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Young People Living with HIV in Zimbabwe Use the Conventional, Religious, and Traditional Health Systems in Parallel: Findings from a Mixed Methods Study

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Abstract: Epidemiologists and other health practitioners increasingly recognize religion as a social determinant of health. This paper is part of a bigger study that examines how religion and tradition influence the health of young people living with HIV in a highly religious society like Zimbabwe. An analysis of 67 interviews and 10 focus group discussions with a phenomenological approach revealed that religious and traditional beliefs influenced the meaning and perception of HIV and the choice of treatment. Study participants consulted religious, traditional, and conventional health practitioners in parallel. Together the three health systems potentially provide a holistic approach that responds to the social, spiritual, psychological, and physical needs of people living with HIV. However, the findings point to a lack of cooperation between stakeholders of the three health systems that led to conflicting approaches that compromised the physical and mental health of study participants. Thus, the findings endorse the importance of strengthening the efforts of everyone involved in HIV care to reach out to other stakeholders and to negotiate a way of collaboration that mitigates negative consequences of disparities and seeks to endorse what is life affirming and leads towards the end of the AIDS pandemic by 2030.

Keywords: young people living with HIV; religious healers; indigenous healers; Zimbabwe; stigma; religion; tradition



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1. Introduction

In this paper, the term ‘religion’ refers to organised and/or shared faith practices or beliefs, while the term ‘spirituality’ refers to the way people relate to the transcendent, including tradition. The term ‘religious healers’ refers to prophets, apostles, pastors, and healers associated with an established religion. Traditional practitioners include traditional healers, traditional birth attendants, herbalists, and spirit mediums that may also be part of an established religion or are solely rooted in African Traditional Religions (ATRs). This paper is part of a larger study that examined the influence of religion/spirituality (R/S) on young people living with HIV (YPLHIV) in Zimbabwe. This paper focuses on an analysis of the qualitative data that describes the important roles of the religious, traditional, and conventional health systems that are used in parallel.

1.1. Religion as Social Determinant of Health

The World Health Organization (WHO) defines the social determinants of health as “the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life” (WHO 2024). Epidemiologists are increasingly recognizing religion as a social determinant of health (Idler 2014). There are a growing number of studies with study populations of people living with HIV (PLHIV). Systematic reviews of this literature have shown that religion can influence the health outcomes of PLHIV in positive and negative ways (Medved Kendrick 2017; Doolittle et al. 2018). How can

we explain the influence of religion on health, including traditional beliefs? In highly religious societies, like Zimbabwe (ZIMSTAT 2017), ontologies of and reactions to HIV are often rooted in religious and traditional beliefs and practices. Thus, while many factors influencing antiretroviral therapy (ART) adherence have long been identified, it is equally important to understand the underlying root causes (beliefs, norms, and attitudes) behind these factors. This is because, as Parry rightly puts it, our attitudes and values are ultimately reflected in our behaviour, skills, and responses (Parry 2013). This is especially true in the context of HIV/AIDS.

The African feminist theologian Dube Shomanah explains that the church (she did not address traditional beliefs) interpret biblical texts in a way that contribute more to the suffering of the infected and affected than to supporting them or to halting the disease. HIV/AIDS are linked to God's punishment for disobedience and immorality. According to her, these interpretations led to the rise in HIV/AIDS stigma. Dube Shomanah questions these interpretations and asks why God's punishment should primarily be directed to the powerless: the poor, women, Black people, children, homosexuals, displaced people, and Africa (Dube Shomanah 2004). Unfortunately, her question remains unanswered. In a recent study among religious leaders in South Africa, 80% reported persisting HIV-related stigma (Alio et al. 2019). Religious and traditional teachings and beliefs not only drive HIV stigma, but they also continue to largely inform the gender roles in society. Religious and traditional teachings identify women as subordinates of men and infringe on their rights to equal opportunities and status. The violation of rights for members of the lesbian, gay, bisexual, transgender, and intersex (LGBTI) community are even worse. Often, religion and tradition teach that heterosexuality is the norm and everything else is against nature, and/or God's initial plan, and thus condemnable.

Becker and Wenzel Geissler rightly argue that religious groupings are instrumental in, are instrumentalised by, and instrumentalise the organisation of HIV-related interventions (Becker and Geissler 2009).

This paper describes the role of religion (including tradition) as social determinant of health for YPLHIV in Zimbabwe. Religious and traditional ontologies of health and wellbeing result in three different health seeking approaches that complement each other and could be a holistic support system. However, because of the lack of cooperation between the stakeholders of these three systems, YPLHIV must navigate between at times contradicting approaches which impact their health and wellbeing negatively. (Wüthrich-Grossenbacher et al. 2023b).

1.2. The Context of Zimbabwe

According to the Zimbabwean 'Inter-Censal Demographic Survey' of 2019, 84% of the population aged 15 years and above are Christians. The largest proportion of Christians belong to the Apostolic sect (34%), followed by Pentecostal (20%), and Protestant (16%) (ZIMSTAT 2017).

While these statistics seem straightforward, it is important to note that people may move freely between different religious groups. One of the informants illustrated this: "For me belief is important. I am born Catholic, went to an Anglican Church, was confirmed there, and in the Catholic Church. Now I visit the 'Seventh Day Adventists' with my mum on Saturdays and go to the Catholic church on Sundays. When I go to the 'Seventh Day Adventists', I just remove my crucifix and earrings. And afterwards I put them on again. . . . Additionally, I need to accompany my husband to his church once a month. His church is Prophet Magaya's church. In that church, people must kneel, when the prophet enters the church. Even I kneel" (study notes).

Prophet-led churches are a common phenomenon in Zimbabwe. Since around 2009, Zimbabwe has witnessed a surge of Christian preachers who call themselves prophets or prophetesses. They claim to be mediators between God and ordinary people, and profess to work miracles, including healings (Chitando et al. 2013).

Muslims, Jews, Buddhists, Hindus, and New Religious Movements are minority groups in Zimbabwe. However, all their members together represent an important section of the population, and they certainly contribute to the welfare of the local society.

Chitando explains that all of the above religions were predated by ATRs. While ATRs are difficult to describe, he ascribes following key aspects to ATRs: “there is no vernacular term for ‘religion,’ religion is inextricably intertwined with daily activities (holism), there is no sacred/profane dichotomy and one is not converted to ATRs: one is actually born into the religion.” (Chitando 2018). According to him, every Zimbabwean is somehow linked to ATRs. Chavunduka agrees and explains that membership of a church (or any other faith community) does not prevent an individual from participating in traditional religion or from practising traditional medicine (Chavunduka 1994). ATRs are not a phenomenon of the past; it is something Zimbabweans deal with continuously. This was especially evident at funerals. Every funeral raised the question of how to deal with the ancestors. Thus, while it is difficult to pinpoint ATRs to a certain belief, ATRs belong to the fabric of the Zimbabwean society.

According to personal observations and conversations, religion has power in Zimbabwe. Giving religious status to politicians (The Herald 2023) and a god-like position to religious leaders (Chitando et al. 2013) pre-empts opposition and opens the door for misuse and abuse. Thirty-one participants in our quantitative study section reported experiencing violence that was perpetrated by religious leaders or religious community members. Unfortunately, religion continues to be appropriated by some to subdue instead of liberate people.

1.2.1. Religion and Health in Zimbabwe

Health and illness are often seen and understood in the traditional and religious context. Nyoni explains that in the Shona belief (80% of Zimbabwean’s population is Shona), there is a hierarchy of spirits. These spirits maintain a friendly relationship between the invisible and the visible world. If the symbiotic harmony between the unseen and the seen world is not respected, there will be negative consequences like diseases and misfortunes (Nyoni 2019). Machinga describes this as follows, “wellness is derived from the cultural understanding of the role of family, community, and the spiritual world in human welfare. Diseases are considered by the Shona culture to have physical, mental, social, spiritual, and supernatural causes. Cure extends beyond physical symptoms to address social and spiritual aspects as well” (Machinga 2011). Shoko agrees with this and points out that HIV/AIDS is a complex socio-economic and cultural phenomenon, which must be considered from the perspectives of indigenous religion and culture and demands a multidimensional approach (Shoko 2018).

Hence, in Zimbabwe, there are three different health systems, namely the conventional, the religious, and the traditional. The religious health system is not an organised system as such. What I mean by ‘religious health system’ is all the religious stakeholders with a perceived healing mandate who are associated with an established religion (mainly, but not exclusively Christianity). God is commonly understood as the ultimate healer. Hence, many turn first to God for help, before seeing a physician. If personal prayer and rituals do not work, the religious healer might be consulted next. Religious healers pray, and/or they perform certain rituals. Unfortunately, faith healings have become a controversial issue in HIV/AIDS care, especially among Christians. The ‘All Africa Conference of Churches’ felt compelled to publish a book about the controversial issue. It explains how issues of health are connected to faith in God and how this is being misinterpreted in Africa, leading people to defy medication and to wait for instant miraculous healing as propagated by some preachers (Eale and Ngige 2021). In Zimbabwe, the refusal of medical help for religious reasons is well known, especially among Apostolic Churches. Non-governmental organization like INERELA⁺ Zimbabwe (the national, interfaith network of religious leaders—both lay and ordained, women and men—who are living with or personally affected by HIV) and the ‘Apostolic Women Empowerment Trust’ work among

Apostolic churches to address these issues. However, during the time of this research, there were several news articles that illustrated the fatal consequences of this kind of theology: young girls were married to older men and died while giving birth at religious shrines (Nyoka 2021). Thus, the Zimbabwean government reaffirmed its call to all those who use faith healing to get registered by the 'Traditional Medical Practitioners Council' (Zinyuke 2023). However, at the time of this research, most religious leaders were not registered or formally organized.

Traditional healers were first professionalized in Zimbabwe after the country's independence in 1980. In 1981, the parliament passed the 'Traditional Medical Practitioners Act'. In July 1981 the organisation of traditional healers called 'Zimbabwe National Traditional Healers Association' (ZINATHA) was established (Shoko 2018). The 'Traditional Medical Practitioners Council' has the mandate to register, regularize and help build capacity for all traditional medical practitioners in Zimbabwe. It is monitored and administered by the 'Ministry of Health and Child Care'. In early 2023, there were 1243 registered traditional healers in Zimbabwe. Traditional practitioners interviewed in this study were all licensed by the 'Traditional Medical Practitioners Council'.

1.2.2. Gender and Reproductive Health in Zimbabwe

Religious and traditional gender roles influence risky behaviour and vulnerability. Girls are more likely to become infected by HIV than boys, and there are more women living with HIV than men. In Zimbabwe, women have little power to negotiate safe sex (Mugweni et al. 2012), and many experience partner violence and abuse (Fry et al. 2016). This does not mean that gender roles are easy for men. The son of a PLHIV complained that young men felt enormous peer pressure to have as many sex partners as possible. He explained that men with many sex partners were respected, and often got leadership roles. This was affirmed by Grade 7 students at a girls' school in Harare. They said that the church taught girls to abstain from sex, while boys were simply warned to be cautious. Their teacher confirmed this and said that boys are congratulated for fathering a child. In contrast, girls who are found to be dating, or pregnant, are chased from home or forced to marry (Hallfors et al. 2016). Once married, women are expected to be faithful, while concurrent relationships are an accepted community norm for men (Mavhu et al. 2011). For non-heterosexuals, the situation in Zimbabwe is difficult. As mentioned earlier, there is widespread stigmatization and discrimination of members of the LGBTI community. According to YPLHIV, being HIV positive and non-heterosexual causes double stigma (Lariat et al. 2024).

1.2.3. HIV/AIDS as Structural Problem

Zimbabwean physician Parry argues that HIV/AIDS is an issue of justice, rights, and responsibilities, both for those affected and for those working towards preventing the spread and mitigating the impact (Parry 2013). She believes that HIV and AIDS affect every aspect of cultural, spiritual, economic, political, social, and psychological life (Parry 2008). Why are HIV and AIDS societal problems? Parry explains that an individual's risky behaviour is not merely a personal free choice, but is profoundly influenced by the degree to which individuals experience financial stability, social control, order, and social cohesion (Parry 2013). Our findings align with this. During data collection, the legal age of consent to sex in Zimbabwe was 16 years. This meant that adolescents were legally allowed to have sex before they could legally access any information or services relating to safer sex practices or contraception, which were only allowed at age 18. This left adolescents at greater risk of HIV, other sexually transmitted diseases, and unwanted pregnancies. The church opposed attempts to lower the legal age to access services related to safer sex practices. Eight religious leaders in our study reported that teaching about sexual health and protection to adolescents was a thorny issue, because it was feared this would encourage young people to engage in early sexual activity. This was in defiance of their awareness that young people in their church were already sexually active. This had dire consequences. Pre-COVID-19,

every third girl married before 18, mainly because of an unplanned pregnancy (Novak 2022). Furthermore, members of the LGBTI community were considered sinners, outcasts, not 'real Africans' and not worthy of protection or participation. Babies with an unclear sex were treated by traditional practitioners to 'look like' female or male. According to an association of LGBTI people in Zimbabwe, members of the LGBTI community experience discrimination and harassment in health access, education, work, and religious spaces. Some issues they highlight are as follows: difficulties in the procurement of HIV prophylaxis (like dental dams used to cover the female genitals during oral sex); discomfort in medical spaces leading to fewer cancer screenings; barriers accessing support services related to gender-based violence; limited access to and criminalization of available fertility options (e.g., in vitro fertilization, adoption, donor insemination); threat of sexual or physical violence; forced marriages to men; deliberate misgendering (GALZ 2021). Sex workers in our study also complained about discrimination and violence (including by the police). While selling sex is legal in Zimbabwe, soliciting is illegal (Global Network of Sex Work Project 2024). Sex workers in this study reported that they felt unprotected by the law and very vulnerable.

We found that HIV and vulnerability were somehow part of a vicious circle. Being poor increased the risk of HIV infection; it was also associated with a higher risk of experiencing violence. Since living with HIV was commonly associated with sinful behaviour, people living with HIV were not considered innocent and therefore not deemed worthy of protection (by church and state authorities). If people are not considered worthy of protection, their access to legal help is limited. In this sense, HIV/AIDS truly is a structural problem.

2. Methods

The main study is a mixed methods study that was approved by the Medical Research Council Zimbabwe (MRCZ/A/2701).

The study contained a quantitative questionnaire that was administered to 804 YPLHIV who were all beneficiaries of an HIV treatment program. The data were collected in 2021. Due to COVID-19 lockdown measures, nearly all the data collection was performed by phone using an open data kit. Besides the R/S measures 'Belief into Action Scale' (Koenig et al. 2015), 'Brief Religious Coping index' (Pargament et al. 2011), and the 'Religious and Spiritual Struggles scale' (Exline et al. 2014), the questionnaire captured the following baseline data: religious affiliation, types of healers and types of traditional medicines and practices involved in patients' lives, participant's concepts of HIV, health seeking behaviour, and risk taking including the experience of violence, confounding variables (especially the COVID-19 pandemic), and possible effect modifiers (demographic factors such as age, location, education, civil status, income). Health was measured with a variable that asked participants how they themselves ranked their health, three variables for viral load results, a variable for opportunistic infections, and the Shona Symptom Questionnaire (Patel et al. 1997) to identify the risk of common mental disorder. The quantitative data were analysed using the statistical software STATA version 17.0 (Stata Corp, College Station, TX, USA). The results of the multilevel mixed effects logistic regressions identified causal relations between R/S aspects and HIV health outcomes and have been published (Wüthrich-Grossenbacher et al. 2023a).

The aim of the qualitative part of the study was to gain information about the 'how, why, what', or in other words, meanings, experiences, and views of participants. It included interviews with 15 religious leaders, 7 health workers, 10 traditional practitioners, 13 people affected by HIV (teachers, caregivers, social workers), and 22 YPLHIV (aged 18–24 years), 10 'Focus Group Discussions' each with 10 YPLHIV (aged 14–17 years), participatory observation notes, relevant news articles and stories, and minutes of online meetings and discussions. The interviews and 'Focus Group Discussions' were analysed using a phenomenological approach: The audio recordings of the 'Focus Group Discussions', and interviews were transcribed verbatim and if necessary, further translated and then thematically coded as described by Saldana (Saldana 2013).

The 1st cycle coding used descriptive coding, where identified topics were captured in notes for individual interviews and passages, in vivo coding to point out what is important for the participant, and initial coding, where codes were recorded line by line. In the process, similar codes were clustered together to identify emerging themes.

In the second cycle coding major themes were generated according to the number of quotations. To find rules, causes and explanations, the next step was to look at sequences, similarities and differences, and frequencies of codes/themes. Patterns of relation were identified by illustrating the link between major themes, and by looking at social networks by listing codes related to Cognition, Emotions, and Units of social organization (cultural practices, type of relations and lifestyle/settlement).

The following focus strategies were used to synthesize the above findings: Choosing the ten most vivid and representational quotes and identifying the three most important themes. Next, all codes were printed out and ordered and re-ordered manually. This helped to structure the narratives.

3. Results

3.1. Findings Regarding the Role of Faith-Communities/Personal Belief

All interview partners said that R/S played an important role. Many said that their faith helped them to accept their HIV status as God's will and that God had a purpose for them. This belief comforted them in troubles and helped them never to give up. God was seen as the giver of life, so without God, there would be no life. God was the supreme power, and many YPLHIV put their trust and hope in God's goodness and love. This faith was important for coping: "I think my belief and my feelings works towards God because each time I face a big difficulty, I kneel down with my knees, and I pray. When I can't, I always say God I can't do anything please do for me, I can't see please see for me, I can't walk please walk for me. So, every time I say this, I have encouragement and I always find myself on my feet and then I'll make things happen. So . . . I have got true faith to God, and I think he is the one that is making me stay now" (YPLHIV 1). Religious communities provided holistic (spiritual, emotional, economic, and mental) support. Religious leaders were perceived as God's mediators, mainly by Apostolic church members. Religious communities were attributed the social responsibility of shaping values, and teaching and practicing justice and mercy.

3.2. How People Described God

God was central for nearly everyone: "Maybe it will be difficult to explain how God is, but I just know that God is there because I have life." (YPLHIV 22). In order of importance (=number of codes) God was described as follows: supreme, deliverer (from evil), rescue and hope in times of need, able to heal (even HIV), giver of life, loving everyone, helping (also to accept HIV status), playing a role in HIV (sending/healing/coping), being able to send illnesses, origin of all healing, always being there, looking after me, hearing me, comforter, caring, giver of energy, provider. In other words, God was overwhelmingly portrayed in positive terms. The love and care of God was hardly questioned and at times, God was the only friend: "My relationship with God helps because at times you may feel neglected by family members or friends so you'll be only left with God . . . only God to tell. So, when you pray to God, you will be believing that the Lord who is the creator of everything, he will be hearing you." (YPLHIV 4).

A caregiver testified that he was only able to care for a YPLHIV because of God: "if God was not there, I would not be able to take care of T, . . . I would not have an understanding heart or be humble." (in-depth interview 8). However, believing that God was all-powerful and loving also raised questions such as these: "Why me God? Why I'm born with HIV and others are not?" (YPLHIV 8). It also made YPLHIV wonder why God didn't help them: "I feel let down by God because of my HIV status: Sometimes you can't even pray. You can't even have the power to pray." (YPLHIV 10) or "If God was here, why am I HIV positive?" (YPLHIV 7). As mentioned earlier, some also felt that God was

punishing them: “I feel God punished me and cursed me . . . It’s confusing because aah I love him, but I feel he punished me, but I don’t know what actually happens. It’s just a mere question.” (YPLHIV 2). In other words, the discrepancy between the belief in the almighty power and goodness of God and their lived experience caused some YPLHIV to struggle. R/S struggles were prominent (Wüthrich-Grossenbacher et al. 2023a).

3.3. What People Said about the Role of Religious Communities

The church (non-Christians also referred to their faith community as ‘church’) was the place where people received teaching about God and ‘good living’. Study participants stated that the church had the role to shape values and by doing this it had a big social responsibility. A huge emphasis was put on the teaching of sexual abstinence outside heterosexual marriage. The findings show that this abstinence proclamation shaped the values in society, primarily in that it led to condemnation, exclusion, and stigmatization. But it was in stark contrast to the sexual practice of the majority. Nearly everyone agreed that people were sexually active outside heterosexual marriage.

Besides religious teachings, the following responsibilities were assigned to churches: to care for those who cannot care for themselves, to give correct teaching about HIV, to work against stigma and discrimination, and very importantly, to give counselling and encouragement. Many said the role of the church was to give hope. Furthermore, religious communities were important for socialisation and fellowship: “the church is good because you will be able to meet with your peers. And then you will be able to share ideas, doing projects working together and then encourage each other. Sometimes you end up forgetting about your worries at church through prayer and association with others” (YPLHIV 4).

Churches were said to help with ‘hand outs’ (food, clothing), practical help (chores), helping to start income generating projects, providing palliative care, and especially organizing and carrying out burials. For many, the church was the first place (after praying to God) to ask for help in time of sickness or need. Still, as mentioned earlier, the church was also a place where YPLHIV experienced a lot of stigma and discrimination. Many interviewees felt that they could not disclose their HIV status in church because of stigmatisation. In addition to seeing HIV as a lack of belief or wrong belief, living with HIV continues to be associated with sexual misconduct and generally sinful behaviour. Interviewees said that being HIV positive potentially disqualified them from singing in the choir, holding a church leadership role, and from marrying a fellow church member. PLHIV feared being excluded from sharing cups, cutlery, etc., with fellow church members. It was also a place of spiritual violence or coercion, where YPLHIV felt pressured to quit their medication, subdue to religious rituals (like casting out demons), and hide their identity. Some interview partners said that this was especially a problem and dangerous for children whose parents did not allow them to access medical care for religious reasons, including vaccinations. In the quantitative questionnaire, 29% of participants reported having been confronted with religious reasons against the use of Western medicine and 26% with religious reasons against cervical cancer screening. Participants who had been confronted with religious reasons against Western medicine had a higher rate of ever stopping ART for religious reasons (35% compared to 29%). Interestingly, those confronted with religious reasons against cervical cancer screening had a significant higher screening rate (45% compared to 19%).

Because of the church’s important role in society, being excluded from belonging to or participating in the church was both a problem but also a reality for some: “To go to church or religion is very important that maybe I don’t go to church because I don’t have the clothes to wear to go to church” (PLHIV 15). Others said that being HIV positive excluded them from going to church, as they believed God was not helping sinners (drug addicts, sex workers, PLHIV). Thus, while church was a place of spiritual and mental renewal and a safe space for some, for others, it was a place of discrimination and contradiction which led to more suffering.

3.4. What People Said about Religious Leaders

YPLHIV went to religious leaders to have them pray for healing, for counselling, and at times also to get handouts in situations of need. In some religious communities, the leaders have a lot of authority and are not questioned. The man of God is considered to have a special relationship with God and be God's messenger. This is not limited to Pentecostal churches, and it can also apply to women leaders, as this female pastor explained: "we as the clergy, when we speak, people understand. When we speak people get it. If I say, 'this is red' when it's green, all the people from my church will say 'it's red', yet it's green—because the pastor has said so." (religious leader 7). This is a dangerous status that leaves room for exploitation, coercion, and manipulation.

Sadly, as mentioned above, discriminatory teaching and actions by religious leaders can fuel stigma and guilt feelings, and even lead to adherence problems. Allegiance to the pastor or prophet may include believing in his/her healing power and lead to defaulting medication: "If I go to the church and they're just saying 'don't take your antiretrovirals', what exactly are we doing? Well, where are we going?" (YPLHIV 12).

Some experienced religious leaders as not being genuine. They reported that religious leaders were looking for money and favoured the rich. Religious leaders were the ones who fuelled stigma. They claimed to love everyone, but they despised PLHIV. Respondents reported that religious leaders did not associate with PLHIV, treated or called them useless, 'always sick', associated HIV with sexual immorality, did not touch PLHIV while praying for them, did not listen to them, did not allow them to be in leadership roles, and generally linked good health to religious performance (=blessing for living correctly).

Religious leaders who lived an immoral life also raised doubts about God: "if there is God, why is he allowing the pastor to go to buy sex to a sex worker whilst he is a man of God? And then I just go to my friends and say, 'the pastor was here for me all night' and the friends they just say 'maybe they just do church because of money. They just want to get money from the people but not praying'. So maybe there is no God in the heaven" (YPLHIV 15). In other words, our participants described the role and influence of religious leaders as important but also as ambiguous. The influence of religious leaders can be positive or negative.

Hence, INERELA Zimbabwe centres its efforts on religious leaders. It actively works against negative stereotyping, misinformation, stigma, and discrimination of PLHIV. The team organises workshops in different faith communities and works with religious leaders of different faiths. The small, dedicated team inspires and motivates religious leaders to welcome and support PLHIV. All the seven religious leaders in our study who had visited workshops by INERELA expressed a loving and caring attitude towards YPLHIV. They reported to focus their teaching and actions on inclusion and support of PLHIV.

Thus, the important role of the religious support system, including faith in God, faith leaders, and faith communities, was apparent.

Furthermore, the findings confirmed the comprehensive understanding of HIV/AIDS. Interestingly, however, the belief in the influence and power of spirits was often not openly acknowledged in direct personal contact. Only very few of the interviewees said that they believed in spirits. But in the quantitative questionnaire, which was more anonymous, only 27% said that there are no spirits, and 4% of the study participants believed that HIV was the result of witchcraft or a spell. Many interviewees explained that HIV/AIDS was one of the incurable diseases foretold by the Bible. Many believed that God could cure HIV/AIDS if he wanted. The origin of HIV was understood as a God-sent consequence of sinful behaviour. Besides this, 15% of respondents to the quantitative questionnaire believed that HIV was brought by the West to weaken Africans. This belief was shared by some traditional healers. The different understandings of the origin and the reason for HIV influenced health-seeking behaviour, risk taking, and health outcomes of YPLHIV (Wüthrich-Grossenbacher et al. 2023b).

3.5. The Role of Traditional Healers

The interviews with 10 traditional practitioners confirmed their important contribution to public health. The majority of the interviews were conducted while visiting them at their place of practice or home. One ATRs healer lived and practiced in a big house in Chitungwiza, a high-density area not far from Harare. While the house looked big from the outside, it was very run down and a rather dirty and smelly place. We met the healer sitting on the floor of the biggest room in the house. He had his utensils spread around him while another man played the Mbira (a traditional musical instrument). The Mbira player had two instruments: one he played to welcome us, and the other one was the 'mbira dzivadzimu'. He explained that he plays the 'mbira dzivadzimu' when the 'sekuru' (healer) wanted to do his work and needed to consult the ancestors. There was a third old man sitting next to the Mbira player. He explained that he was possessed with what he called a 'Gombwa', a medium spirit that was on his back. He continued to explain that he was the spiritual chief of the area. He was able to connect with the ancestors and they speak to him in dreams. So, whenever the healer wants to work, he needs the approval of the chief.

The other ATRs healer lived in a remote, rural area and was also working as part of a team. They were a team of three: the 'sekuru' was the one possessed by the spirit, the translator understood what the spirit communicated, and there was also the wife of the healer. There were several drum players and dancers, but they were not mentioned as being part of the team. Wife and husband both consulted the ancestors. The wife was weeping heavily while we were there. The healer explained that she was carrying the burden of all the 'children' who come for help. The more she cried, the more help they would get from the ancestors.

All other traditional healers worked on their own. One lived in a high-density area and owned a house. Her house was clean and she looked healthy. All other healers I visited were in remote rural places, some only reachable by foot. They lived in poverty and most of them were old and fragile. Many had health issues. They belonged to different religions (Roman Catholic, Muslim, multiple religions).

I was told that each traditional healer is inspired by his/her ancestors. Whenever a person comes for help, traditional healers consult the spirits for guidance. The spirits will reveal the cause of a problem, the nature of the problem, and the solution for it. The right treatment or the place of a special herb are often revealed in dreams. Different healers may use the same herb for different illnesses. In other words, each person and each illness is treated according to the inspiration by the spirit. This also implies that healers do not copy each other's medicine.

This was different with one person who described himself as a herbalist. Besides being trained in the knowledge of herbs and healing methods by his parents, he had also visited other herbalists and had learnt from them, and he had attended courses about traditional medicine at the University of Zimbabwe. He had more than 1000 herbs that he had numbered and recorded, and a pinboard with lots of different herbs and their use. He had acquired medical knowledge from a huge medical book he had been given many years before, and he was very proud that his work was based on scientific knowledge. Besides herbs, he also had a bottle with a black magic charm, and there were snake skins, a lizard, and other things pinned to the walls of his room. He lived in a barn of an abandoned farm, which used to be a storeroom for fertilizer. This place had been allocated to him by the local representative of the ruling party.

All traditional healers said that they are consulted by people from all walks of life. Some claimed that doctors and nurses would also seek their help, especially if they did not know how to treat a patient. Most commonly, this happened in cases of strokes and when a patient is struck by lightning. People consult traditional healers for all sorts of health issues (often sexually transmitted diseases), sexual problems, relationship problems, for the pursuit of luck, and so on. When asked about abortion, all explained that this was against their ethics. Several even said that they strengthened the pregnancy when being asked for abortion. Many traditional healers claimed that they could heal HIV, but all said that they

did not want to interfere with ART treatment. In other words, if someone was already on ART, they would either not treat them or make sure their treatment would not interfere with ART. This was confirmed by our quantitative data. None of the herbal treatments taken by participants interfered with their viral load result.

Traditional healers also said that Christians mainly visited them in the dark. Several said that pastors would come and ask for powers to gain more authority or to gain more congregants. None of them seemed to be concerned by the hypocrisy of religious leaders who openly speak against traditional healers and yet visit them in secret. Chirongoma opposes this hypocrisy and the Christian condemnation of traditional healers. She urges the Christian church to embrace traditional healers as part of God's healing agency. She argues that "An integrated approach to health and healing enables individuals and families to appreciate the fact that at the heart of all the systems is the quest to support life. Health practitioners from the diverse health systems must be seen as agents of God." (Chirongoma 2016).

3.6. *The Parallel Use of the Three Health Systems*

Some participants used the conventional, the religious, and the traditional health systems in parallel. The consulted faith healers were mostly prophets or apostles. Chavunduka explains that there are many similarities in the medical practice of Christian prophets and traditional healers. According to him, they both focus on the social and psychological causes of illness. He says that the difference is the medium through which the diagnosis is revealed. While for the traditional healers the source of revelation are the spirits, for Christian healers the source of revelation is the Holy Spirit (Chavunduka 1994). Our findings confirm this. Prophets from Apostolic churches often used holy water, stones, and other blessed objects which were supposed to bring luck. They also used herbs, bones, or animal skins for the same purpose. Some traditional healers stated that apostles and prophets visited them at night and asked for medicine that would give them more influence and power. Furthermore, there is also a similarity in worship practices and deliverance services (the casting out of demons and spirits). Many of the Apostolic churches repeatedly sing the same verse and dance the same rhythm and seem to reach a trance-like state in their worship and deliverance services.

In addition, similarly to spirit mediums, some prophets claim to have special access to the spiritual world and God. This might culminate in a 'god-like' veneration. There are churches with a hierarchical membership system. According to one of the informants, the monthly price for premium membership was 500 USD three years ago. Premium membership meant a parking space close to the entrance of the church, a seat in the first row of the sanctuary and with that, closer access to the prophet. Closer access to the prophet implied bigger blessings. A room in their home had to be dedicated to the daily worship of the prophet. This informant was the wife of a premium church member. When her husband's business did not yield enough profit, she was told that this was the consequence of her failure to accompany her husband to church and to unite spiritually with him. She was summoned to the prophet's office and seriously threatened. According to the prophet, her disloyalty to the prophet hindered her husband's blessings.

The so called 'Gospel of Prosperity' is firmly established in Zimbabwean Christianity, not only in Pentecostal churches but also in mainline denominations (Gunda 2018). In those churches, bad luck, failure in business, or incurable illnesses like HIV/AIDS are seen as a personal failure of correct belief and religious conduct. Eleven interviewees reported that HIV was linked to poor religious performance. This kind of teaching not only fuels stigma and discrimination but it also puts enormous pressure on PLHIV. Hence, 16% of our participants experienced considerable/intense spiritual struggles (Wüthrich-Grossenbacher et al. 2023a).

Nevertheless, Christian hospitals and faith-based organizations have long been at the forefront of supporting the sick and offering support to the vulnerable, especially in connection with HIV. Parry points out that churches tend to reach out to the poorest of the

poor and provide services in areas where no one else would go (Parry 2013). This is in line with the findings of the interviews. Many interviewees reported that their only material and emotional support came from churches and church-based organisations.

There is a big disparity in the public recognition and acceptance of the role of religious groups and stakeholders and those of traditional practice. Overall, healing services in Christian churches seem to be accepted publicly. All over Harare, big billboards advertise for certain prophets and churches that promise healing, deliverance, and prosperity. Some of these megachurches are very rich, and people pay a fortune in the hope of being bestowed with material and spiritual blessings. In contrast to this, the consultation of traditional healers is often not performed in the open and traditional healers receive little recognition in public. While some informants claimed that traditional practitioners are supported by the government, all the traditional healers and the herbalist in this research were poor and lacked adequate support. This is in stark contrast to their important contribution to the local health system.

Thus, traditional practitioners yearn for more recognition politically and in the medical field. They claim that they contribute a lot to society, and this is substantiated by our quantitative data. A total of 60% of our participants relied on at least one herbal supplement (out of a list of 26 herbs used for medical purposes). Traditional practitioners are an integral, substantial, and important part of the health system in Zimbabwe, but most of them receive neither a salary nor pension, a room in a clinic, personal protection material, or respect from their medically trained colleagues. Many live in poverty, they do not have the financial means to promote their knowledge or even medicine. One herbalist mentioned he was confident that he had found a herb that healed epilepsy. A government official had encouraged him to get it registered and patented, but the herbalist lacked the knowledge and the funds to apply for ethical approval and all the other requirements needed to test the drug. This exemplifies that traditional practitioners' position is very weak in comparison with conventional medicine.

4. Discussion

When asked about the ideal health support, half of the participants of the quantitative questionnaire wished to choose their health practitioner according to the cause of their illness. The parallel use of the three systems carries opportunities and challenges.

4.1. Opportunities of the Parallel Use of the Three Health Systems

Holistic Care: Firstly, the three health systems respond to the understanding of health and wellbeing that includes the spiritual, social, physical, and mental dimensions. Participants explained that it was important to find the cause of an illness or misfortune and that they chose their health provider according to the identified or supposed cause. They felt that medical practitioners did not consider spiritual and social aspects, and thus, they also had to consult religious and traditional practitioners to address the source of the problem. In other words, the existence of the three parallel health systems allows for a holistic approach to care.

Referral system: It seems that in some instances there was also a referral system operating. Traditional practitioners and religious leaders referred YPLHIV to medical doctors, and a few doctors said that they sometimes also referred patients to religious counsellors. At least three traditional healers claimed that medical doctors and nurses also referred patients to them, especially when someone was struck by lightning. In other words, if practitioners of the three health systems acknowledge the expertise of each other and refer patients, if necessary, patients will be cared for in the best possible way.

Accessibility and affordability: Most participants claimed that their life was God-given, and thus, their first source of help was God. In other words, if they felt their health or wellbeing was challenged, they would first pray and ask God for help. Praying did not necessarily exclude the consulting of a health practitioner. Often, the decision of where to seek further help was guided by the accessibility or affordability of that help. Religious

and traditional practitioners help for free and live in the community, while transport to go to the medical health facility and the user fees at clinics and hospitals were often a problem. Furthermore, the herbal treatment given by traditional practitioners is often free, while the price of drugs prescribed by medical doctors was considered too high. In other words, religious and traditional practitioners provide medical care that is accessible and affordable, and with this they help carry some of the burdens of public health service.

Indigenous knowledge: Traditional practitioners explained the importance of respecting Zimbabwean culture and religion, not only for the individual but for the social cohesion of the Zimbabwean people. Traditional practitioners showed a deep concern for the well-being of the population and environment and had huge knowledge about nature and local culture. Thus, traditional practice was embedded in the culture, social structure, and physical environment of the local people. It was resource-orientated, used a participatory approach, and was sustainable. Traditional practitioners' knowledge of Zimbabwean's wealth of medicinal plants is a treasure that has the potential to boost the healthcare system. Increasing the recognition and use of traditional medical knowledge and indigenous plants could help to regain more independence from the Western-dominated pharma industry. Unfortunately, traditional practitioners felt that the potential of their knowledge and service was not valued. Several traditional practitioners mentioned that they loved to share their knowledge and wanted to be integrated into the health system but did not get a chance. Traditional practitioners should get a chance to prove the efficacy of their herbal drugs. Indigenous herbal drugs could provide a sustainable and affordable contribution to public health in Zimbabwe.

Spiritual Care: Spiritual Care describes an approach to medical care that acknowledges, respects, and recognizes R/S resources and needs of patients, and integrates them into their care. For a stigmatizing health condition like HIV especially, Spiritual Care is very important. However, participants said that R/S was usually not of interest to medical practitioners. Spiritual struggles like the questions of 'why me?' or 'has God punished me?' or the feeling of having been let down by God, self-condemnation, and religious doubts were not addressed by medical professionals. Likewise, patients also did not feel at ease to reveal fears of having been bewitched or being possessed by evil spirits to medical professionals. For these kinds of questions, they went to a religious or traditional practitioner or counsellor. Most YPLHIV said that they received religious counselling and that they were helped by praying with or being prayed for by religious stakeholders. Traditional healers saw themselves as experts in dealing with health problems which were the result of a spell, witchcraft, or an angered ancestor. Likewise, religious leaders claimed to be able to deliver patients from demons, spells, and evil influences. In other words, it was the religious and traditional practitioners who acknowledged and addressed the R/S resources and needs of YPLHIV, and by doing this, provided Spiritual Care.

4.2. Challenges of the Parallel Use of the Three Health Systems

Incompatibility of treatment: Some herbal treatments are known to interfere with ART (Fasinu et al. 2015). However, herbal treatments given by traditional practitioners were given without written information about the content or the dose of the medication. This information would be important for medical practitioners to verify possible incompatibilities between drugs.

Contradicting teaching about sexual health: Some traditional and religious teachings do not allow women to ask for safe sex practices, or unmarried people to use contraceptives. It was commonly believed that allowing young people access to contraceptives was encouraging them to engage in early sexual activity. While promiscuity was condemned openly, it was often silently condoned or even expected for males. Also, in some traditional and religious communities, child marriages and polygamy are still common.

Stigmatisation of HIV: Some religious teaching stipulated PLHIV as sinners or demon possessed.

Delay of onset of or compromised antiretroviral medication intake: Traditional practitioners who believe that they can heal HIV with herbs may delay the onset of antiretroviral treatment. The same is true for religious leaders who believe that they have God-given power to heal HIV, or who teach that PLHIV should only trust in God and not in medicine. There are also certain religious practices and rituals that compromise antiretroviral treatment, like dry fasting over several days, where people said they were not allowed to drink or eat (or take pills).

Traditional practices with heightened risk of HIV infection: At least two traditional practitioners said that they were treating people with 'injections'. They explained that they use razor blades to cut the skin and then they rub the treatment into the wound. This procedure has a heightened risk of HIV transmission. One healer explained that sometimes she examined people's private parts. In her hut, there was no running water, so hygiene was probably not guaranteed.

Potentially harmful cultural and religious norms: Patriarchal norms were many. Participants explained that men had to be strong. This was also given as a reason why most violence is perpetrated by men and accepted as 'normal'. For men, seeking medical help, talking about personal problems, or giving in to an argument were considered weaknesses. Thus, apparently men are reluctant to test for HIV or to get treatment. One religious leader said the following: "A lot of us, die in silence. Because, by just sharing our stories, or how we feel, in our context, eeh, it doesn't show that you are strong. In our culture you have to keep things within your armpits, you don't have just to tell everybody how you feel. So, I think, this is something that has been there since time immemorial, and it has been eeh cultivated and watered by patriarchy." (Religious Leader 1).

Besides not talking about problems, sexuality was also claimed to be a taboo subject. However, this was contrary to experience. Talking about sexuality was very prominent in the media. In church, sex was often spoken about, but exclusively in a normative way that discriminated against and judged sexual practice outside heterosexual marriages. Traditional practitioners also had no problem with talking about sexuality, although they would not mention the word as such, but used descriptive words. A homophobic attitude was common in both religious and traditional settings. Religious and traditional stakeholders saw anything outside heterosexual marriage as unnatural, ungodly, and in need of correction. Nearly all religious leaders said they would counsel or treat non-heterosexual people to become 'normal'. One traditional practitioner had herbs for 'sex-change'. He said he would use these herbs if the sex of a patient (mostly children) was not clear.

Contradicting beliefs: This was the most prominent claim, and it appears to be the biggest challenge. Some religious leaders said that they personally were using traditional herbs. Many also believed in the existence of spirits and ancestors. But they also believed that the Bible did not allow the consultation of spirits or ancestors. This belief utterly disqualified the consultation of traditional practitioners because most of the traditional healers claim to be possessed by, or at least to consult and depend on spirits and ancestors while doing their work. In addition, some traditional practitioners felt that medical professionals disregarded cultural and ancestral rules and therefore caused disharmony. In their view, medical professionals needed to start respecting traditional religion and culture to appease the spirits and ancestors and to restore harmony. However, most medical professionals were very much against the spiritualization of HIV infection. They opposed both religious deliverance ministries and traditional practice.

Competition: Several traditional practitioners claimed that church leaders feared that they could lose members if they allowed their followers to visit traditional practitioners.

4.3. Collaboration between the Three Systems

Interestingly, there was nearly the same number of people who said that there was no agreement possible between stakeholders of the three systems and that it was a waste of time to even try (18 participants), and those who said that collaboration between the

three systems was the only way forward (17 participants). This illustrates the divide between opinions.

The parallel consultation of practitioners of the three health systems by 40% of participants in the quantitative questionnaire, illustrates the importance of religion (or belief) as a social determinant of health. Religious and traditional ontologies of health influenced the health seeking behaviour of our participants. However, interestingly, participants were reluctant to acknowledge the consultation of traditional healers. Religious healers (mainly Christians) were widely recognized, but traditional practice was conducted in secret. In other words, traditional ontologies of health are not recognized as equally valid to the conventional medical approach and/or the Christian doctrine of healing. One might argue that the values and approaches of the current public health system continue to reflect the European post-Enlightenment precepts of the former missionaries and colonialists. One such example is the witchcraft suppression act of 1899, which suppresses the practice of *pretended* witchcraft. This implies that officially, formal courts do not believe in witchcraft. This is in stark contrast to the traditional beliefs in Zimbabwe, and it is one example that illustrates the unequal standing of traditional and ‘modern’ ontologies, and what Simmons labels “historical epistemic violence” (Simmons 2012).

The creation of the ‘Traditional Medical Practitioners Council’ was one way to improve the standing of traditional healers in Zimbabwe. However, the traditional healers in this study all said that they lacked government support and that they were not included in policy making and public health planning. They only had limited access to academic institutions, and they generally lacked financial and other resources. Admittedly, generally, the public health sector in Zimbabwe is under resourced and there is a lack in other health sectors too. Importantly, the public health financing is heavily influenced by international donors (Mhazo and Maponga 2022). In other words, the integration of all stakeholders into the HIV care approach also—or even largely—depends on the recognition of religion as important social determinant of health by international donors. The recent call of the World Health Organization for “A positive vision of health that integrates physical, mental, spiritual and social well-being” (WHO 2023) is very promising. I hope that this positive vision of health that includes the spiritual aspect of well-being will inspire future approaches to health care that value and respect traditional knowledge and include all stakeholders in HIV care.

Collaboration between all three health providers has the potential to achieve what none could achieve alone, namely a genuinely holistic, religiously, and culturally sensitive and meaningful care of PLHIV.

5. Conclusions

The findings of this study confirm the importance of local religious ontologies of health for YPLHIV in Zimbabwe. This is in line with WHO’s increasing recognition of the importance of spiritual well-being. It is time that everyone involved in HIV care (including donors and HIV program developers) incorporated R/S aspects in their HIV approach and started to collaborate with stakeholders of the religious and traditional health sectors. The existing three health systems in Zimbabwe have a huge potential to provide a holistic, affordable, accessible, culturally relevant, and religiously sensitive HIV care. However, at present, religious stakeholders with a perceived healing ministry are not part of the ‘Ministry of Health and Child Care’, and therefore, they are not regulated or trained. Hence, YPLHIV are confronted with religious teachings and practices that are potentially harmful and compromise their health. Thus, registration of all faith healers in the ‘Traditional Medical Practitioners Council’ might be the right step forward. Yet, this would also mean strengthening the position of the ‘Traditional Medical Practitioners Council’ and including in its leadership stakeholders from a diversity of faith traditions, so that it can truly fulfil its mandate to regulate, train, and build capacity for all faith healers.

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References

- Alio, Amina P., Lerato Makhale, Stefanie Hornschuh, Khuthadzo Hlongwane, Kennedy Otwombe, Michael Keefer, and Janan J. Dietrich. 2019. "Loving the Sinner, Hating the Sin": An Investigation of Religious Leaders' Perceived Role in the Lives of Persons Living with HIV in Soweto, South Africa. *Journal of Global Health Reports* 3: e2019021. [CrossRef]
- Becker, Felicitas, and Wenzel Geissler. 2009. *Aids and Religious Practice in Africa*. Studies of Religion in Africa. Leiden: Brill.
- Chavunduka, Chavunduka L. 1994. *Traditional Medicine in Modern Zimbabwe*. Harare: University of Zimbabwe Publications.
- Chirongoma, Sophia. 2016. Exploring the Impact of Economic and Sociopolitical Development on People's Health and Well-Being: A Case Study of the Karanga People in Masvingo, Zimbabwe. *HTS Teologiese Studies/Theological Studies* 72: 9. [CrossRef]
- Chitando, Ezra. 2018. The Religions of Zimbabwe in Their Plurality. In *Aspects of Pentecostal Christianity in Zimbabwe*. Edited by Lovemore Togarasei. Cham: Springer International Publishing, pp. 15–32. [CrossRef]
- Chitando, Ezra, Masiwa Ragies Gunda, and Joachim Kügler, eds. 2013. *Prophets, Profits and the Bible in Zimbabwe: Festschrift for Aynos Masotcha Moyo*. Bible in Africa Studies, Etudes Sur La Bible En Afrique; Bibel-in-Afrika-Studien, v. 12 = v. 12 = v. 12. Bamberg: University of Bamberg Press.
- Doolittle, Benjamin R., Amy C. Justice, and David A. Fiellin. 2018. Religion, Spirituality, and HIV Clinical Outcomes: A Systematic Review of the Literature. *AIDS and Behavior* 22: 1792–1801. [CrossRef] [PubMed]
- Dube Shomanah, Musa W. 2004. *Grant Me Justice!: HIV/AIDS & Gender Readings of the Bible*. Edited by Rachel Angogo Kanyoro. Pietermaritzburg: Cluster Publications.
- Eale, Bosela E., and Njoroge J. Ngige. 2021. *Addressing Contextual Misleading Theologies in Africa Today*. Philadelphia: Fortress Press. [CrossRef]
- Exline, Julie J., Kenneth I. Pargament, Joshua B. Grubbs, and Ann Marie Yali. 2014. The Religious and Spiritual Struggles Scale: Development and Initial Validation. *Psychology of Religion and Spirituality* 6: 208–22. [CrossRef]
- Fasinu, Pius S., Bill J. Gurley, and Larry A. Walker. 2015. Clinically Relevant Pharmacokinetic Herb-Drug Interactions in Antiretroviral Therapy. *Current Drug Metabolism* 17: 52–64. [CrossRef]
- Fry, Deborah, Charity Hodzi, and Tendai Nhenga. 2016. *Addressing Social Norms That Underpin Violence Against Children in Zimbabwe: Findings and Strategic Planning Document*. Harare: Ministry of Public Services, Labour and Social Welfare. Available online: <https://www.unicef.org/zimbabwe/media/311/file/ADDRESSING%20SOCIAL%20NORMS%20THAT%20UNDERPIN%20VIOLENCE.pdf> (accessed on 18 October 2023).
- GALZ. 2021. LGBTI Violations Report. Available online: <https://galz.org/wp-content/uploads/2022/12/LGBTI-VIOLATIONS-REPORT-1-2.pdf> (accessed on 18 October 2023).
- Global Network of Sex Work Project. 2024. Zimbabwe | Global Network of Sex Work Projects. Available online: <https://www.nswp.org/country/zimbabwe> (accessed on 2 February 2024).
- Gunda, Masiwa Ragies. 2018. The Pentecostal Gospel of Prosperity and the Divisive Nature of Mega-Church Superstar Men of God (Prophets) in Zimbabwe. In *Aspects of Pentecostal Christianity in Zimbabwe*. Edited by Lovemore Togarasei. Cham: Springer International Publishing, pp. 111–24. [CrossRef]
- Hallfors, Denise Dion, Bonita J. Iritani, Lei Zhang, Shane Hartman, Winnie K. Luseno, Elias Mpofo, and Simbarashe Rusakaniko. 2016. "I Thought If I Marry the Prophet I Would Not Die": The Significance of Religious Affiliation on Marriage, HIV Testing, and Reproductive Health Practices among Young Married Women in Zimbabwe. *SAHARA-J: Journal of Social Aspects of HIV/AIDS* 13: 178–87. [CrossRef]
- Idler, Ellen L., ed. 2014. *Religion as a Social Determinant of Public Health*. Oxford: Oxford University Press. [CrossRef]
- Koenig, Harold, Zhizhong Wang, Faten Al Zaben, and Ahmad Adi. 2015. Belief into Action Scale: A Comprehensive and Sensitive Measure of Religious Involvement. *Religions* 6: 1006–16. [CrossRef]
- Lariat, Joni, Webster Mavhu, Thandiwe Mudhumo, Pueshpa Shaba, Sharon Sibanda, Rufaro Mbundure, Carol Wogrin, Abigail Mutsinze, Nicola Willis, and Sarah Bernays. 2024. Leaving No One behind? Addressing Inequitable HIV Outcomes by Attending to Diversity: A Qualitative Study Exploring the Needs of LGBTIQ+ Young People Living with HIV in Zimbabwe. *PLOS Global Public Health* 4: e0002442. [CrossRef] [PubMed]

- Machinga, Madzvita. 2011. Religion, Health, and Healing in the Traditional Shona Culture of Zimbabwe. *Practical Matters Journal* 4: 1–8.
- Mavhu, Webster, Lisa Langhaug, Sophie Pascoe, Jeffrey Dirawo, and Frances Cowan. 2011. A novel tool to assess community norms and attitudes to multiple and concurrent sexual partnering in rural Zimbabwe: Participatory attitudinal ranking. *AIDS Care* 23: 52–59. [CrossRef]
- Medved Kendrick, Haley. 2017. Are Religion and Spirituality Barriers or Facilitators to Treatment for HIV: A Systematic Review of the Literature. *AIDS Care* 29: 1–13. [CrossRef]
- Mhazo, Alison T., and Charles C. Maponga. 2022. The Political Economy of Health Financing Reforms in Zimbabwe: A Scoping Review. *International Journal for Equity in Health* 21: 42. [CrossRef]
- Mugweni, Esther, Stephen Pearson, and Mayeh Omar. 2012. Traditional Gender Roles, Forced Sex and HIV in Zimbabwean Marriages. *Culture, Health & Sexuality* 14: 577–90. [CrossRef]
- Novak, Dan. 2022. With More Girls Pregnant, Zimbabwe Pushes a Return to School. *Voice of America*, January 13.
- Nyoka, Shingai. 2021. Zimbabwe Arrests after Child Bride Dies Giving Birth at Church Shrine. *BBC News*, August 19.
- Nyoni, Bednicho. 2019. *Abundant Life and Basic Needs: African Religions as a Resource for Sustainable Development, with Special Reference to Shona Religion*. Bible in Africa Studies. Bamberg: University of Bamberg Press, Volume 23.
- Pargament, Kenneth, Margaret Feuille, and Donna Burdzy. 2011. The Brief RCOPE: Current Psychometric Status of a Short Measure of Religious Coping. *Religions* 2: 51–76. [CrossRef]
- Parry, Sue. 2008. *Beacons of Hope: HIV Competent Churches: A Framework for Action*. Geneva: WCC Publications, World Council of Churches.
- Parry, Sue. 2013. *Practicing Hope: A Handbook for Building HIV and AIDS Competence in the Churches*. EHAIA Series; Geneva: World Council of Churches Publications.
- Patel, Vikram, E. Simunyu, F. Gwanzura, Glyn Lewis, and Anthony Mann. 1997. The Shona Symptom Questionnaire: The Development of an Indigenous Measure of Common Mental Disorders in Harare. *Acta Psychiatrica Scandinavica* 95: 469–75. [CrossRef]
- Saldaña, Johnny. 2013. *The Coding Manual for Qualitative Researchers*, 2nd ed. Los Angeles: SAGE.
- Shoko, Tabona. 2018. Traditional Herbal Medicine and Healing in Zimbabwe. *Journal of Traditional Medicine & Clinical Naturopathy* 7: 2. [CrossRef]
- Simmons, David S. 2012. *Modernizing Medicine in Zimbabwe: HIV/AIDS and Traditional Healers*. Nashville: Vanderbilt University Press.
- The Herald. 2023. President Honoured as Minister of God. *The Herald*. Available online: <https://www.herald.co.zw/president-honoured-as-minister-of-god/> (accessed on 14 February 2024).
- WHO. 2023. Draft-Who-Well-Being-Framework.Pdf. Available online: https://cdn.who.int/media/docs/default-source/health-promotion/draft-who-well-being-framework.pdf?sfvrsn=259a7c40_5 (accessed on 2 January 2024).
- WHO. 2024. Social Determinants of Health. Available online: <https://www.who.int/health-topics/social-determinants-of-health> (accessed on 31 January 2024).
- Wüthrich-Grossenbacher, Ursula, Abigail Mutsinze, Ursula Wolf, Charles Chiedza Maponga, Nicholas Midzi, Masceline Jenipher Mutsaka-Makuvaza, and Sonja Merten. 2023a. Spiritual and Religious Aspects Influence Mental Health and Viral Load: A Quantitative Study among Young People Living with HIV in Zimbabwe. *BMJ Global Health* 8: e012671. [CrossRef]
- Wüthrich-Grossenbacher, Ursula, Nicholas Midzi, Masceline Jenipher Mutsaka-Makuvaza, and Abigail Mutsinze. 2023b. Religious and Traditional Beliefs and Practices as Predictors of Mental and Physical Health Outcomes and the Role of Religious Affiliation in Health Outcomes and Risk Taking. *BMC Public Health* 23: 2170. [CrossRef]
- ZIMSTAT. 2017. INTER-CENSAL DEMOGRAPHIC SURVEY 2017. Available online: https://www.zimstat.co.zw/wp-content/uploads/publications/Population/population/ICDS_2017.pdf (accessed on 11 January 2023).
- Zinyuke, Rumbidzayi. 2023. Faith Healers Told to Register. *The Herald*. Available online: <https://www.herald.co.zw/faith-healers-told-to-register/> (accessed on 3 February 2024).

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