory employs time as a central focus, and like syndemic theory, emphasizes the embodied interactions of health issues and large-scale social problems, such as poverty and inequality. Chronicity, in particular, highlights the enduring and compounding challenges of living with chronic illness, and addresses how experiences over the life course – reflections on the past, hopes and expectations for the future, as well as ongoing social support, familial care, and economic and emotional strain – can profoundly influence one's experience of poor health (Manderson and Smith Morris, 2010). By combining syndemic and chronicity theories, Weaver and Mendenhall (2014) argue, a more holistic view of lived experience emerges, accounting for both the complex causal pathways of co-morbidity, and the lifelong but everyday processes of coping and resilience required for living with chronic disease like HIV.

In this vein, scholars have increasingly focussed attention on the behaviours, social conditions, biological traits or diseases that provide protection against syndemic disease interactions, which Singer and colleagues call countersyndemics (2017). Initially, examples of countersyndemics

focussed more specifically on how disease interactions may *improve* health, such as co-infections of HIV and measles, which lowered HIV viral loads and delayed disease progression (Singer, 2009). Recently, a focus on protective behaviours and social contexts has broadened the definition of countersyndemic (Singer et al., 2017). In research exploring syndemic HIV, substance abuse, and depression among New York Latinas, for example, Martinez et al. (2018) describe how the cultural meaningfulness of motherhood reduced young women's syndemic risk. Similarly, indicators of Hispanic acculturation protected Hispanic women from syndemic substance abuse, violence, HIV risk, and depression (Gonzalez-Guarda et al., 2012). As their work suggests, the practice of culturally meaningful behaviours itself may be countersyndemic.

Babu's healing may also function in countersyndemic ways, and his popularity was perhaps reflective of 'some deeper cultural longing that biomedicine is not able to address' (Vähäkangas, 2015, p. 4), commonly expressed among Tanzanians (Langwick, 2008). At the time of research and his 'miracle cure', Babu was a retired, 76-year old pastor from the Evangelical Lutheran Church of Tanzania (ELCT) (Malebo & Mbwambo, 2011). Similar to many faith healers throughout sub-Saharan Africa, he claimed that God had shown him in a dream the process for making and distributing the healing tea. In this capacity, he described himself as 'simply function[ing] as an instrument of God,' and therefore different from traditional healers (*waganga*) in Tanzania who are sought out for their expertise in healing with medicinal plants (Mattes, 2014, p. 173). Despite his claim, he incorporated traditional healing practices that are culturally significant to a wide regional audience as well – *mugariga* tea has been used for centuries by local Sonjo and Masaai pastoralists (Malebo & Mbwambo, 2011; Vähäkangas, 2015).

Despite his healing fitting a familiar mould, Babu was exceptional, 'an extraordinary phenomenon' (Mattes 2014, p. 170). Widespread reports of his healing fuelled his popularity, and his 'magic cup' drew hundreds of thousands of people from Tanzania and abroad (Vähäkangas, 2016). He inspired lively, public debates regarding the complexity of healing and medicine, appearing in newspapers practically daily in 2011 (see also Mattes 2014). Once news reports increasingly highlighted stories of pilgrims who had not been cured of whatever ailed them – and of some 'infuriated' by the deaths of their relatives, as Mattes (2014) recounts – the number of people heading to Loliondo decreased dramatically.

## Methods

This article is part of a broader investigation of the effects of global health policy changes and donor scale-down on the lives and well-being of PLHIV. Here, I focus on ethnographic data collected over the course of 14 months in 2011–2012 at Nguzo Hospital, a referral hospital in northern Tanzania which serves a rural, largely agropastoral, population. For this paper, I focus on semi-structured interview, health, and survey data (including socioeconomic status and social support) I collected with 75 mothers receiving biomedical treatment at Nguzo Hospital, the majority of whom (71) had participated in the hospital's PMTCT programme within the past eight years. I recruited informants at the hospital's HIV clinic as they came for their monthly appointments, and interviewed women in an unused room in the clinic with a research assistant bilingual in Swahili and the language of the largest ethnic group in the area.

Interviews with women were conducted primarily between March and June, 2012, and as described in their stories presented below, focussed on their care at the HIV clinic, common stressors they experienced, and the ways in which they maintained their health while encountering changes in services provided at the clinic. Women's self-reported CD4+ count, which declines as HIV progresses, was used to indicate immune function. Socioeconomic status was determined based on the number of locally-relevant markers of status they achieved (e.g. ability to speak Swahili, having children enrolled in school) and items women reported owning (e.g. phone, electricity, cattle). Instrumental social support was measured on a Likert scale, and included women's

perceived ability to borrow money and food items, and access childcare (1 = very easy, 4 = very difficult).

Women completed the Swahili-language version of the Hopkins Symptom Checklist - 25 (HSCL-25) (Kaaya et al., 2002), a 25-question survey tool which evaluates 'non-specific emotional distress' – psychiatric distress attributable to psychiatric conditions – as well as (more specifically) symptoms of both anxiety and depression (Mollica et al., 2004, p. 22). Fifteen of the 25 questions are consistent with a DSM-IV diagnosis of major depression, and include items such as 'low energy' and 'feeling lonely.' The remaining ten questions may signal experiences of generalised anxiety disorder, and include the questions 'feeling restless' and 'scared for no reason' (Mollica et al., 2004, p. 22). Kaaya and colleagues (2002) established the HSCL-25's validity in identifying 'caseness' for major depression and generalised anxiety disorder among HIV+ Tanzanian populations. In their research, however, they discovered that many Tanzanians may have a 'cultural orientation' to downplaying the severity of psychiatric symptoms, which results in the HSCL-25's limited ability to determine symptom severity in Tanzanian contexts (Kaaya et al., 2002, p. 16).

Finally, I relied on participant observation and informal interview data, particularly regarding the fascination with Babu's rise to fame. This research was approved by the IRB at the University of Florida (IRB #2010-U-0596), and given clearance by the National Institute for Medical Research and the Commission for Science and Technology in Tanzania (COSTECH #2011-87-NA-2010-133). Verbal informed consent was obtained from all informants, and I use pseudonyms for Nguzo Hospital and all personal names to ensure anonymity.

## **Sample**

The 'average' woman I interviewed had been enrolled in ART for three and a half years, had disclosed her HIV status to others, and was married with 3–4 children. The majority of women also had a partner who was HIV+. Based on scores of 'non-specific' emotional distress, anxiety and depression from the HSCL-25, half of participants indicated some sort of emotional distress using the standard threshold of >1.75 (out of 4) (Mollica et al., 2004). As described above, however, there is debate regarding what should be considered an appropriate threshold for determining emotional distress among Tanzanians (see Kaaya et al., 2002; Pike & Patil, 2006). Because threshold scores have not been clinically determined in Tanzanian contexts, I use the continuous version of the HSCL (1.00 - 4.00) rather than the threshold (< 1.75 or >1.75) in statistical measures.

A third of the women involved in my research – 25 of 75 women – went to see Babu in the recent past to drink a cup of his tea, while maintaining their adherence to ART. Using Student's t-test, which measures the degree to which differences between groups may have happened by chance, some important differences emerge between those women who saw Babu and those who did not. In particular, those women who travelled to see him reported significantly fewer symptoms of emotional distress – the combined measure of both anxiety and depression together – and fewer symptoms of anxiety and depression, individually (Table 1).

## **Living a 'hard life' with HIV**

Amidst declining HIV care services and few resources available to treat mental illness, the women in the following stories exemplify the syndemic suffering of HIV and emotional distress in rural Tanzania. In this section, I describe the long-term struggles many women encountered as they worked to maintain their treatment and live a meaningful life with HIV. I highlight three stressors that were most strongly associated with symptoms of emotional distress: experiences of stigma, increasing poverty, and concerns for family, which together constituted what many referred to as a 'hard life.' As their stories illustrate below, many women experienced several stressors at the same time, compounding the suffering experienced.

**Table 1.** Summary Statistics, PMTCT/CLINIC Survey.

Category	All (n=75)	Took Babu's <i>kikombe</i> (n=25)	Did Not See Babu (n=50)
Age	30.71 (+/- 5.79)	30.48 (+/- 5.23)	30.84 (+/- 6.15)
# Married	41	11	30
Religious Affiliation	Lutheran: 42 (56%) Muslim: 12 (16%) Catholic: 10 (13.3%) Pentacostal: 7 (9.3%) Unknown: 4 (5.3%)	Lutheran: 17 (68%) Muslim: 4 (16%) Catholic: 3 (12%) Pentacostal: 0 (0%) Unknown: 0 (0%)	Lutheran: 25 (50%) Muslim: 8 (16%) Catholic: 7 (14%) Pentacostal: 7 (9.3%) Unknown: 4 (8%)
Social Support (instrumental)	3.12 (+/- .48)	3.17 (+/- 0.47)	3.11 (+/- .064)
SES	10.53 (+/- 4.07)	11.64 (+/- 3.58)	10.0 (+/- 4.27)
Years on ARVs	3.58 (+/- 2.73)	4.36 (+/- 2.19)	3.15 (+/- 2.94)
Self-reported CD4+	414.59 (+/- 241.32)	426.2 (+/- 238.6)	392.28 (+/- 234.78)
Number of Stressors	1.68 (+/- 1.13)	1.52 (+/- 1.00)	1.75 (+/- 1.20)
HSCL Index	1.95 (+/- .61)	1.69 (+/- .49)**	2.07 (+/- .64)**
Anxiety Score	1.86 (+/- .70)	1.60 (+/- .55)*	1.99 (+/- .74)*
Depression Score	2.01 (+/- .64)	1.75 (+/- .57)*	2.13 (+/- .64)*

Asterisks highlight comparisons that revealed statistically significant differences (\*\* $p < 0.01$ ; \* $p < 0.05$ )

### **Bahati: experiences of stigma and poverty**

I met Bahati one late afternoon in mid-April, 2012, while she waited for her appointment at the clinic. I had seen her waiting since the morning with her baby in tow. Bahati was 37 years old, and had been diagnosed with HIV in 2005 during a routine antenatal care visit. She had been through the hospital's PMTCT programme three times – in 2005, 2006, and again in 2011. Her four living children were all HIV-, but she had had two children die, one from malaria, and another from an unknown reason, in addition to a miscarriage. So far, she had been able to manage her HIV relatively well – her CD4+ count of 571 indicated normal immune function, and she was not experiencing any side effects or symptoms of opportunistic infections, though she suffered from symptoms of both anxiety and depression.

Like many women, Bahati spoke with me about how she sometimes experienced a 'hard life.' She divorced in 2007, and her ex-husband, who she believed was HIV-, lived with her three older children a few hours away. She wasn't able to see those children often, and 'didn't know for sure' if they were going to school, which worried her. Bahati was similarly concerned about her ability to care for her youngest child as a single parent, though she lived with her parents since her divorce. She expressed exasperation over her current circumstances, citing her divorce as profoundly difficult:

Things are hard, [when] you can't get the things you need, what do you do? You try as hard as you can, but everything is difficult, ... like when [my husband and I] divorced. You have no money, you worry to yourself that you don't have anyone to help you.

She struggled to make ends meet. With a primary school education, she was only able to make a small amount of money selling tea, fried eggs, and doing various 'small jobs.' Further, widespread stigmatisation of HIV affected her ability to do business. As she noted:

Life is a little more difficult for people with HIV because people stigmatise you ... like if you sell tea or something, people say to each other 'ahhhh - she has HIV, *bwana*, you can be infected by her'.

Bahati's experiences of stigma were common among women I interviewed: nearly half ( $n = 37$ ) identified HIV stigma as a stressor, and many described in detail how they experienced it in their daily lives. As many scholars have described, HIV stigma can take many forms and stem from multiple causes. HIV-related stigma can be associated with perceptions of morality or fears of contagion, and contribute to social distancing, which can result in increasing poverty (Chan & Tsai, 2016; Maughan-Brown, 2010). For Bahati, her divorce may also have been a case of abandonment by her husband. Among some serodiscordant couples, one partner's positive HIV diagnosis was sometimes interpreted as an indication of unfaithfulness, which could have prompted their separation.

Stigma also changes over time. As Parker and Aggleton (2003) describe, stigma must be understood as a dynamic social process 'linked to the reproduction of inequality and exclusion' (p. 19). While Bahati recounted how HIV stigma contributed to her increasing poverty, Aisha, a 29-year old married mother of two, described how poverty itself could worsen HIV stigma:

If you can take care of yourself, people don't stigmatise you because you can do your work and you don't ask for help from others. But if you don't have this ability, you will have problems, people will stigmatise you.

Aisha, notably, did not suffer from symptoms of anxiety or depression. She explained that in her experience, 'taking care of yourself' (an ability to sustain a livelihood) prevented stigma, and suggested that concern among family members of the increasing caregiving support required of advancing illness is a principal cause.

### ***Maria and Grace: increasing poverty and worry for children and family***

Maria's experience illustrated some problems that can arise with an increasing inability to 'take care of yourself,' attributed in part to the scale-down in clinic services. Maria was 35 and unmarried with four children, and had been diagnosed with HIV in 2007. She was suffering from moderate HIV infection, with a CD4+ count of 296, and experienced symptoms of anxiety and depression. I interviewed her in April 2012, after she had walked five hours – with her baby on her back – to the clinic for her monthly appointment. She had been enrolled in PMTCT care twice at that point, and the bus fare she previously received from the hospital had been eliminated, as part of donors' large-scale reduction in 'care' services implemented after the global recession (Moyer & Igonya, 2014). The food support she received the first time in the PMTCT programme had also been cut, and to eat and to feed her children, she farmed an acre of land that she rented, and relied on the small salary she received as a day labourer. She rented an apartment for herself and her children after leaving her parents' house, who 'despised' her because of her HIV+ status.

Maria's description of the loss of services over time, and the increasing demands the loss of services subsequently placed on her, contributed to her 'hard life.' Her social isolation from her family, however, stood out as making her feel particularly despondent. What that loss of familial support would mean for her children in the future was central to her worries. When I asked her about help she received from her relatives in raising her children, she responded:

My relatives don't give me anything. They will tell me, you know your troubles here, you must go, there is no food to give you.

Profound worry for one's children was commonly described by women (42%). Many women worried that their children would have HIV, experience suffering, or as one mother put it: 'will have problems if I die.' Grace's story illustrates some of these fears. At the time of our interview in April, 2012, Grace had been on ARVs for nine months, after testing HIV+ during her antenatal care visit the previous July. She was 31 years old and married with four children, all of whom were HIV-negative.

Grace was relatively poor compared with most other interviewees: she had only a primary school education, and her family had a few chickens and goats, but no farm or wage labour. She described how living with HIV could be difficult; she didn't have enough strength to work, had frequent headaches, and sometimes forgot to take her ARVs. Nevertheless, her CD4+ count of 762 indicated normal immune function, but she experienced many symptoms of anxiety and depression. Her husband – the only person she told of her HIV status – had not yet been tested for HIV himself. The newness of her diagnosis, and her concern for her husband's health, likely contributed to her worries. Overwhelmingly, she worried for her children if she or her husband died, tearfully describing how 'I sometimes worry that they will be made to suffer, by my relatives, by the relatives of my husband.' As she explained her concerns for her family, she perceived herself as worthless, now that she had HIV and experienced difficulties navigating her new diagnosis:

If I think about how I don't have a way to do (anything), if I think about my sickness ... I see myself as a person without importance.

Grace's repeated reference to 'thinking' can be interpreted as 'thinking too much,' a common idiom of distress in sub-Saharan Africa which can index ruminating worries associated with the experience of suffering, local moral concerns, and broader social changes (Kaiser et al., 2015). Further, Grace's phrasing may indicate the loss of hope that can accompany an HIV diagnosis. Grace's belief that she didn't 'have a way to do anything' to improve her health and resolve her feelings of inadequacy and unimportance signal hopelessness in her ability to persevere (Mattingly, 2010). Conversely, actively working toward a more positive imagined future may in turn ease the syndemic suffering of HIV and emotional distress. Engaging in medical pluralism is one way in which PLHIV may do this, as the women in the following stories demonstrate.

### **Medical pluralism & resilience**

Like the women interviewed in this research, many PLHIV who are vulnerable to syndemic HIV and mental illness demonstrate resilience to it. As Bhardwaj and Khort (2020) argue, examining contexts in which syndemic HIV and mental illness may be expected to occur – but do not – can illuminate potentially countersyndemic factors that may improve health outcomes (Singer et al., 2017). In this section, I outline some characteristics about Babu and his healing pilgrimage that women described, which may have influenced their experiences of emotional distress in countersyndemic ways. I interpret the relationship between seeking care from Babu and fewer experiences of emotional distress in two ways. First, women who expressed fewer symptoms of emotional distress may have already been better able – financially, socially, psychologically – to seek additional forms of care, including Babu's *kikombe*. This could be the case particularly for women with more social support from family, which allowed them to make the expensive trip, or because they felt more control over their lives and could engage more agentially in care-seeking. Second, Babu's *kikombe* may also have facilitated some therapeutic effect influencing emotional distress. This could potentially occur through mechanisms such as increased engagement of social networks in women's care seeking, a physiological 'meaning response' (Moerman, 2002), or a perceived interaction with God, bringing solace and comfort to women experiencing distress (Luhmann, 2013). Finally, I describe how all of these factors may play a role in fostering resilience and countering women's syndemic suffering.

### **Social support & therapy management groups**

Seeking care from Babu was not associated with survey measures of (instrumental) social support or socioeconomic status (Table 1). However, women may have received significant support not adequately captured through survey methods, which perhaps reduced distress in women's lives. Other ethnographic data help illustrate this, including the stories of seeking Babu's *kikombe* described by several women.

Lucia's journey to see Babu, mentioned in the introduction, took approximately four days: one full day by bus to reach Loliondo from Nguzo town, two days waiting in line, and one day to return. Her trip was also expensive; round trip bus fare to Loliondo cost about TSh 75,000 (US\$ 47), more than the average day labourer's monthly salary, which far exceeded Lucia's. She was one of the poorer women interviewed, with no farm, cattle, or chickens, and her income from selling fruit fluctuated with the seasons. Nevertheless, she made the trip – most likely with support from family – and seemed pleased to have done so, explaining that someone could recover from illness after seeing Babu.

Travel costs sometimes exceeded the rate Lucia paid. Winnie (36 years old) ultimately paid Tsh 350,000 (US\$ 215) to see Babu. Though she made some money selling doughnuts, neither she nor

her parents had enough to pay her way to see Babu, so they sold two household cows, enough to bring her HIV+ child along with her.

For her care, Winnie had the support of her family to go see Babu. The liquidation of family resources – the selling of cattle – demonstrates their commitment to her and her child's health. As many scholars of African healing have noted (see Olsen & Sargent, 2017), control over a patient's care principally lies among kin, what Janzen (1978) calls the 'therapy management group.' In this group, relatives determine a 'shared view of clinical reality' and prioritisation of treatments, which in rural Tanzania, would almost certainly include traditional medicine and/or faith healing (Feierman, 1985, p. 78). Because seeking Babu's *kikombe* likely involved assistance from family, it may also indicate the continuous involvement of family in one's treatment. Those women whose 'therapy management groups' were actively involved in their treatment seeking were likely involved in other aspects of their lives, perhaps reducing feelings of abandonment and stigmatisation, as well as increasing women's access to familial sharing networks.

### ***Faith healing & a local 'meaning response'***

Taking Babu's *kikombe* may have had some buffering effect on emotional distress as well. Like in much of Africa, medical pluralism is the rule, rather than the exception, among Tanzanians; as Langwick (2008) writes, 'biomedicine is only one element in a broader therapeutic ecology' (p. 428). Throughout much of Africa, traditional medicine and faith healing are principal avenues through which many patients productively manage the needs for social integrity and community alongside their needs for physical health (Olsen & Sargent, 2017). Religious rituals and teachings have authority and power often unrivalled by biomedicine in Tanzania (Becker, 2009; see also Probst, 1999), as HIV is frequently experienced as 'embedd[ed] within religious conceptual frameworks' (Mattes 2014, p. 170). In contexts of medical insecurity and disparities in the availability of biomedical health services, plural systems of care also fill temporal and treatment gaps: sufferers draw on all available resources that may contribute to good health (Carruth, 2014; Schoepf, 2017).

Healing may be achieved in several ways. First, anthropological research on the placebo effect suggest there are important links between the expectation of healing and healing itself, mediated by the cultural meaningfulness of a particular healing practice or symbol (Schoepf, 2017). Moerman (2002) redefines this process as a 'meaning response' instead of a placebo effect, because the mechanism itself – the meaningfulness of a treatment linked with an expectation of being healed – is not itself inert, but a powerful way through which healing occurs. The expectation of being healed, or of feeling better in some way, may have contributed to women's reporting of fewer symptoms of emotional distress. In interviews, several informants who did take Babu's *kikombe* reported an easing of some bodily complaints that are related with common symptoms of anxiety and depression. For example, Agnes, age 35, reported 'strong chest pains, but after having (Babu's) drugs, the pain has reduced.' Upendo, age 22, described having 'many headaches,' common among those suffering from anxiety, which had stopped after she visited Babu. Beatrice, age 36, told me that she 'had difficulties breathing' which was 'the main reason for visiting Babu,' which she reported decreasing 'a bit' after seeing him.

Second, Babu also uses cues that are culturally meaningful to many Tanzanians – *mugariga* tea has been used for centuries by Sonjo, Maasai, and Datoga pastoralists – and can have numerous health benefits, including use as an antioxidant, antiviral, antidiarrheal, and antihelminthic (Malebo & Mbwambo, 2011). Engaging in activities and behaviours that are widely recognised as culturally meaningful may also provide health benefits (Dressler, 2004) and may explain the appeal of Babu's healing to the numerous non-Christians who also went to see him; in this sample alone, four of the 25 women seeking Babu's *kikombe* were Muslim (Table 1).

Third, other mechanisms involving the role of faith and ritual may be implicated in Babu's healing. Babu's *kikombe*, for example, exemplifies the hybrid nature of 'traditional' medicine and faith healing in Tanzania today (Marsland, 2007). The mechanism of Babu's therapy is not the herbal treatment itself, he claimed, but God working through him to heal the patient through the tea.

Because he embodied this divine channel, he was the only one who could pour the tea into cups and distribute it to healing effect (Mattes, 2014). Like many other faith healers in East Africa, Babu's idea for the treatment came to him in a series of dreams, in which God instructed him to use *mugariga* to heal people with chronic diseases, particularly HIV (Malebo & Mbwambo, 2011). While 'taking the *kikombe*,' pilgrims therefore believed they were ingesting not only tea, but coming into immediate presence with God through interacting with Babu. Experiencing God in real life, Luhrmann (2013) notes – going from a general belief in God to a specific belief that God is immediately present to help cope with devastating illness – may 'make real' the healing process and contribute to improved health (p. 710).

### ***'Having faith:' stories of healing***

Many women described their expectations of healing and the importance of faith for the effectiveness of Babu's *kikombe*. Rehema, a 28 year old mother of one, explained her experience of healing after seeing Babu. She was never married and had no partner, though she did have a close relationship with her mother, and could rely on her for some help when she needed it. Despite being one of the more highly educated women in my sample – she completed two years of secondary school – she was also one of the poorest, with no access to a farm, nor did she have cows or chickens. She began taking ARVs in 2008 while pregnant with her child, who at nearly four years old was HIV-negative. She experienced few symptoms of anxiety and depression, and her CD4+ count, at 745, indicated normal immune function despite having HIV.

Like some women, Rehema seemed hesitant at first to explain how she found faith healing to be effective, perhaps assuming that as a Westerner I might admonish her for seeking forms of care other than biomedical treatment (Mattes, 2014). She began by describing 'changes I do not understand and am not sure about' after seeing Babu, but added that the flu she had at the time of her visit 'disappeared completely and afterwards my health started to improve.' She also noted that prior to seeing Babu, she appeared to others as 'someone who could be suffering from a particular problem [HIV], but now one cannot notice since my body has regained weight, unlike before when I was weak.' Further, she emphasised the importance of faith and living a moral life in achieving and maintaining good health: 'The effectiveness of [Babu's] drug comes only through faith. But the moment you recover, you are not supposed to indulge yourself in worldly pleasures that don't please God.'

Like Rehema, Maggie (age 30), also perceived positive change after seeing Babu, which she felt she could not yet understand or describe, but attributed it to her faith, the 'only' way through which Babu's healing could work. Asha, a 24 year old mother of three, advised other people to go see Babu, stating that 'I wish [others] to benefit [from Babu's *kikombe*]. They too have heard that Babu can heal them, so let them go. That is, if they have faith that Babu can heal them, they will be well.'

As these women's stories illustrate, 'having faith' in Babu's *kikombe* was essential to their healing (Mattes, 2014). 'Having faith' may also function as a form of hope in the range of experiences of healing (Bernays et al., 2007) – as these women described after seeing Babu – some of which could be attributed to improved emotional health. For Rehema, Agnes, Upendo, and Beatrice, taking Babu's *kikombe* resolved specific ailments they experienced: the flu, chest pains, headaches, and trouble breathing, respectively. Additionally, Maggie and Rehema described a more general feeling of well-being after seeing Babu, which they relayed to me as a positive change that they could not explain, much like Lucia's comment from above: 'I cannot understand, myself, I just feel okay.' Babu's *kikombe* could also indirectly lessen the social stigma surrounding HIV infection, as Rehema described, by reducing the appearance of weakness, a visible cue some people use to assume HIV infection.

These social and spiritual events such as an encounter with God, the engagement of familial therapy management groups, and a broader network of social support making the trip to see Babu possible may all constitute ways in which the culturally meaningful practice of seeking

Babu's tea, along with maintaining their ART, helped encourage resilience among women vulnerable to syndemic HIV and emotional distress. When viewed through a lens of syndemic suffering, ways in which women experience both disease and healing is illuminated; as Weaver and Mendenhall (2014) describe, it prioritises a 'holistic exploration of illness' women experience in context (p. 104), including their efforts to cope with chronic disease.

## Conclusion

The experience of living with HIV, an illness with complex social, moral, and biological interactions, may require multiple intersecting health care approaches and forms of support over patients' lifetimes. This paper describes one instance of medical pluralism, which for many of the women interviewed, exemplifies appropriate treatment according to local systems of cultural belief, meaning, and authority (Langwick, 2008). The mechanisms that may be engaged here include the public ritual pilgrimage that may have addressed significant social and moral elements of healing, a possible 'meaning response' (Moerman, 2002) in which expectations of healing translated into feeling better, as well as perceptions of immediate interaction with God through Babu's treatment. Alternatively, women who were more able to go see Babu – either through more social support, financial, or psychological means – were possibly already experiencing decreased rates of emotional distress. Several of these factors may combine in idiosyncratic ways for each of these women to experience fewer symptoms of emotional distress, compared with those who did not see Babu. In total, these complex interactions and coping strategies may, more broadly, signal reduced vulnerability to syndemic HIV and emotional distress.

There are some limitations in this work. First, all research participants were actively seeking biomedical care during the research period. Therefore, this research excludes HIV+ women more at risk for emotional distress, including those not adherent to ART, and women too sick to visit the hospital. Additionally, several women may have been hesitant to discuss with me their experiences with non-biomedical healing modalities, particularly as engagement with them is frequently considered dangerous among biomedical practitioners (Mattes 2014), often with good reason (see Thielman et al., 2014). Many women denied using traditional and faith healing until I mentioned Babu by name, including the commonly-used *miti shamba* (trees from the field). This suggests that I may have underestimated the number of women who sought non-biomedical care, though the degree to which these modalities are used is unclear (Schoepf, 2017).

Despite these limitations, these findings suggest that meaningful, pluralistic healing may be important in coping with HIV, perhaps particularly for reducing symptoms of emotional distress that frequently co-occur. However, it is also essential to consider the structural conditions of biomedical HIV care and treatment – including treatment delivery and psychosocial support – and how they influence successful life-long adherence to ART (Bernays et al., 2007). Rapidly declining 'care' services offered at the hospital's HIV clinic likely exacerbated the stressors women experienced, and potentially influenced rates of emotional distress and increased the need to find care elsewhere (see Thielman et al., 2014). While multiple forms of healing may be important in maintaining health in contexts of chronic disease in Tanzania, considering how to improve biomedical programmes to reflect the long-term, diverse healing needs of PLHIV should be prioritised (Bernays et al., 2007; Moyer & Igonya, 2014).

The ability to persevere in contexts of medical insecurity is important, not only to adhere to treatments, but to attend to the social and moral dimensions of a liveable life with HIV. Focus on the syndemic suffering of HIV and emotional distress highlights the difficulties in managing stressors while at the same time maintaining the perseverance necessary to maintain health. By engaging multiple forms of healing that attend to the diverse biological, moral and social interactions encountered when living with HIV, people may have better health outcomes, and equally important, be better able to live meaningful lives.

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