



NOVA

University of Newcastle Research Online

nova.newcastle.edu.au

O'Brien, Stephen M. "Community mobilisation and HIV activism in Zimbabwe",  
Published in the *Journal of Contemporary African Studies* Vol. 38, Issue 1, p. 138-153  
*Educational Review* (2020).

**Available from:** <http://dx.doi.org/10.1080/02589001.2020.1746747>

This is an Accepted Manuscript of an article published by Taylor & Francis in the *Journal of Contemporary African Studies* on 31/03/2020, available online:  
<http://dx.doi.org/10.1080/02589001.2020.1746747>

**Accessed from:** <http://hdl.handle.net/1959.13/1429962>

# Community mobilisation and HIV activism in Zimbabwe

Stephen M. O'Brien

To cite this article: Stephen M. O'Brien (2020) Community mobilisation and HIV activism in Zimbabwe, *Journal of Contemporary African Studies*, 38: 1, 138-153, DOI: 10.1080/02589001.2020.1746747

To link to this article: <https://doi.org/10.1080/02589001.2020.1746747>

stephen.obrien@newcastle.edu.au

## ABSTRACT

Community mobilisation and activism is thought to encourage HIV testing and treatment and assist patient recovery. This article draws on interviews conducted with 60 people living with, and affected by HIV, in four marginalised areas of Harare, Zimbabwe. The lenses of civil society and social movements are used to analyse how people living with HIV draw on, and construct, systems of support based on the ways in which their communities know and understand the epidemic. I consider how neighbourhoods negotiate and assert community and individual needs in relation to HIV and how such systems can develop into community networks and wider coalitions. The article concludes by positing that, by interrogating official responses to the epidemic, HIV-related activism and social movements can help to domesticate formal commitments to international health protocols and compliance, particularly in terms of the intent, as well as the participatory rhetoric, of health based rights.

## KEYWORDS

Antiretroviral therapy; community mobilisation; HIV; qualitative research; Zimbabwe Social Forum

One of the shifts in the international HIV response in recent years has been a renewed interest in the concept of community. This refocus is related to the increased availability of antiretroviral therapy treatment (ART) and the consequent need for people living with HIV to be identified and start treatment at an earlier stage in their infection (Barr, Amon, and Clayton 2011). Community and activist organisations were among the first to alert people to the realities of the epidemic (Treichler 1999), and to pressure governments to place treatment on national health agendas in countries such as Australia (Power 2011), Brazil (Gómez and Harris 2016), South Africa (Moyle 2015), the United States (Watkins-Hayes 2014) and Zimbabwe (Jackson and Kerkhoven 1995). Following the widespread introduction of biomedical therapies, however, the international AIDS effort shifted to the supply and administration of drug-related technologies (Nguyen et al. 2011). Health planners only then began again to examine the potential of broad community involvement in providing care, generating HIV awareness and reducing treatment costs (Campbell et al. 2010), with the full realisation of the expense involved in supporting patients on ART (Nguyen et al. 2011; Vermund et al. 2012).

The United Nations General Assembly Special Session on HIV/AIDS (UNGASS) which was held in 2000, reflected this new awareness, and the UNGASS declaration referred to public participation and civil society as important elements of a global alliance to eliminate HIV (United Nations 2001). In Zimbabwe, these ideas were mirrored around the same time in the creation of the HIV/AIDS policy and national strategic framework and the 3% AIDS levy on wages to fund HIV programmes, as well as in efforts to involve civic, religious, community and business organisations and people living with HIV in the activities and governance of the National AIDS Council (NAC) (National AIDS Council [NAC] 2004; Bhat et al. 2016).

Participation and civil society are contested concepts, and this article discusses how their varying interpretations are played out and influence the way in which people living with HIV and their communities act collectively and individually to manage the virus and their health. I present unique data which analyses different expressions of collective solidarity, their interconnections and how they relate to broader social movements and the Zimbabwean state. After situating the theoretical and historical context of civil society and social movements in Zimbabwe and outlining the study's methodology, I will draw upon this

study's research data to interrogate the dialectic between HIV-related activism and health based rights and their implications for HIV treatment.

## **Background**

Civil society is a theoretical concept which helps to explain the dynamics underlying HIV-related community mobilisation. If we imagine the 'civil' as the social space beyond the household (Lewis 2002), the interstice between the state and the market (Giddens 2009), the domains of neighbourhoods, churches, clubs and workplaces (Meiksins Wood 1990, 63), or the 'realm of social and political activity' (Neocosmos 2009, 268), it helps us to contextualise and connect the specific sites where people living with HIV seek treatment and support.

In Zimbabwe, where the elites are being reconfigured and consolidating economic/political power, civil society may embody conflict with processes of elite formation and maintenance alongside mainstream liberal and neo-liberal notions about free markets and social order. When intervening in social and economic spheres, therefore, HIV activists face the dilemma of whether to adjust and accommodate to existing structures or organise to challenge them (Hearn 2001). Civil society, the media, the market and ideological/political institutions are all sites of struggle (Ncube 2010), where claimants to political and economic legitimacy seek power through coercion, consent or resignation (Dorman 2001). Such processes are described by Gramsci (1971) as a war of manoeuvre (coercion) and position (ideology) in a battle for social hegemony.

An understanding of conflict as a social driver is relevant in a country such as Zimbabwe where civil society can assume both hegemonic and counter-hegemonic dimensions (Ncube 2010). Social contestations provide the framework where individual agency can give rise to ideas and knowledge and forms of organising which develop movement identities. Eyerman and Jamison (1991, 21) use the term 'movement intellectuals' to develop Gramsci's idea of intellectuals emerging organically out of struggles. Such intellectuals generate ideas, produce knowledge, organise, evaluate and develop identities in a social context of cognitive praxis. This approach helps to conceptualise processes by which activists, such as

people living with HIV, either remain quiescent or change their ways of understanding the social order, break their normal routines and mobilise collectively.

Social structures or the conditions of material existence pattern the routines or habitus of daily life (Bourdieu 2010). If disrupted, these structures can open up the potential for people to influence and reshape these same structures. The new engagements (or interactions) between people and their social environment can generate collective learning and further generate the connections that can drive social movement praxis and agency (Marx 1977 [1888]). Interactions between people and their social environment potentially disrupt socio-cultural practices, develop new technical abilities in activism and, through 'meaning-filled action' (Eyerman and Jamison 1991, 164), generate new expressions of organising.

While social movement theories and approaches have been applied in HIV-related studies, such as those by Campbell and Cornish (2010), Campbell et al. (2011) and Gregson et al. (2011), Grebe (2008, 6) has commented that 'AIDS activism' as such is too narrow to be considered a social movement. However, the range of activism generated by HIV and AIDS (as discussed in this article) is quite diverse, and sociological concepts such as civil society and theories around social movements help us to understand the actions and achievements of HIV activists in Zimbabwe.

### **The problematic of civil society in Zimbabwe**

Civil society in Zimbabwe has been shaped by the colonial period (1890–1980), when colonial powers limited the property, democratic, commercial and other rights of the black majority (McCandless 2011). After independence, though, some political and civil restrictions were retained by the new ruling party, the Zimbabwe African National Union-Patriotic Front (ZANU-PF) (Sachikonye 2011), and independent expressions of civil society such as women's associations and trade unions were not encouraged (Ranchod-Nilsson 2008; Muzondidya 2009). The new Government did invest strongly in education and health (Bond and Manyanya 2003). However, later economic failures related to the introduction of structural adjustment policies undermined these social determinants (Muzondidya 2009). As

unemployment increased and social service spending diminished, community, faith and non-government organisations tried to fill the gaps which emerged in caring for the vulnerable (Batsell and Patterson 2005).

This shift was also reflected in a fall in support for ZANU-PF as civil society became vocal and social movements emerged amongst students and the working class. In response, the state activated its repressive apparatus and, after the Movement for Democratic Change (MDC) was formed in 1999, mobilised its supporters around a redistributive/nationalist discourse (Raftopoulos 2009). These events provide the background to competing claims about representativeness made by civil society groups, for example, war veterans, trade unions and churches (Sachikonye 2011; Helliker 2012) and were reflected in contestations around issues such as the rule of law, property rights, civil liberties, structural adjustment and land reform (Chiroro 2013; McCandless 2011). These debates also underlie the fractures, factions and regrouping that occurred within both ZANU-PF and the MDC (Mazarire 2013; Tendi 2016).

By interpreting the stories of research participants through the lenses of civil society and social movements, this study is unique in that it develops an understanding of some of the underlying dynamics and contributions of community mobilisation and activism around HIV in conflictual states like Zimbabwe. It also adds to the literature on HIV around questions such as the relationship between activism and HIV (Grebe 2008; Burchardt, Patterson, and Rasmussen 2013), the social dynamics that empower community responses (Nhamo, Campbell, and Gregson 2010), power and behaviour (Campbell and Cornish 2010), and social movements (McCandless 2011; de Waal and Ibreck 2013).

## **Methods**

In-depth qualitative interviews were conducted by the author in 2010 in partnership with four locality-based HIV support groups which recruited the research participants from amongst their networks. Each group was based in one of four localities which together provided a cross-section of the lower socio-economic areas of Harare. They included the old inner city (Mbare), the industrial residential (Glenview), the peri-urban informal (Epworth)

and the satellite dormitory (Chitungwiza). These locations are characterised by poverty, intermittent utility services, waterborne diseases and high population density.

The group in locality one was organised as a faith-based fellowship by people who felt that they needed more spiritual, psycho-social and practical/material support than that offered by their regular churches. In locality two, the participants were organised by a long-term HIV activist who was adept at accessing and mobilising accommodation, orphan support, HIV awareness and home-based care (HBC) services. Most of the participants from the third area tended to focus on problems at an individual level, although several were involved in support groups external to their neighbourhood. The respondents interviewed from the fourth locality existed as a network of activists who saw work around stigma and discrimination as the most critical way to respond to the epidemic. All of the groups included people who had been among the first to enrol on ART in Zimbabwe and were further linked through their involvement in the Zimbabwe Social Forum (ZSF).

Through purposive and convenience sampling, respondents were personally invited to join the study on the basis of being affected or infected by HIV. While participants were reimbursed for their travelling costs, they were not otherwise remunerated. Fifteen people from each of the four localities were interviewed: 25 men and 35 women, in sessions that lasted from 45 to 90 min each. The average age of the participants was 39, the youngest being 18 and the oldest 69, with most being aged 31–45. All participants had received at least primary schooling, most had undertaken some level of secondary education and four participants had studied at tertiary level. While participants were not chosen on the basis of their ethnicity, all spoke Shona, the main language of north and eastern Zimbabwe, and were conversant in English. Interpreting was provided where necessary and respondents were given the option of speaking in Shona.

The research design involving qualitative semi-structured interviews was especially useful for exploring lived experience, as it encouraged participants to talk and express meanings and interpretations (Ezzy 2002) in relation to HIV. Out of the research question, 'What is the lived experience of HIV?', I sought to explore four aspects: social stigma; access to treatment; understandings about HIV transmission; and the social and community context in which the participants lived. This article mainly deals with findings pertaining to the latter.

A series of questions or talking points accompanied each aspect, with the purpose of being either introductory, follow-up, probing, specifying or interpreting (Kvale and Brinkmann 2009). In order to minimise potential fear and anxiety regarding HIV status, the interviews were conducted in a trusted space, the offices of a legal aid NGO.

Participants were not directly asked their status in either the recruitment process or the interviews in order to respect the voluntary nature and confidentiality of disclosure. Forty-eight of the 60 participants indicated that they were HIV positive by either discussing their personal health, the circumstances in which they discovered their status or their treatment therapies; and thirty one mentioned that they were enrolled on ART. To further ensure privacy, each person was identified by a unique pseudonym. The interviews were conducted by the author, a researcher with several years' experience in Zimbabwe, and a Shona speaking research assistant. In accordance with a reflexive approach to data gathering (Ezzy 2002), the interview schedule and questions were semi-structured, reviewed on the basis of emerging evidence and tailored to the situation of each participant. The discussions were digitally recorded and transcribed in full. Ethics clearance was obtained from the author's university and the Research Council of Zimbabwe.

During and subsequent to the fieldwork, I systematically appraised the field notes and transcripts and identified central themes, and from these themes applied a series of codes to develop an overall generalised framework for analysis within the interpretative traditions of qualitative research (Ezzy 2002). This methodology, and the various steps that I took to initiate the study (ethics compliance, cultural and language training, and meetings with community leaders etc.), allowed me to conduct this research as one of the few explorations of the lived experience of HIV in Harare, with an appreciation as well of both the study's limitations and potential.

## **Results**

The inductive thematic approach to data gathering and analysis revealed how the participants' responses were shaped by individual biographies and therapeutic possibilities, as well as by the disruption of *habitus* caused by the myriad of HIV-related issues arising



from and shaped by the political and structural environment, civil society and the social networks to which they were linked. In the first section, I focus on those stories which illustrate the impact of HIV on personal and community lives.

### **HIV as personal issue**

As a starting point in the interviews, the participants were asked to talk about how HIV impacted on themselves, their immediate family and their communities. Their accounts confirmed that, for most of the participants, the epidemic shattered old routines:

In the late 1980s we were hearing stories about a new incurable disease that was killing people and those who died weren't body viewed; they were just wrapped in black plastic and put in a coffin and buried like that ... [We only] got a clear idea [of what was happening] in the mid-1990s. (Isaac, male, aged 40, HIV positive)

Most of the people in my locality are out of work, the houses are small and crowded. We have water shortages and poor services so sewerage is all over the place ... With five or 10 people living in one room they face problems of TB, HIV, AIDS and diarrhoea. One loo [toilet] will be used by many people. (Sinai, male, aged 39, HIV positive)

At the end, my sister's child died from HIV; she ... had been messing in her blankets. Another daughter developed sores on her private parts and also died from AIDS in 2008 and she was 22 years ... The other one was 24 and married with two girls and one boy, and they all died as well, one from dehydration, the other infant from vomiting continuously and the third one was born HIV positive. The children passed away in 2001 and the mother in 2004. (Gertrude, female, aged 69, HIV positive)

Various levels of meaning lay within these accounts. Inadequate communication about HIV (Isaac), poor social determinants – unemployment, housing, and sanitation (Sinai), the loss of whole families, particularly women and girls (Gertrude), and the disruption of funeral and cultural practices (Isaac), were typical of participants' stories. As only 10 of the participants had formal employment, the majority of them subsisted by micro trading, bartering or providing services (for example, portage, hairdressing, room-letting and gardening) in places where they found gaps between the state and the market. Such flexible routines are well suited for activism.

Several of the older participants shared Isaac's opinion that they only 'got a clear idea' about HIV in the mid-1990s, a decade after the virus was officially recognised in Zimbabwe, and before the state intensified its HIV coordination in the late 1990s (Fraser et al. 2010). By the year 2000, the plethora of family tragedies similar to those told by Gertrude, along with funerals, awareness campaigns and media reports, are thought to have disrupted normal routines to the extent that Zimbabweans began to talk more openly about HIV and to develop their awareness of the infection (Muchini et al. 2010). These conversations appear to have translated into epidemiologically significant numbers of people having fewer sexual partners and using condoms more effectively (Ibid). Multiple expressions of individual agency thus slowed the spread of the virus to the extent that HIV prevalence fell from around 25% of the adult population in 2000 to 14% in 2010 (Fraser et al. 2010).

It is interesting that these conversations, rather than formal programmes, have been linked to the change in sexual behaviours. Similarly, in this study, participants expressed negative views towards the nation's overall response to HIV and AIDS. The following comments are representative of this general view:

[In 2008] there were shortages of drugs due to the economic crisis ... [Medical staff] would even take advantage of that ... They would take the hospital clinic's tablets and sell them on the street to the people who have money so the poor man [*sic*] when he comes to collect his tablets, there won't be any. A lot of people died during those times. (Jacob, male, aged 41, HIV positive)

NAC is a corrupt institution; they get the AIDS levies and spend all the monies on vehicles and workshops; ... it is supposed to represent us but they are not [doing so]. The culture in this country has been to squander public monies ... instead of buying anti-retroviral [ARVs] or CD4 count machines ... Most of the personnel in NAC are not HIV positive, you see the contradiction there? (David, male, aged 51, HIV positive)

Jacob is referring to the public health crisis which accompanied the social and economic implosion of 2008–2009 and which was temporarily resolved with the Government of National Unity (GNU) between the MDC and ZANU-PF (2009–2013) (Mazarire 2013). David refers to the national coordinating body, the National AIDS Council which, like many parastatal agencies, had lost credibility and was subject to allegations such as those voiced

by David, Jacob and others, as well as in the literature (Rödlach 2006). One of the NAC's early priorities was to establish ward, district and provincial AIDS Action Committees (NAC 2004) which, as this study found, facilitated local interactions between activists which established precedents for later collaborations.

Dissatisfaction also extended to NGOs, and Hazel was one of several participants who expressed frustration with the work of NGOs in the HIV/AIDS sector:

There is still the degree of corruption even within the small [NGOs]. So many HIV-positive people have been complaining of these big guys ... using and making money out of us. But all the same there are genuine organisations that benefit people, although dependency can occur. (Hazel, female, aged 36, HIV positive)

Hazel's mention of dependency is reflected in Nhamo, Campbell, and Gregson's (2010) discussion of agency in HIV-prevention programmes. Her reference to the big guys is also consistent with comments by other scholars such as Skovdal et al. (2011) concerning programme insensitivity and Batsell's (2005) observations in relation to wastage and mis-prioritisation.

Hazel and David's complaints regarding corruption were typical of the participants' negative perceptions of social institutions and the national HIV effort. This demonstrates how HIV can impact on *habitus* by transforming individual perceptions of illness from a personal issue, such as coping with illness and death, to the broader social and political problem of access to care. As the discussion in the next section outlines, such transformations impacted on social and political attitudes and heightened the potential of social movements around HIV.

### **HIV as social problem**

At the time of the interviews, the stabilisation of the economy and the drafting of a new Constitution facilitated space for community activism and organising. Having been early to enrol on ART, many of the participants re-established routines and strategies around managing their condition, and their health had recovered. They extended their networking and HIV praxis by joining and forming support groups in the process of becoming

therapeutic citizens (Nguyen 2005). Their understanding of the social and economic context in which they lived is evident in the ways in which they articulated their needs. Joy (female, aged 45, HIV positive), for example, wanted access to 'a piece of land to farm'; for Ima (female, aged 37, HIV positive), 'employment that brings income to those who are positive' was important, whereas Jacob emphasised 'free education'. Other issues raised which also recall the social determinants of health included pensions like they receive in South Africa – Chris (male, aged 47, HIV positive); 'money to afford a balanced diet' – Mabel (female, aged 41, HIV positive); 'food packs' – Wilbert (male, 45 years, HIV positive); and 'food supplements' – Claudette (female, aged 39, HIV positive). Others expanded the rights agenda:

Support must be from the state, not donors. I mean ARVs, services for orphans who are going to school who have nobody to care for them ... We have [the] national AIDS levy so we shouldn't rely on donors. (Isaac, male, aged 40, HIV positive)

The government ... should also ... assist people to get land, houses to shelter themselves ... so they can't be thrown out of their lodging [for being HIV positive]. (Zachary, male, aged 50, status not declared)

To get more acceptance [for people living with HIV], we need a massive awareness programme from the political leadership ... Politicians, cabinet, judges, bishops, priests. (David, male, aged 51, HIV positive)

The idea that 'the state, not donors' must support orphans, run 'awareness campaigns' and provide drugs challenges neo-liberal assumptions about individual responsibility.

Furthermore, such views imply that deep structural changes are needed to overcome the social inequity that perpetuates and sustains the epidemic and which devastates the lives of the poor (Parker and Aggleton 2003).

The potential for community activism in delivering HIV care in Zimbabwe had been demonstrated when HBC was promoted as an alternative to hospital care early on in the epidemic (Jackson and Kerkhoven 1995). This shift occurred with state clinics either closing or becoming unaffordable due to rising fees (Muzondidya 2009). The out-of-pocket expenses of individual households became the main source of national HIV funding, as per

capita health financing fell to levels as low as US\$0.19 (Mundawarara and Mapanda 2010; Nyazema 2010). With limited international health funding, weak socio-economic and political structures, and a fragile health system (Nyazema 2010), the participants in the study described how they created and activated their own systems of support. Managing the impact of the epidemic on their individual and collective lives gave rise to the ideas, forms of knowledge and methods of organising which took on broad political dimensions as outlined below.

### **HIV as political problem**

When describing where their interactions and conversations occurred, participants mentioned social spaces outside the household such as boreholes, kombi buses, their places of worship, informal market trading areas, sporting events, home based care and community gardening activities, and political meetings. Lucy (female, aged 36, HIV positive) mentioned how neighbours looked out for each other's children, lent each other rent money and gave guidance and advice about managing their health. About 10 of the participants described how they utilised the long waiting times at ART dispensaries and clinics to organise among their peers, discuss their health, evaluate folk remedies and exchange recipes, food and even ARTs.

In terms of self-help projects, Havison (male, aged 47, HIV positive) described how the cooperative he belonged to pooled money to buy foodstuffs and assist 'anyone in need'. Other participants described how their support groups identified sympathetic landlords, made job referrals and discussed 'health problems and diets' (Lucy, female, aged 36, HIV positive). Perhaps the most demanding of the volunteer tasks was that of caring for patients in their homes:

I have five HBC patients. I spend time with each one making sure that they are taking their drugs, getting food, are living in a clean room and maybe offer some counselling. (Luke male, aged 60, HIV negative)

We help out those people who are HIV positive, especially the bedridden. [We show their relatives] how to care for, bathe and feed the sick ... I see five people once or twice a week. (Maria female, aged 42, HIV positive)

Participants explained the ethos behind their volunteering in terms of 'I have passion for working with people' (Joy), 'It makes me happy to see my patients recovering' (Luke) and because 'I had [also] been bedridden' (Sara, female, aged 32, status not declared). Their experiences illustrated how shared interpretations of the social world, such as transitioning from cared to carer, can help frame shared experiences into collective HIV identities (Burchardt, Patterson, and Rasmussen [2013](#)).

Activism which creates independent collective identities consequently potentialises social movement intellectualism which is regarded suspiciously by ZANU-PF. Mabel explained how in 2006 the cooking clubs which her support group had established were shut down following accusations of being an MDC front. According to Wilbert, 'politicians' stopped him from providing meals to HIV-positive orphans during the 2008 cholera outbreak. Stan discussed similar incidents:

In 2008, ZANU-PF closed [the local NGO-run clinic]; ... people went without drugs for about two to three months and a lot people died before the [Minister for Health] intervened. (Stan, male, aged 50, HIV positive)

On a geo-political level, ZANU-PF has defended the ideological terrain on HIV. The party has threatened to curb and bring under 'control' whatever independence NAC was perceived to exercise (ZANU-PF 2004, 133) and was quick to claim credit for the decline in the country's HIV incidence and prevalence (O'Brien and Broom 2010). The party's sensitivity to an energised civil society was also exemplified in the stories several participants told about the Operation Murambatsvina demolitions of 2005. Partly justified by the government as slum clearance in response to HIV (see for example, Chimedza 2008), but mostly perceived as punishment to the urban poor for supporting the opposition (Moore 2018a), the mass demolitions destroyed homes, livelihoods and access to HIV treatment of thousands.

However, these incidents also illustrate the resilience and adaptability of the participants in quickly realigning their community engagement. Most of the participants had entered HIV activism during the heightened land invasions, electoral violence and civil restrictions of 2000–2003 (Raftopoulos 2009). Some, like Wilbert, had evolved from a HBC volunteer to a movement intellectual, as evident in his description of his neighbourhood as an 'opposition

stronghold' where people could 'air their views', 'resist anything' and even carry out 'uprisings'. This description further suggests how collaborations for survival (as sketched above), including sharing tips about food, income opportunities and therapies and so forth, can normalise new daily routines and generate agency around health activism and therapeutic citizenship.

### **Disrupted habitus, agency and reshaping structures**

Most of the participants on ART had been part of the first intake of 8000 public patients in 2004 and were well aware of the ongoing need for treatment therapies and monitoring once enrolled on ART. The resumption of hyperinflation from 2004 made it difficult for the government to maintain logistics associated with operating the programme and thus shortages of ART occurred (Fraser et al. 2010). ART supply was further prejudiced in 2008 when the Reserve Bank appropriated US\$7.3 million of funds set aside by NAC for the purchase of drugs (O'Brien and Broom 2010). Such arbitrariness sparked public protests around the availability of drugs and ancillary treatment as seen in these comments:

We have demonstrated on the street for adequate ARVs so, when anyone thinks there is a shortage, there is an outcry ... At the beginning of this year there was a shortage of ... second line drugs. (Issac)

Nothing tangible is being done by NAC. We used to make demonstrations out of this NAC ... we had meetings with NAC representatives ... but nothing was delivered. (Joy)

We are demanding more CD4 count machines in clinics, wards, hospitals, etc., etc., and for a national HIV card; ... we need to be enrolled on ART when we are still fit and before your CD4 blood cell count goes under 200. (Jacob)

The Chitungwiza ZSF successfully organised people living with HIV and AIDS to come out in the open. (Wilbert)

Participants also demanded 'free health for all' (Jacob), 'earlier ART enrolment' (Wilbert), and 'better medication, free medication' (Byron, male, aged 25, HIV status not declared). These calls demanded that the government meet its formal commitments, such as those made at UNGASS, to allow patients meaningful involvement in their treatment and to

deliver life-saving biomedical therapies. The Zimbabwean state, unlike South Africa at the time (Moyle 2015), actually played an important role in placing access to generic drugs on the agenda in international trade negotiations (Bond and Manyanya 2003). As the Zimbabwe Social Forum (ZSF) was part of the (at that time) influential international anti-globalisation movement, this provided a context in which the state allowed the political space for the ZSF to occur. Hundreds of HIV activists were among the several thousands who attended ZSF gatherings from 2003 to 2011. HIV activists, in particular, used the space to 'come out in the open' (Wilbert), mobilise independently of both the state and political parties, and to articulate demands around treatment and the broad social context in which they experienced HIV (Zimbabwe Social Forum 2004; Bond 2005; Larmer, Dwyer, and Zeilig 2009).

That the ZSF created a safe, collaborative and confidence-building opportunity to contest the hegemony exerted by ZANU-PF over HIV-related civil society was confirmed by Munyaradzi Gwisai, a former ZSF leader (by email to the author on April 9, 2013). In other words, HIV activists of varying backgrounds, who had previously engaged with each other in the district structures of the NAC, were able to again interact with their peers but, this time, on the more neutral terrain of the ZSF. Indications that a more sophisticated HIV movement was emerging was telegraphed by the inclusion of HIV-related demands in the anti-systemic protests which occurred in 2005, just a few months after the dislocations caused by Operation Murumbatsvina (Bomba 2005).

HIV activists reconnected and recombined in a fluid process between ZSF gatherings, which meant that some retained a ZANU-PF framework (such as land reform beneficiaries), some were oriented to NGOs and service provision, while the more critically inclined became involved in the assemblies and debates then occurring around a new Constitution (Gwisai 2011, 2012); still others, though, moved between these different poles. Thus, for several years, the ZSF provided a realm of activity for hundreds of HIV activists in which they organised within larger gatherings of up to several thousand people. These meetings articulated 'economic and social grievance[s], ... service delivery and political alternatives' (Larmer, Dwyer, and Zeilig 2009, 49), and inspired and educated new activists in a wide range of issues, in particular around gender (Zeilig 2010). These new activists also learnt



how to insert issues such as ART shortfalls and state violence into public discourse which at times helped limit state arbitrariness (Larmer 2008).

Nonetheless, as evident in the accounts of Mabel, Wilfred and Stan, if the shifting boundaries between the public and private realms (de Waal and Ibreck 2013) were not expertly navigated, then activism brought vulnerability. In February 2011, for example, police raided the office of the Zimbabwe Labour Centre in Harare (de Waal and Ibreck 2013) and arrested 45 people, a number of whom had participated in this study. After a long court case and an international campaign, the charges against them, which included high treason, were eventually dropped.

Significantly, some of the demands articulated by the participants in the interviews were conceded when the new Constitution of 2013 recognised 'the right to health care' (Republic of Zimbabwe 2013, 46). Similarly, despite the problems and limitations, the ART programme actually increased to reach around half of the 600,000 people clinically in need of treatment by 2010 (NAC and Ministry of Health and Child Welfare 2012). In addition, the lowering of the CD4 count threshold to 200 (as mentioned by Jacob) started to be implemented. In this regard, civil society can play a critical role in developing health interventions (Paxton 2012). Without suggesting a definitive cause and effect relationship, it is worth noting the activist interventions outlined in this study: the advances which occurred around ART and the constitutional right to health coincided with the agenda and demands that partly grew out of the agency, reconfigurations of habitus and new identities of the HIV activists of the 2003–2010 period.

## **Discussion**

This article has explored the efforts made by people living with HIV to confront the reality by which public association with HIV infection is linked to a diminished social role and standing (Parker and Aggleton 2003), and to organise openly so that the full therapeutic potential of HIV treatment technologies are achieved (Barr, Amon, and Clayton 2011). Significantly, despite the perceived failure of 'politicians, cabinet, judges, bishops' to take leadership on HIV, many of the participants in this study have progressed beyond the initial diagnosis of

HIV to understand and manage their condition in a way which recognises the social context in which health is influenced. Their narratives went beyond individual health solutions around diet, adherence and avoiding reinfection etc., to touch on the social determinants that influence health outcomes such as housing, employment, access to care, and education.

Around two-thirds of those interviewed had adopted very public identities as HIV activists. Their self-assurance around their new personas was mostly derived from, and reinforced by, contact with fellow activists, peers and support groups. Engaging with peers in the social milieu of the ZSF involved the mixing of people from different backgrounds with similar problems and solutions (Larmer, Dwyer, and Zeilig 2009; Zeilig 2010). While the four support groups involved in this study had different levels of organisation and sophistication of analysis, their understanding around the needs of people living with HIV and solutions to the epidemic were similarly collaborative.

The reimagining of new identities brought entry into wider networks and access to possibilities to meet and strategise with other like-minded activists. Such alliances could potentially transform personal concerns around HIV (issues relating to culture, stigma and treatment) into broader social and political problems which were in accordance with the state's formal rhetoric of 'health for all' and 'participation'. Nonetheless, this transformation was not without risk. Where such counter-hegemony took on too much of an anti-systemic praxis, it also took on the risk of state counter-responses, as befell participants in this study.

The arrests of 2011 were related to ZANU-PF's nervousness about the possible impacts of the Arab Spring mobilisations then occurring in northern Africa. Furthermore, this can be seen in the context of the election aftermath in 2018 when at least seven people were shot by state security forces (Moore 2018c) just a few months after soldiers and civilians marched in the streets together during the ousting of Mugabe (Moore 2018b). These events once again demonstrate the shifting boundaries between participation (and mobilisation) and the limits set by the state in public and private realms (de Waal and Ibreck 2013). For a certain layer of participants, the opportunity to test boundaries and articulate their own social and economic solutions to Zimbabwe's problems, was a risk worth taking. The emergence of a small, but confident, HIV movement in Zimbabwe in the 2010s, is an

important example of the cognitive praxis that creates the objective and subjective conditions for movement intellectuals to interact with peers and their social environment to develop further advocacy and mobilising abilities.

While resource and structural causes for poor quality health care are not easily overcome, many of the demands the activists put forward were for sophisticated and achievable improvements to the national response to HIV. Effective health communication and meaningful participation, for example, are areas which can be improved without huge expense. The genuine involvement of people living with HIV in their care can improve oversight and effectiveness of programmes. High level, accessible communications by national figures can help address HIV-related stigma. The participants understood that healthy bodies restored through ART need ongoing CD4 counts, blood tests and other biomedical technologies that require long-term targeted commitments from the state. A state approach addressing key social determinants could, for example, include innovative ways to offer income or income generating support for people living with HIV. As an outcome of the dialectic between structure and agency, the emergence of HIV activists (as evident from their stories) created the basis for mobilisations around HIV that were directed towards achieving structural change. Further research will be needed to assess whether the social activists (and the embryonic social movement described above) continue to represent popular concerns or have been co-opted, repressed, or exhausted; or, perhaps, are awaiting the social and political conditions which favour activism to resurface in another form.

Ten years on, the author retains lines of contact with the key HIV movement intellectuals who participated in this study. While HIV prevalence has declined to 13.3% and ART has expanded to reach 84.2% of the total HIV population (Ministry of Health and Child Care and NAC 2018), the resumption of hyperinflation, and the return to political and economic crisis, looms large over the daily concerns and struggles of the HIV infected and affected as well as the movement's intellectuals.

## **Conclusion**

Interpreting stories of HIV activism through the lenses of civil society and social movements can help to develop an understanding of the informal and formal HIV support systems around which people organise and mobilise. The networks created by such activism can generate wider coalition building which can help to domesticate formal commitments to international health protocols and compliance with the intent, as well as the participatory rhetoric, of health based rights. Developing less hierarchical relationships between health systems and their users can not only help to provide better support and care for men and women, but also support the refashioning of HIV positive identities and sustain self-management of care.

### Disclosure statement

No potential conflict of interest was reported by the author(s).

### Note on contributor

**Stephen O'Brien** is a casual academic in the School of Humanities and Social Science at The University of Newcastle, New South Wales, Australia.. His main research interest is the lived experience of HIV. He also teaches Social Policy in the Bachelor of Community Services TAFE NSW Higher Education. He can be contacted at: [stephen.obrien@newcastle.edu.au](mailto:stephen.obrien@newcastle.edu.au).

### References

1. Barr, David, Joseph Amon, and Michaela Clayton. 2011. "Articulating a Rights-Based Approach to HIV Treatment and Prevention Interventions." *Current HIV Research* 9 (6): 396–404. doi:[10.2174/157016211798038588](https://doi.org/10.2174/157016211798038588)
2. Batsell, Jake. 2005. "AIDS, Politics, and NGOs in Zimbabwe." In *The African State and the AIDS Crisis*, edited by Amy S. Patterson, 59–78. Burlington, VT: Ashgate.
3. Bhat, Nisha, Peter Kilmarx, Freeman Dube, Albert Manenji, Medelina Dube, and Tapuwa Magure. 2016. "Zimbabwe's National AIDS Levy: A Case Study." *SAHARA-J: Journal of Social Aspects of HIV/AIDS* 13 (1): 1–7. doi:[10.1080/17290376.2015.1123646](https://doi.org/10.1080/17290376.2015.1123646)
4. Bomba, Briggs. 2005. "My Four Days Inside Mugabe's Prisons." *Kubatana*. Accessed April 29,

2014. [https://www.kubatana.net/html/archive/opin/051125bb.asp?sector=opin&year=2005&range\\_start=1](https://www.kubatana.net/html/archive/opin/051125bb.asp?sector=opin&year=2005&range_start=1).

5. Bond, Patrick. 2005. "Zimbabwe's Hide and Seek with the IMF: Imperialism, Nationalism and the South African Proxy." *Review of African Political Economy* 32 (106): 609–619. doi:[10.1080/03056240500467104](https://doi.org/10.1080/03056240500467104).
6. Bond, Patrick, and Masimba Manyanya. 2003. *Zimbabwe's Plunge. Exhausted Nationalism, Neo-Liberalism and the Search for Social Justice* (2nd ed.). Scottsville. London. Harare: University of Natal Press; The Merlin Press; Weaver Press.
7. Bourdieu, Pierre. 2010. *Outline of a Theory of Practice*. Cambridge: Cambridge University Press.
8. Burchardt, Marian, Amy Patterson, and Louise Rasmussen. 2013. "The Politics and Anti-Politics of Social Movements: Religion and HIV/AIDS in Africa." *Canadian Journal of African Studies* 47 (2): 171–185. doi:[10.1080/00083968.2013.829936](https://doi.org/10.1080/00083968.2013.829936).
9. Campbell, Catherine, and Flora Cornish. 2010. "Towards a 'Fourth Generation' of Approaches to HIV/AIDS Management: Creating Contexts for Effective Community Mobilisation." *AIDS Care* 22 (Suppl. 2): 1569–1579. doi:[10.1080/09540121.2010.525812](https://doi.org/10.1080/09540121.2010.525812).
10. Campbell, Catherine, Yugi Nair, Sbongile Maimane, and Andrew Gibbs. 2010. "Strengthening Community Responses to AIDS: Possibilities and Challenges." In *HIV/AIDS in South Africa 25 Years On: Psychosocial Perspectives*, edited by Poul Rohleder, Leslie Swartz, Seth Kalichman, and Leickness Simbayi, 221–235. New York, NY: Springer.
11. Campbell, Catherine, Kerry Scott, Mercy Nhamo, Kate Morley, Constance Nyamukapfema, Claudius Madanhire, Morten Skovdal, Lorraine Sherr, and Simon Gregson. 2011. *Social Capital and AIDS Competent Communities: Evidence from Eastern Zimbabwe*. London, UK: The London School of Economics and Political Science.
12. Chimedza, Tinashe. 2008. "Bulldozers Always Come: 'Maggots', Citizens and Governance in Contemporary Zimbabwe." In *The Hidden Dimensions of Operation Murambatsvina*, edited by Maurice Vambe, 87–102. Harare: Weaver Press.
13. Chiroro, Bertha. 2013. "Turning Confrontation Into Critical Engagement: The Challenge of the Inclusive Government to Zimbabwean Civil Society." In *The Hard*

*Road to Reform: The Politics of Zimbabwe's Global Political Agreement*, edited by Brian Raftopoulos, 117–141. Harare: Weaver Press.

14. de Waal, Alex, and Rachel Ibreck. 2013. "Hybrid Social Movements in Africa." *Journal of Contemporary African Studies* 31 (2): 303–324.  
doi:[10.1080/02589001.2013.781320](https://doi.org/10.1080/02589001.2013.781320).
15. Dorman, Sara. 2001. "Inclusion and Exclusion: NGOs and Politics in Zimbabwe." PhD, University of Oxford, Oxford. <https://www.era.lib.ed.ac.uk/handle/1842/493>.
16. Eyerman, Ron, and Andrew Jamison. 1991. *Social Movements: A Cognitive Approach*. University Park, PA: Pennsylvania State University Press.
17. Ezzy, Douglas. 2002. *Qualitative Analysis Practice and Innovation*. Crow's Nest, NSW: Allen and Unwin.
18. Fraser, Nicole, Allison Herling Ruark, Marelize Gorgens, Victoria James, Amos Milanzi, Mark Colvin, Helen Ibbetson, Nomasomi Mpofu, and Masauso Nzima. 2010. *Zimbabwe: Analysis of HIV Epidemic, Response and Modes of Transmission*. Harare: Republic of Zimbabwe.
19. Giddens, Anthony. 2009. *Introduction to Sociology*. Cambridge: Polity.
20. Gómez, Eduardo, and Joseph Harris. 2016. "Political Repression, Civil Society and the Politics of Responding to AIDS in the BRICS Nations." *Health Policy and Planning* 31 (1): 56–66. doi:[10.1093/heapol/czv021](https://doi.org/10.1093/heapol/czv021).
21. Gramsci, Antonio. 1971. *Selections from the Prison Notebooks of Antonio Gramsci*. London: Lawrence and Wishart.
22. Grebe, Eduard. 2008. *Networks of Influence: A Theoretical Review and Proposed Approach to AIDS Treatment Activism*. Cape Town: University of Cape Town.
23. Gregson, Simon, Phyllis Mushati, Harry Grusin, Mercy Nhamo, Christina Schumacher, Morten Skovdal, Constance Nyamukapa, and Catherine Campbell. 2011. "Social Capital and Women's Reduced Vulnerability to HIV Infection in Rural Zimbabwe." *Population and Development Review* 37 (2): 333–359.  
doi:[10.1111/j.1728-4457.2011.00413.x](https://doi.org/10.1111/j.1728-4457.2011.00413.x).
24. Gwisai, Munyaradzi. 2011. "Political and Economic Crisis: A Luta Continua." *Rosa Luxemburg Stiftung*, 4. Accessed April 29, 2014. [https://www.rosalux.co.za/wp-content/files\\_mf/zimbabwe\\_political\\_economiccrisis4\\_2011ip.pdf](https://www.rosalux.co.za/wp-content/files_mf/zimbabwe_political_economiccrisis4_2011ip.pdf).

25. Gwisai, Munyaradzi. 2012. *The Zimbabwe COPAC Draft Constitution and What It Means for Working People and Democracy*. Harare: Zimbabwe Labour Centre.
26. Hearn, Julie. 2001. "The 'Uses and Abuses' of Civil Society in Africa." *Review of African Political Economy* 28 (87): 43–53. doi:[10.1080/03056240108704502](https://doi.org/10.1080/03056240108704502)
27. Helliker, Kirk. 2012. "Civil Society and State-Centred Struggles." *Journal of Contemporary African Studies* 30 (1): 35–47. doi:[10.1080/02589001.2012.641723](https://doi.org/10.1080/02589001.2012.641723).
28. Jackson, Helen, and R. Kerkhoven. 1995. "Developing AIDS Care in Zimbabwe: A Case for Residential Community Centres?" *AIDS Care* 7 (5): 663–686. doi:[10.1080/09540129550126317](https://doi.org/10.1080/09540129550126317).
29. Kvale, Steinar, and Svend Brinkmann. 2009. *InterViews: Learning the Craft of Qualitative Research Interviewing*. Los Angeles, CA: Sage Publications.
30. Larmer, Miles. 2008. "The Zimbabwe Arms Shipment Campaign." *Review of African Political Economy* 35 (117): 486–493. doi:[10.1080/03056240802411198](https://doi.org/10.1080/03056240802411198).
31. Larmer, Miles, Peter Dwyer, and Leo Zeilig. 2009. "Southern African Social Movements at the 2007 Nairobi World Social Forum." *Global Networks* 9 (1): 41–62. doi:[10.1111/j.1471-0374.2009.00241.x](https://doi.org/10.1111/j.1471-0374.2009.00241.x).
32. Lewis, David. 2002. "Civil Society in African Contexts: Reflections on the Usefulness of a Concept." *Development and Change* 33 (4): 569–586. doi:[10.1111/1467-7660.00270](https://doi.org/10.1111/1467-7660.00270).
33. Marx, Karl. 1977 (1888). "Theses on Feuerbach." In *Karl Marx and Frederick Engels: Selected Works in Three Volumes*. Vol. 1. edited by Institute of Marxism Leninism, 13–97. Moscow: Progress Publishers. (Orig pub. 1888). .
34. Mazarire, Gerald. 2013. "ZANU-PF and the Government of National Unity." In *The Hard Road to Reform: The Politics of Zimbabwe's Global Political Agreement*, edited by Brian Raftopoulos, 71–116. Harare: Weaver Press..
35. McCandless, Erin. 2011. *Polarization and Transformation in Zimbabwe: Social Movements, Strategy Dilemmas, and Change*. Lanham, MD: Lexington Books..
36. Meiksins Wood, Ellen. 1990. "The Uses and Abuses of 'Civil Society.'" *Socialist Register* 26: 60-84...
37. Ministry of Health and Child Care, and National AIDS Council. 2018. *Zimbabwe National and Sub-National HIV Estimates Report 2017*. Harare: NAC and Ministry of Health and Child Welfare. .

38. Moore, David. 2018a. "Reading Zimbabwe Internationally: Little Errors." *Larger Truths. South African Journal of International Affairs* 25 (2): 263–272. doi:[10.1080/10220461.2018.1474379](https://doi.org/10.1080/10220461.2018.1474379).
39. Moore, David. 2018b. "A Very Zimbabwean Coup: November 13–24, 2017." *Transformation: Critical Perspectives on Southern Africa* 97: 1–29. doi:[10.1353/trn.2018.0009](https://doi.org/10.1353/trn.2018.0009).
40. Moore, David. 2018c. "Zimbabwe: A Future Finely Balanced Between Democracy and Militarisation." *The Conversation*. Accessed December 6, 2018. <https://theconversation.com/zimbabwe-a-future-finely-balanced-between-democracy-and-militarisation-102214>.
41. Moyle, Didi. 2015. *Speaking Truth to Power: The Story of the AIDS Law Project*. Auckland Park: Jacana Media.
42. Muchini, Backson, Clemens Benedikt, Simon Gregson, Exnevia Gomo, Rekopantswe Mate, Owen Mugurungi, Tapuwa Magure, Bruce Campbell, Karl Dehne, and Daniel Halperin. 2010. "Local Perceptions of the Forms, Timing and Causes of Behavior Change in Response to the AIDS Epidemic in Zimbabwe." *AIDS and Behavior* 15 (2): 487–498. doi:[10.1007/s10461-010-9783-z](https://doi.org/10.1007/s10461-010-9783-z).
43. Mundawarara, Tinashe, and Bekezela Mapanda. 2010. *Corruption Burns Universal Access*. Harare: Zimbabwe Lawyers for Human Rights.
44. Muzondidya, James. 2009. "From Buoyancy to Crisis, 1980–1997." In *Becoming Zimbabwe: A History from the Pre-Colonial Period to 2008*, edited by Brian Raftopoulos and Alois Mlambo, 167–200. Harare: Weaver Press.
45. National AIDS Council. 2004. *The Story So Far: 2000–2004 Zimbabwe*. Harare: NAC.
46. National AIDS Council, and Ministry of Health and Child Welfare. 2012. *Overview of the State of the HIV Treatment and Care Programme in Zimbabwe*. Harare: NAC and Ministry of Health and Child Welfare.
47. Ncube, Cornelias. 2010. "Contesting Hegemony: Civil Society and the Struggle for Social Change in Zimbabwe, 2000–2008." PhD, University of Birmingham, Birmingham.
48. Neocosmos, Michael. 2009. "Civil Society, Citizenship and the Politics of the (Im)Possible: Rethinking Militancy in Africa Today." *Interface: A Journal for and About Social Movements* 1 (2): 263–234.



49. Nguyen, Vinh-Kim. 2005. "Antiretroviral Globalization, Biopolitics and Therapeutic Citizenship." In *Global Assemblages: Technology, Politics, and Ethics as Anthropological Problems*, edited by Aihwa Ong and Stephen J. Collier, 124–144. Malden, MA: Blackwell Publishing.
50. Nguyen, Vinh-Kim, Nathalie Bajos, Françoise Dubois-Arber, Jeffrey O'Malley, and Catherine Pirkle. 2011. "Remedicalizing an Epidemic: From HIV Treatment as Prevention to HIV Treatment is Prevention." *AIDS* 25 (3): 291–293. doi:[10.1097/QAD.0b013e3283402c3e](https://doi.org/10.1097/QAD.0b013e3283402c3e).
51. Nhamo, Mercy, Catherine Campbell, and Simon Gregson. 2010. "Obstacles to Local-Level AIDS Competence in Rural Zimbabwe: Putting HIV Prevention in Context." *AIDS Care* 22 (2): 1662–1669. doi:[10.1080/09540121.2010.521544](https://doi.org/10.1080/09540121.2010.521544).
52. Nyazema, Norman. 2010. "The Zimbabwe Crisis and the Provision of Social Services: Health and Education." *Journal of Developing Societies* 2 (2): 233–261. doi:[10.1177/0169796x1002600204](https://doi.org/10.1177/0169796x1002600204).
53. O'Brien, Stephen, and Alex Broom. 2010. "The Prevalence and Politics of HIV/AIDS in Zimbabwe: Examining the Ideological, Political and Historical Factors Behind the 'Decline'." *Politikon* 37 (2–3): 309–328. doi:[10.1080/02589346.2010.530448](https://doi.org/10.1080/02589346.2010.530448).
54. Parker, Richard, and Peter Aggleton. 2003. "HIV and AIDS-Related Stigma and Discrimination: A Conceptual Framework and Implications for Action." *Social Science & Medicine* 57 (1): 13–24. doi:[10.1016/S0277-9536\(02\)00304-0](https://doi.org/10.1016/S0277-9536(02)00304-0).
55. Paxton, Nathan. 2012. "Political Science(s) and HIV: A Critical Analysis." *Contemporary Politics* 18 (2): 141–155.
56. Power, Jennifer. 2011. *Movement, Knowledge, Emotion: Gay Activism and HIV/AIDS in Australia*. Acton: ACT: ANU E Press.
57. Raftopoulos, Brian. 2009. "The Crisis in Zimbabwe, 1998–2008." In *Becoming Zimbabwe: A History from the Pre-Colonial Period to 2008*, edited by Brian Raftopoulos and Alois Mlambo, 201–232. Harare: Weaver Press.
58. Ranchod-Nilsson, Sita. 2008. "Gender Politics and Gender Backlash in Zimbabwe." *Politics and Gender* 4 (4): 642–652. doi:[10.1017/S1743923X08000524](https://doi.org/10.1017/S1743923X08000524).
59. Republic of Zimbabwe. 2013. *Constitution of Zimbabwe*. Harare, Republic of Zimbabwe. Accessed December 23,

2013. <https://www.sokwanele.com/documents/constitution-zimbabwe-final-draft-1-february-2013/03022013>.
60. Rödlach, Alexander. 2006. *Witches, Westerners, and HIV: AIDS and Cultures of Blame in Africa*. Walnut Creek, CA: Left Coast Press.
  61. Sachikonye, Lloyd. 2011. *When a State Turns on its Citizens: 60 Years of Institutionalised Violence in Zimbabwe*. Harare: Weaver Press.
  62. Skovdal, Morten, Catherine Campbell, Claudius Madanhire, Zivai Mupambireyi, Constance Nyamukapa, and Simon Gregson. 2011. "Masculinity as a Barrier to Men's Use of HIV Services in Zimbabwe." *Globalization and Health* 7 (13): 1–14.  
doi:[10.1186/1744-8603-7-13](https://doi.org/10.1186/1744-8603-7-13).
  63. Tendi, Blessing-Miles. 2016. "State Intelligence and the Politics of Zimbabwe's Presidential Succession." *African Affairs* 115 (459): 203–224.  
doi:[10.1093/afraf/adv074](https://doi.org/10.1093/afraf/adv074).
  64. Treichler, Paula. 1999. *How to Have Theory in an Epidemic: Cultural Chronicles of AIDS*. Durham: Duke University Press.
  65. United Nations. 2001. *Declaration of Commitment on HIV/AIDS. United Nations General Assembly Special Session on HIV/AIDS 25–27 June 2001*. New York: United Nations.
  66. Vermund, Sten, Mohsin Sidat, Lori Weil, José Tique, Troy Moon, and Philip Ciampa. 2012. "Transitioning HIV Care and Treatment Programs in Southern Africa to Full Local Management." *AIDS* 26 (10): 1303–1310.  
doi:[10.1097/QAD.0b013e3283552185](https://doi.org/10.1097/QAD.0b013e3283552185).
  67. Watkins-Hayes, Celeste. 2014. "Intersectionality and the Sociology of HIV/AIDS: Past, Present, and Future Research Directions." *Sociology* 40: 431–457.
  68. Zeilig, Leo. 2010. "Zimbabwe: Struggle, Dictatorship and the Response of the Social Movements." *Links International Journal of Socialist Renewal*. Accessed December 1, 2018. <https://links.org.au/node/1768>.
  69. Zimbabwe African National Union-Patriotic Front. 2004. *Central Committee Report to the Fourth National People's Conference*. Harare: ZANU-PF.
  70. Zimbabwe Social Forum. 2004. "Access to HIV/AIDS/Global Fund." *Zim Forum Speak* 8 (1): 9. Accessed December 23, 2013. <https://www.actionaid.dk/sw30000.asp>.

