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MAKING AND UNMAKING BONDS: HUMANITARIANISM, LOCAL POLITICS AND PEACEBUILDING IN SOUTHEASTERN ZIMBABWE, 1988 TO 1992.

ABSTRACT

For a long time, perspectives of governments, civil societies and humanitarian organisations have overshadowed the voices of host communities during humanitarian emergencies. In a few instances where literature mentions host communities, they are often portrayed as homogenous groups that share similar views and attitudes towards those in need of assistance. In this article, I draw from host-refugee interactions to argue for the incorporation of local voices in civil society and humanitarianism studies and to illustrate the need to disaggregate host communities and pay attention to local politics during interventions. The influx of thousands of migrants from different countries and ethnic groups, changes the environment of the host community positively and negatively. Often, initial benevolence gives way to hostility as resource scarcities and insecurities arise. When this happens, it creates an environment of suspicion, blame, and stigma, which negatively impacts relations and cohesion between the two groups. Paying attention to local residents' diverse perspectives during humanitarian emergencies may contribute to conflict prevention and peacebuilding.

Keywords: *Humanitarianism, social cohesion, host differentiation, refugees, peacebuilding, narratives, Chilonga, Zimbabwe*

1. INTRODUCTION

Using narratives and newspapers, this article explores the views and interpretations of host communities following a disease outbreak that killed nearly 200 Mozambican refugees in Chambuta camp, located on Zimbabwe's southeastern border with Mozambique, in August 1992. Since the 1980s, humanitarianism literature, particularly that on refugees and displacement, has largely focused on the suffering of refugees.[1] Barbara Harrell Bond's book especially explored the Ugandan refugee assistance in Southern Sudan and showed how relief organisations failed to, "listen to refugees who were progressively understood in literature as victims unable to fend for themselves".[2] In the 1990s, Liisa Maalki's work on Hutu refugees from Burundi living in Tanzania similarly indicated how refugees suffered in silence. Narratives of refugees suffering were further strengthened by medical humanities scholars between the 1980s and 1990s as new forms of media and technology made certain kinds of suffering visible during the famine in Ethiopia and the Rwandan genocide.[3] As Maalki demonstrated, "the suffering body of the refugee held particular importance in the camps because it was seen by humanitarians as providing a more reliable account of experience than a refugee's stories or words".[4] The refugee's suffering body became a prime object of investigation aimed at influencing more effective interventions in humanitarian spaces, especially in refugee camps.[5] This way of seeing put more emphasis on the refugees and significantly undermined the negative and unintended consequences of humanitarian interventions on host communities.

Over the past decade, scholars such as Michel Agier and Ilana Feldman have embarked on understanding the unintended consequences of humanitarianism as well as teasing out new meanings of the political in

1 BE Harrell-Bond, *Imposing aid: Emergency relief to refugees* (Oxford: Oxford University Press, 1986); L Malkki, *Purity and exile: Violence, memory, and national cosmology among Hutu refugees in Tanzania* (Chicago: Chicago University Press, 1995); L Malkki, "Speechless emissaries: refugees, humanitarianism, and dehistoricization", *Cultural Anthropology* 11 (3), 1996, pp. 377-404; L Malkki, *The need to help: The domestic arts of international humanitarianism* (Durham: Duke University Press, 2015); KL Jacobsen, "Making design safe for citizens: A hidden history of humanitarian experimentation", *Citizenship Studies* 14 (1), 2010, pp. 89-103; G Coleman , "Hacker politics and publics", *Public Culture* 23 (3), 2011, pp. 511-616.

2 BE Harrell-Bond, *Imposing aid,* p. xii.

3 M Ticktin, "Transnational humanitarianism," *Annual Review of Anthropology* 43, 2014, p. 276.

4 Malkki, "Speechless emissaries", p. 384.

5 J Robbins, "Beyond the suffering subject: Toward an anthropology of the good", *Journal of the Royal Anthropological Institute*, 19, 2013, pp. 447-462.

and around humanitarian spaces.[6] Using their work as intellectual scaffolding, this paper extends the argument that refugee camps are not exceptional and isolated humanitarian spaces, set apart from the ordinary spaces of life or host communities. Their set-up and function, in some cases, unintentionally create social and political complexities as well as hostile environments in and around them. As such, there has been a notable scholarly shift in literature, which reveals an increased interest in the welfare of host populations of late. Scholars such as Feldman have stressed the need to mainstream service delivery and ensure that the host population benefits significantly from the services that humanitarian organisations provide.[7] This argument is more discernible in refugee studies which claim that such an approach harnesses the potential of refugees, discourages parallel service delivery and encourages social cohesion.[8] In eastern Zimbabwe, for instance, this approach has resulted in, "cordial relations, peaceful co-existence and cooperation among Tongogara camp refugees and their hosts".[9] Veronika Fajth et al have shown that economic interaction fostered trust between Congolese refugees and their hosts in Rwanda.[10] In Cameroon, the health delivery system improved with the presence of refugees.[11] However, I argue that despite the existence of these works, less attention has been paid to host communities' own voices on how they comprehend various challenges resulting from humanitarian emergencies. The majority of humanitarianism works that discuss host communities' needs and challenges largely present a technocratic and romanticised view of the community as a single unit, homogenous, equal, undifferentiated, and accommodative of refugees.

This paper challenges this view by examining how a disease outbreak at Chambuta refugee camp in southeastern Zimbabwe in 1992 created

6 M Agier, "Humanity as an identity and its political effects (A note on camps and humanitarian government)", *Humanity* 1 (1), 2010, pp. 29-45; I Feldman, "The humanitarian condition: Palestinian refugees and the politics of living", *Humanity* 3 (2), 2012, pp. 155-172.

7 S Feldman, "Development assisted integration: A viable alternative to long-term residence in camps?" *PRAXIS, The Fletcher Journal of Human Security* 12, 2007.

8 I Idris, *Effectiveness of various refugee settlement approaches,* K4D Helpdesk Report 223 (Brighton: Institute of Development Studies, 2017).

9 J Mhlanga and GA Muchinako, "Burdens or benefits: A critical analysis of the nexus between refugees and host communities in Zimbabwe", *Human Ecology* 60, 2017, pp. 2-3.

10 V Fajth *et al*, "How do refugees affect social life in host communities? The case of Congolese Refugees in Rwanda," *Comparative Migration Studies*, 7 (33), 2019.

11 L Tatah *et al.*, "Impact of refugees on local health systems: A difference in differences analysis in Cameroon", *PLoS One* 11 (12), 2016.

an enduring resentment of refugees in the surrounding host communities. Beth Elise Whitaker calls for a disaggregation of the host community based on gender, class and age.[12] Updating Whitakers' concept of host community heterogeneity, this article makes an empirical and methodological contribution by considering the importance of incorporating local voices in humanitarianism studies. I emphasise why it is essential to disaggregate the host community and pay attention to local politics. More significantly, I reflect on how incorporating local voices reframes debates on humanitarianism. By focusing on local narratives of host communities' experiences, perspectives and attitudes towards refugees and epidemic disease, this article addresses the fundamental assumptions about relations between affected populations and their hosts as well as humanitarian interventions in emergency situations. I further argue that paying attention to local residents' diverse perspectives during humanitarian emergencies may contribute to conflict prevention and peacebuilding between refugees and host communities.

This research places people at the centre of analysis by drawing from their narratives of disease to demonstrate the importance of understanding local politics during humanitarian crises. I carried out 18 in-depth interviews with villagers, village heads, health personnel and former refugees in Chilonga between September and December 2020. My informants in Chilonga have been threatened with eviction by the government, which intends to displace them for a Lurcene grass irrigation project since 2019.[13] Therefore, interviews were conducted in a tense environment with heavy intelligence and military presence. This affected the recruitment of participants as some people feared for their lives. However, in other instances, the imminent eviction evoked memories about the earlier displacement of locals when the refugee camp was established and therefore yielded more information for this study. Although plagued by memory loss and exaggeration, in-depth interviews proved critical in showing variations in what hosts think about the refugees, displacement, diseases and drought. Most interestingly, interviews also reveal a differentiated and unequal host community, divided along clan and socio-economic lines.

I also consulted newspaper reports on Mozambican refugees at the Herald House Library in Harare during the same period. The various newspaper reports provide the Zimbabwean government's perspectives on the refugees as well as details on camp construction, administration, refugee influx, disease outbreaks, public health interventions, foreign aid, alleged corruption and misuse of donated goods by government officials. Ideally,

12 BE Whitaker, "Refugees in Western Tanzania: The distribution of burdens and benefits among local hosts", *Journal of Refugee Studies* 15 (4), 2002.

13 *New Zimbabwe*, 7 June 2020.

archival material produced by the Department of Social Welfare would have yielded more information on administration, logistics, refugee statistics and epidemiology, but government documents from the 1990s are closed and, therefore, inaccessible to the public. Furthermore, the Ministry of Health's public health annual reports for the period under study are surprisingly silent on the public health situation in refugee camps. I, therefore, rely on newspaper reports for statistics regarding the inflow of refugees and disease epidemiology which makes it difficult to establish solid demographic and epidemiological patterns.

Notwithstanding these limitations, a comparison of interviews and newspapers reveals different stories about the disease outbreak. The government and its partners viewed the disease outbreak as a purely public health crisis occurring during the emergency phase of a humanitarian crisis. The link between refugee conditions and the threat of diseases is well established in historical, medical and anthropological literature. Scholars have explored, at length, how population movements are related to disease occurrence among refugee communities, which have emerged because of socio-political factors such as wars, civil strife and famine. Refugees and internally displaced populations are particularly vulnerable to the risk of disease as the camps in which they live are often poor and a result of complex humanitarian emergencies.[14] Cholera, measles and meningitis account for 75 per cent of epidemics in refugee camps, as conflict and displacement concomitantly increase population vulnerability and reduce the system's response capacity. Overcrowding, poor water and sanitation conditions, lack of vaccines, delayed diagnosis and reduced access to treatment often lead to the increased occurrence, severity and case fatality of infectious disease.

On the other hand, local residents' comprehension of public health remains characterised by complex intersections between biomedical and indigenous notions of disease, the body and the environment. Local residents identify both sanitary and spiritual causes of the disease outbreak. Some blame the refugees for poor sanitation, while others view the diseases as a curse from the ancestors over the unjustified displacement of local families paving the way for the construction of the refugee camp. In addition, some community members also believe that their ancestors were unhappy with the presence of the Barwe refugees, an ethnic group that they believed to be made up of cannibals and witches.

By using narratives and perceptions of both refugees and host communities, this article reflects on the politics of voice and representation

14 M Rowland and F Nosten, "Malaria epidemiology and control in refugee camps and complex emergencies", *Annals of the Tropical Medicine and Parasitology* 95 (8), 2001.

in history. It allows us to understand local interpretations of displacement, the occurrence of diseases, and interventions, thus informing humanitarianism policies from below. The policy implications are clear. Policymakers and practitioners need to be aware of these perspectives and establish alliances with local communities. For instance, while there are significant efforts to understand the disease problems of refugees, awareness campaigns regarding diseases associated with refugees should be included in health education among host communities to prepare them and allay unnecessary anxieties and avert blame and othering. Although this may not immediately eliminate "false" notions, it may at least bridge the various explanatory models and encourage cohesion between the two groups. Furthermore, I emphasise the need to pay attention to cleavages within host communities, be they ethnic, political, clan or socio-economic. Governments tend to narrowly consult villagers and local authorities, if they do at all, prior to launching intervention strategies. Yet, the success of interventions hinges on the attitude of local communities. Local voices are indispensable in intervention processes.

The first section of the article shows that initially, the host community and the refugees established mutual relations based on a shared ethnic identity and refugee experiences despite the subsequent displacement of several families from the campsite. The penultimate section discusses the refugee influx that led to the disease outbreak at the Chambuta refugee camp. The last section examines how the disease outbreak changed the attitude of most members of the host community from initial kindness to hostility. It explores alternative causal explanations of the disease outbreak as understood by local residents and considers what the majority of the hosts view as long-term impacts of refugee presence on their land.

2. MAKING BONDS: SHARED IDENTITIES, EXPERIENCES, AND DEVELOPMENT

From the early 1980s, Mozambican refugees became an integral part of Zimbabwean communities along the Zimbabwe-Mozambique border. Commonly identified by Zimbabweans as *makarushu*, a derogatory name derived from the cashew nuts plantations of Mozambique, the refugees self-settled in local villages and worked on farms along the scarcely populated border. Some refugees spontaneously settled among their Zimbabwean relatives along the border areas. Other refugees chose to live in camps strategically located along the border. Njakeni Zumo, a former Mozambican refugee, moved with her family to Zimbabwe and self-settled in Chikombedzi,

a rural area on the southeastern border, in 1980. “I gave birth to my first child the year that Robert Mugabe came to power. I think others who followed from Mozambique came later when my child was four or five years old. People who came from Mozambique first settled in local villages for many years. This was just bush, so we just settled without seeking any approval from Zimbabwe government authorities”.[15] Her family lived in Chikombedzi for many years. During the 1992 drought, most of the refugees left for the refugee camps where the Zimbabwean government promised to look after them. But some did not go into camps; they continued to live in the villages.

The Zimbabwean government had established four refugee camps along the Mozambican border to accommodate asylum seekers fleeing from the Mozambican civil war, which had left houses burnt, food stolen, and people mutilated, kidnapped or dead.[16] These camps were Tongogara, Nyangombe, Nyamakiti and Mazoe River Bridge. The steady stream of refugees surged in 1987 when the war intensified. The Zimbabwean government established a fifth camp in 1988 to accommodate the tens of thousands of refugees in transit to bigger camps such as Tongogara. This camp was Chambuta, located in the Chilonga communal area along the southeastern border with Mozambique. Njakeni and her family moved from Chikombedzi to Chambuta refugee camp in 1992. They heard that there were trucks fetching Mozambicans to refugee camps, and they decided to go to Chambuta, leaving their crops in the fields before harvesting.[17]

The Chambuta camp derives its name from the Chambuta family, who heads one of the several villages under the Masuamele chieftainship. When searching for land on which to settle the refugees, government officials consulted the Chambuta village head, who then identified and allocated the piece of land where the camp was constructed. It is however important to note at this point that this piece of land was located on the boundary of the Chambuta village under the Masuamele chieftainship and the Velemu village of the Chilonga chieftainship. Officially, the land fell under the jurisdiction of the Velemu village head and the Chilonga chieftainship. Consequently, upon camp construction, several families from Velemu village were displaced while

15 Interview: Author with Njakeni Zumo, Former Mozambican Refugee, Pfuveni Village, Chilonga, Zimbabwe, 15 October 2020.

16 L Hultman, “The power to hurt in civil war: The strategic aim of RENAMO violence”, *Journal of Southern African Studies* 35 (4), 2009; CC Kelso, “Turning the Refugee Tide”, *Cultural Survival Quarterly Magazine*, 17 (1), 2010, available on-line at https://www.culturalsurvival.org/publications/cultural-survival-quarterly/turning-refugee-tide, accessed 5 December 2022. For more information on the causes of the Mozambican civil war see, S Funada-Classen, *The Origins of war in Mozambique history of unity And division* (Tokyo: Ochanomizu Shobo Co Ltd, 2012).

17 Interview: Author with Zumo, 15 October 2020.

Chambuta villagers were widely employed in the camp. The Zimbabwean government upgraded Chambuta to a permanent refugee camp in July 1990. The camp quickly gained a deadly reputation. With a holding capacity of 20 000, by mid-1992, the camp held over 25 000 people. A drought-induced influx between June and August 1992 introduced an estimated 11 500 refugees to the camp, and in no time, available resources failed to cope.[18] The system at Chambuta collapsed, and a public health nightmare unfolded.

Interviews with villagers and village heads in Chilonga show that initially, from the mid-1990 to the outbreak of diseases in 1992, they largely welcomed the Mozambican refugees who settled in the Chambuta camp. Factors that encouraged cohesion include a shared ethnic identity, language and experiences. Moreover, to the villagers, the construction of a refugee camp with a school, a police post and a clinic represented a positive step towards the development of their area, which until 1990 had none of these facilities.

The creation of the Zimbabwe-Mozambique border in 1891 "separated" different ethnic groups, which easily and frequently traversed borders for political, economic and social reasons. Such ethnic groups include the Shangani, who occupy southern Mozambique and Zimbabwe. The Shangani were the major ethnic group in the Chambuta refugee camp. Since colonial times the Shangani maintained kinship and cultural ties across the border, and in times of crisis, they provided refuge to those in need. These ties contributed to a mutual relationship between the hosts and the refugees when the camp was set up. The hosts viewed Mozambican refugees as relatives, not refugees. Cephas Chambuta, a village head and former administrator in the camp, explained,

> We had a mutual relationship with refugees; as you know, we are related […] they are Chauke (a Shangani totem). They are our parents since our ancestors came from Mozambique; these were our relatives, our uncles. They freely came into our villages, and we had beer parties together and exchanged food items. Some would sleep over and returned to the camp the next morning since there was a 6pm curfew. We also had intermarriages, I have a sister who was married to a refugee, and she went to Mozambique.[19]

18 Kelso, "Turning the Refugee Tide".

19 Interview: Author with Cephas Chambuta, Chambuta Village head and former worker at the camp, 63 years old, Chambuta Village, Chilonga, Zimbabwe, 20 September 2020. Cephas worked in the Camp under the Social Welfare Department of the Government of Zimbabwe from the time it was established.

Ingwani Madomba of Chambuta village, who also worked at the camp, added,

> The authorities realised that these people were also Shangani; we were relatives separated by the border. Some were related through intermarriages. When they came, local people also got married to refugees. Most women from here left with their refugee husbands upon repatriation. Misunderstandings were settled by the traditional courts, and there was not so much conflicts and hatred.[20]

A former refugee who lives in Machiloli village, John Murami, attests to the generous reception of the hosts,

> I married my wife when I moved to the camp. My in-laws accepted me because I was an honest person. From the time I was living in the camp, I built good relations. Now I am ageing, I am happy, I have a family and a home. I am very grateful to the local community for looking after me.[21]

Even members of the displaced families interacted positively with the refugees despite simmering grievances. "It was not the refugees' fault. They had nowhere to go. They needed shelter, and as their relatives, we supported them", said James Chitsange of Velemu village.[22] These perspectives illustrate that a shared ethnic identity significantly contributed to the acceptance of refugees by the majority of the host community.

In addition, shared experiences of crisis and refuge seeking considerably influenced good relations between the hosts and the refugees. Having been refugees in Mozambique during the Zimbabwe war of liberation, Zimbabweans understood the need for refuge during conflict and showed appreciation for their stay in Mozambique. As indicated earlier, from the early 1980s, when Zimbabwe attained independence, chiefs and village heads along the borders settled Mozambican refugees who sought refuge during the civil war.[23] According to Thomas Salani of Chambuta village,

> When refugees settled here, the Mozambique National Resistance (*Resistência Nacional Moçambicana*, RENAMO) militia followed and killed people in the villages accusing Zimbabweans of harbouring refugees. They would not go into the camp but killed people in the villages. Sometimes people slept in the bush, hiding from RENAMO. It was painful, and we wondered why we were dying to protect refugees,

20 Interview: Author with Ingwani Madomba, Former worker at the camp and Local villager, 64 years old, Chambuta Village, Zimbabwe, 24 September 2020.

21 Interview: Author with John Murami, 69 years old, Former refugee, Machiloli Village, Chilonga, Zimbabwe, 21 September 2020.

22 Interview: Author with James Chitsange, Velemu villager, 50 years old, Velumu, Zimbabwe, 1 October 2020.

23 *The Herald*, 7 February 1995. The government strongly discouraged village heads and chiefs from informally settling Mozambicans in their areas.

> but since we were once refugees in Mozambique during our own war of liberation, we were giving back.[24]

Evidence of cohesion on the ground includes social visits, beer parties, and intermarriages, sharing water and exchanging food items. Since the refugees received food aid, they bartered goods with local residents. Barter trading of food items, in particular, created cohesion. The refugees often smuggled food out of the camp to be sold on the black market in surrounding villages and nearby towns of Chiredzi and Masvingo.[25] People from villages that surround the camp claim that during the 1992 drought, they did not suffer greatly. They exchanged their goats and vegetables for mealie meal, tinned fish, beans, dried fish and clothing with the refugees.[26] The refugees also accessed water from the surrounding villages when their population surged and the water supply diminished during the 1992 drought. The close proximity of the hosts to the camp gave them an advantage in building relationships with the refugees, which in turn made it possible for them to survive the drought. Those who came from other places across the country looking for maize meal in the camp usually waited for weeks before they found suppliers.

A local villager, Thomas Salani, reminisces the refugee camp as a "town", a place where they got everything they needed from clothing to food before and during the drought.[27] The presence of the refugee camp not only saved the hosts from the drought but brought modernity closer to home. For decades, locals lived in this "forgotten" part of the country without access to retail stores, schools, clinics, roads, toilets and clean water. The refugees came with development. Village head Cephas Chambuta says,

> There were no roads here, no bridges; now we have roads; from Lundi bridge, there was no road from Makosiya to Chilonga, but now we have it because of the people from Mozambique. The secondary school that we now have, we inherited it from the Mozambicans. We also have grocery stores, a clinic and a police station which we didn't have.[28]

These sentiments of appreciation are widely shared across the host villages. Despite these positive perceptions, however, when disease struck the camp in 1992, elements of suspicion, blame and othering emerged as hosts blamed refugees for the disease outbreak.

24 Interview: Author with Thomas Salani, Local Villager, 62 years old, Chambuta Village, Zimbabwe, 20 September 2020.
25 *The Herald*, 16 March 1992.
26 Interview: Author with Livison Chikutu, 46 years, Velemu Village Head, Velemu Village, near Chambuta Camp, Zimbabwe, 4 October 2020.
27 Interview: Author with Thomas Salani, 20 September 2020.
28 Interview: Author with Cephas Chambuta, 20 September 2020.

3. THE REFUGEE INFLUX AND THE MAKING OF A PUBLIC HEALTH NIGHTMARE AT CHAMBUTA

At the end of 1992, when Mozambican president Joaquim Chissano signed an agreement with the RENAMO "rebel" leader Afonso Dhlakama which ended the 17-year civil war, the refugees' numbers estimates were 230 000 for Zimbabwe, 25 000 for Zambia, 350 000 for South Africa and 1.3 million for Malawi (the highest population).[29] An estimated 300 000 refugees spontaneously returned to Mozambique on their own, but the majority remained outside the country, fearing the threat of a renewed war. Besides the fear of civil war-related violence, the 1992 drought that hard hit Southern Africa presented a new threat to Mozambican refugees, whose estimated 2.3 million population already needed food assistance because of the induced displacements.

The severe drought forced thousands more to flee, creating emergencies in Zimbabwe's refugee camps. When it opened as a transit camp in 1988, Chambuta had 338 people. In January 1992, 859 refugees had settled in the camp, and by May 1992, the refugee population had risen to 16500.[30] In July 1992, Chambuta admitted more than 1000 refugees weekly. The refugee population in the camp swelled to 25 323 by October 1992, as the camp received an average of 4500 people monthly. These included some of the refugees who had initially self-settled in Zimbabwean villages. There were nearly 120 000 self-settled refugees along the Zimbabwean borders, and the 1992 drought forced some of them to go into camps where they expected to be fed. Consequently, in August 1992, 206 deaths were recorded, with crude mortality daily rates ranging between 3.5 and 8.2 deaths per 10 000 populations.[31] Diarrhoea, dehydration, malnutrition and measles accounted for 75 per cent of all reported deaths.

The official narrative drawn from various reports by the Zimbabwe Department of Social Welfare, the United Nations High Commission for Refugees (UNHCR) and other humanitarian organisations places the disease outbreak within the typical initial emergency phase following a refugee influx. During this period, refugee camps experience high mortality rates mostly due to preventable and treatable infections, often exacerbated by malnutrition, overcrowding, and poor access to water. Diarrhoea, measles, malaria, and

29 Kelso, "Turning the Refugee Tide".

30 *The Herald*, 20 June 1992.

31 Center for Disease Control (CDC), "Mortality among Newly Arrived Mozambican Refugees—Zimbabwe and Malawi, 1992", *Morbidity and Mortality Weekly Report (MMRV)* 42 (24), 1993, available online at https://www.cdc.gov/mmwr/preview/mmwrhtml/00020997.htm, accessed 5 December 2020.

respiratory tract infections rapidly spread across the refugee population, and the focus on healthcare during this period is on immediate lifesaving interventions within the camp.[32] The reports maintain that it was a diarrheal disease outbreak resulting from malnutrition due to lack of food during the prolonged civil war, the displacement period as Mozambicans moved to Zimbabwe, and the 1992 drought that occurred across Southern Africa. The measles outbreak among refugee children was a result of restricted access to vaccines during wartime.

In March 1992, the Chambuta camp received an average of 50 new arrivals per day. This number increased between July and September 1992 to approximately 300 newcomers daily.[33] Most of the newcomers at Chambuta were emaciated when they arrived at the camp. For many years they had failed to cultivate crops because of the war.[34] The drought worsened their situation, and they spent days without food on their way to the camp. They required medical attention and put a strain on the already stretched health facilities. Nearly 300 to 400 refugees in the camp were treated daily for food deficiency-related diseases.[35] Malnutrition, measles and diarrhoea were the major causes of death among children in the camp. At the camp clinic, the nursing staff failed to cope. Only eight nurses and four nursing aids worked around the clock.[36] John Dzingai, a former nurse at the camp, remembers people dying as they waited to be treated during the influx period. He insists that more than half of the refugees were malnourished and developed diarrhoea when they began the feeding programme. He likens this to how overfed cattle develop diarrhoea after a prolonged dry season, "Some patients recovered, but some who were severely malnourished would get overwhelmed and die upon feeding. An average of 15 deaths per day occurred during the influx period from March 1992 to August 1992".[37] The soaring refugee population created sanitary problems as the existing facilities could not cope with the large numbers in the camp. At the same time, shelter materials were in short supply. The drought affected the availability of grass for roofing. The refugee influx at the camp also affected the food aid programmes as authorities failed to provide the daily World Food Programme

32 P Spiegel, 'Health programmes and policies associated with decreased mortality in displaced people in post emergency phase camps: A retrospective study,' *Lancet* 360 (9349), 2002.

33 *The Herald*, 13 October 1992.

34 Interview: Author with Evelyn Hokela, Former Chambuta Refugee, Married to a local man, 65 years old, Hokela Village Hokela Village, Zimbabwe, 23 September 2020.

35 *The Herald*, 16 March 1992.

36 Interview: Author with Mr Makuyana, Environmental Health Technician, 66 years old, Chiredzi Hospital, Chiredzi, Zimbabwe, 23 September 2020.

37 Interview: Author with John Dzingai (pseudonym), 56 years old, Nurse, Chambuta Camp Clinic, Zimbabwe, 26 September 2020.

stipulated 400g per individual.[38] The 1992 drought diminished Zimbabwe's food supplies and strained medical and social programmes.

Several local and international non-governmental organisations intervened through the adoption of several medical interventions such as vaccinations, the construction of sanitation facilities, and humanitarian efforts like food distribution and supply of materials for shelter, among others. The Department of Social Welfare coordinated a sanitation and feeding programme as it partnered with non-governmental organisations through its Refugees Services Unit. The programme focused on preventive measures, primarily the provision of adequate food, safe water, toilets and shelter to curb the disease outbreak. The Red Cross, which was involved in assisting the refugees in moving from Mozambique to Zimbabwe and settling them in various camps, increased their monthly rations of maize meal, beans, seeds and clothing.[39] The Red Cross also screened the refugees for malnutrition. Redd Barna, a Norwegian organisation which provided shelter to the refugees upon settlement, increased its funding by 30 per cent.[40] The Catholic Development Commission (CADEC), which had begun work in Chambuta when it was used as a transit camp, provided supplementary feeding schemes, blankets and toilets to new arrivals.

The UNHCR, in collaboration with the Baptist Church, sunk twelve boreholes and constructed a water purification and reservoir system for the camp.[41] *Medicines sans Frontiers,* in collaboration with UNHCR, brought in more health personnel to assist Zimbabwean nurses. The Ministry of Health set up a satellite clinic at the Joachim Chissano School in order to increase health care services. All admissions were however made at the main clinic, which had a bed capacity of 32. Refugee women took turns cooking for the malnourished. There was a good ambulance system, and the Ministry of Transport repaired and maintained the road which was used to transport acute cases to Chiredzi Hospital.[42] The Zimbabwean Ministry of Health initiated a massive measles vaccination programme. Environmental health technicians led sanitation and hygiene awareness programmes insisting on the importance of sanitary measures such as hand washing, covering of food, use of toilets, rubbish pits, buckets with lids, and safe water within the camp. Through these interventions, the Zimbabwean government and its partners reported that they had successfully contained the disease outbreak within the camp as morbidity and mortality cases dropped from September 1992.

38 *The Herald*, 13 October 1992.
39 *The Herald*, 23 March 1992.
40 *The Herald,* 20 June 1992.
41 *The Baptist Press*, January 1990.
42 Interview: Author with John Dzingai, 26 September 2020.

However, these public health interventions left out host communities and targeted refugees only. The hosts only had unrestricted access to curative health services at the refugee camp clinic. Preventive measures, such as sanitation and hygiene and vaccinations, in particular, were limited to refugees. Yet, despite the closed and isolated nature of the refugee camp as well as the perceived restriction of refugees' movements in the camp, there was close interaction between refugees and host communities. Regarding infectious disease control programmes, for instance, it makes little epidemiological sense to become involved with one group and not with the other; the organisms which cause diseases are not so bureaucratically selective. Although John Dzingai, the former nurse at Chambuta camp, insists that the disease outbreak did not spread into surrounding villages, interviews with Velemu villagers claimed that the disease outbreak spread into their village and killed several people, as shall be shown below. These incidences triggered hate and stigma as Velemu villagers, particularly, blamed the refugees for causing the disease outbreak. The earlier established social cohesion waned. In contrast to the official narrative given by the government and international organisations, below, I unpack the different reasons why the majority of the hosts believed that the refugees were the source of diseases.

4. UNMAKING BONDS: POOR SANITATION, DISEASE OUTBREAKS AS A CURSE

Drawn from interviews, the local narrative does not associate disease among refugees with the effects of war-induced famine, nor with malnutrition as a result of the 1992 drought. In their experience, refugees had food in abundance, and bartering food aid was a common survival strategy for local people during the drought. The explanation for the disease outbreak lies elsewhere. Depending on their village of origin, local residents associate the disease outbreak with overcrowding and poor sanitation, the anger of ancestral spirits or both. Both Chambuta and Velemu villagers widely identify the diarrheal disease as cholera which resulted from overcrowding and poor sanitation in the refugee camp. Those from Chambuta village, who mostly worked in the camp, for instance, Cephas Chambuta and Ingwani Madomba emphasise poor sanitation, while Velemu villagers, who were displaced as a result of the camp subscribe to the poor sanitation explanation but stress that the disease outbreak was a curse, a punishment from their ancestors following the displacement of several families from the campsite, to pave the way for refugees' settlement. These alternative and diverse explanations of diseases are important in two ways. First, they show the heterogeneity of host

communities, informed by clan and loss or benefits derived from the camp establishment. Second, they reflect an extra spiritual dimension to causal explanations of disease that are normally couched strictly in biomedical terms. It is these alternative explanations that determine the successful integration of refugees within host communities.

The first alternative explanation shared across the two villages but mostly drawn from Chambuta villagers is that there was poor sanitation at the personal refugee level and in the camp. Despite the availability of toilets, some of the refugees preferred to use the bush, and there was human waste everywhere.[43] At night someone would just go near the house and defecate, and flies would transmit the diseases. The clinic staff taught refugees about sanitary measures. They distributed soap for washing hands, buckets and other utensils. Non-governmental organisations provided disinfectants to put in toilet pits. They encouraged the refugees to eat warm food. They also taught them how to construct dish racks, but they were overwhelmed by the influx.[44] It remained difficult for the government and non-governmental organisations to provide most of the basic necessities in the camp, especially shelter and sanitation. The influx overwhelmed the available resources. In addition, the multi-ethnic composition of the refugees meant that they were different people coming from different areas with different understandings of sanitation and hygiene. Amongst them were the Nyungwe, Barwe, Shangani, Sena, and Ndau. They were given soap but generally lacked sanitation practices.[45] Some would not bathe or wash their clothes and dishes. Men particularly spent several days and nights going to beer parties within the camp and outside.[46] These interviews highlight how difficult it was to achieve satisfactory sanitary conditions in the camp. Access to water, soap and other amenities did not guarantee the adoption of sanitary measures in the Chambuta camp.

Personal observation shows that the pit toilets in the camp were too close to the houses. Therefore, coupled with overcrowding, occasional water shortages and incessant heat, disease transmission was difficult to contain. Velemu villagers argue that the “cholera” outbreak spread to their village due to close interaction with the refugees and killed many people,

> Mr Mawewe suffered from cholera, so did Rabhi, as well as the old man Mamombe. Peter and three more people got sick and were saved by the clinic. They had diarrhoea with blood. People in Base 1, particularly when they first settled, did not like using toilets. They used the bush, and as the camp expanded, there was a lot of dirt

43 Interview: Author with Ingwani Madomba, 24 September 2020.
44 Interview: Author with Evelyn Manyise, 53 years, Zimbabwean married to a Mozambican Former Chambuta Refugee, Muloveli village, Machindu, Zimbabwe, 13 October 2020.
45 Interview: Author with Cephas Chambuta, 20 September 2020.
46 Interview: Author with Cephas Chambuta, 20 September 2020.

> and that led to diseases. The refugees were unhygienic; there was poor sanitation in the camp. We got to a point where we felt that it was better for the refugees to go back or be relocated elsewhere. In 1994 they were repatriated to Mozambique. We were happy that they went back, said Phineas Chitsange.[47]

Local residents believe that the food and beer they shared and exchanged with refugees were contaminated. They claim that initially, they thought this was a natural disease but later realised that this outbreak was a result of overcrowding. "We even suspect that it came with some of the refugees who were coming from Tongogara and found favourable conditions in the overcrowded camp conditions and through interaction, the disease spread to local villages. Our people died as a result. We had never experienced diarrheal outbreaks before", said James Chitsange of Velemu village.[48] "Although the refugees were repatriated their cholera remained" Lucas Velemu lamented.[49] In 1993, a diarrheal blood outbreak killed several people in Velemu and Makosiya villages, with between 16 to 20 people dying in Velemu alone. Official reports claim that it was enterohemorrhagic e.coli, a different type of diarrheal disease imported from South Africa by labour migrants.[50] Although there were no cases among refugees, Velemu villagers link it to the 1992 diarrheal disease outbreaks in the camp.

The second alternative explanation emanating from Velemu village is that the disease outbreak was a punishment from their ancestors, who were angry over the Zimbabwean government's failure to consult the correct traditional leadership, the instant displacement of locals from the campsite without compensation and the destruction of ancestral shrines during camp establishment. These ideas are not unique to the Shangani of southeastern Zimbabwe. Fraser McNeill demonstrates how biomedical understandings of AIDS have either been rejected or incorporated into local understandings of health, illness and death by the Venda of South Africa.[51] Adam Ashforth observes similar ideas on how AIDS is associated with witchcraft and is framed as a "sent disease" in South Africa.[52] These alternative causal explanations of disease are informed by a religious conviction that,

47 Interview: Author with Phineas Chitsange, 48 years old, Velemu Village, Zimbabwe, 23 October 2020.
48 Interview: Author with James Chitsange, 1 October 2020.
49 Interview: Author with Lucas Velemu, 70 years old, Traditional healer/ Spirit medium, Changoma Village, Zimbabwe, 19 October 2020.
50 Interview: Author with John Dzingai, 26 September 2020.
51 FG McNeill, *Aids, politics, and music in South Africa* (Cambridge: Cambridge University Press, 2011).
52 A Ashforth, "An epidemic of witchcraft? The implications of aids for the post-Apartheid state", *African Studies* 61 (1), 2002.

> There exists an invisible world, distinct but not separate from the visible world, that is inhabited by spiritual beings with which they can communicate and which they perceive to have an influence on their daily lives. This 'spirit idiom' governs relations both of one person to another, or of one person to a community, but also of people to the land.[53]

Therefore, similar to other regions of the world, religion has a marked influence on authority and legitimacy in African societies and as Stephen Ellis and Gerri ter Haar argue, African epistemologies should be incorporated into our understanding of contemporary Africa.[54] Spirituality particularly is an important framework for constructing meanings around the disease. In this article, I argue that these perspectives are fundamental in determining the successful integration of refugees and hosts. I show how these alternative views, attitudes and perceptions have a long-term impact on relations and peacebuilding between the two groups.

Despite the mutual relationship that characterised the interaction between the hosts and the refugees, there remained simmering unexpressed grievances among members of displaced families in Velemu village. Nearly three decades after the disease outbreak, the blame lingers long after the refugees left. Velemu villagers blame recent spates of drought on refugee presence and argue that even the dead should have been repatriated. They claim that their ancestors withheld the gift of rain because of the burial of refugees on their land. The anger and hate towards refugees that is revealed in these narratives developed after the disease outbreak, as interviews reveal that during the initial stages of camp set-up, the host community interacted positively with the refugees.

Reflecting on the Ebola interventions in West Africa, Fred Martineau *et al*. emphasise the centrality of local knowledge, of direct and immediate engagement with local actors and their diverse perspectives.[55] Livison Chikutu, the current Velemu village head, asserts that the land upon which the refugee camp was built belongs to the Velemu/ Chitsange people, not Chambuta. Chambuta is under chief Masuamele; the Camp is under chief Chilonga. However, when government officials came for consultation, they ended up in Chambuta's area of jurisdiction. They told people in Chambuta about the plans to set up a refugee camp. The Chambuta village head showed them a piece of land between Chambuta and Velemu villages. Although sparsely populated, the land was inhabited by ten Chitsange

53 S Ellis and G Ter Haar, "Religion and politics: Taking African epistemologies seriously", *The Journal of Modern African Studies* 45 (3), 2007, p. 387.

54 Ellis and Ter Haar, "Religion and politics", p. 387.

55 F Martineau *et al*., "Epistemologies of Ebola: Reflections on the experiences of the Ebola response anthropology platform", *Anthropological Quarterly* 90 (2), 2017.

families, who were not consulted about the refugee camp and were forced out of the designated camp area. “The displaced families lost many of their possessions. They were removed immediately without prior notice so many of them lost livestock, their houses and farming areas”.[56] The ten families include Dubula, Bhawa, Manyonga, Mahata, Dumazi, Gara, Ndendereka, Mhame, Chioko and Kunyarara. Families like Kunyarara, Dubula and Bhawa lost farms and had to look for other fields. The government did not compensate them.

In contrast to displaced families, those from Chambuta village constituted the majority of the camp workers. During camp construction, when the organisations that were serving the camp recruited local people for camp construction, they employed from the Chambuta area,

> Former refugee camp staff, for instance Galela and Madomba, were from Chambuta and gave information to the surveyors and the organisations who came to assist the refugees. They were employed in siting, camp construction, the building of camp infrastructure, toilets, and registration of refugees.[57]

The Chambuta village head misinformed the government and its partners about that area because he was not the owner of that land.[58] The government consulted the wrong people, people who did not only own the land but who were not going to be directly affected by the camp settlement. That is how the camp came to be known as Chambuta.[59] Livison Chikutu argues that prior to camp establishment, the Velemu village was inaccessible, while Chambuta village is located along the main road. Therefore, government officials decided to consult the Chambuta instead of moving further to other villages.

> When they saw how bushy it was, they assumed that it was unoccupied, yet several families were settled there [...] Our forefathers settled there in 1963; that place was sacred; it had shrines. That is why it was left as a bushy area with very few settlements on its outskirts.[60]

Chikutu claims that the refugees experienced a few challenges when they were setting up the camp but did not know that it was because they had violated the place as a result of misinformation or lack of it.

> After the camp was set up, people got sick, there were disease outbreaks, and healers and diviners from Mozambique said the diseases and deaths were caused by angry ancestral spirits. Chief Masuamele was consulted, and he held a ritual ceremony, but

56 Interview: Author with Livison Chikutu, 4 October 2020.
57 Interview: Author with Livison Chikutu, 4 October 2020.
58 Interview: Author with Livison Chikutu, 4 October 2020.
59 Interview: Author with Livison Chikutu, 4 October 2020.
60 Interview: Author with Livison Chikutu, 4 October 2020.

> there was no change. The Mozambican traditional leaders said this place does not belong to Masuamele; it belongs to Chilonga. The people who are holding rituals are not the owners of this land, meaning Masuamele, who was not in any way connected to the ancestors. To end the disease and deaths, the diviners recommended an ancestral appeasement ceremony led by Chilonga. Chief Chilonga came and held the ritual ceremony, and the situation improved. The ancestors were not happy over the name given to the camp. Names are very important in our culture; if you give a family name to a child who does not belong to your lineage, you would have given him spirits that do not belong to him, and things will go wrong for him. He will know no peace.[61]

Other Velemu villagers, for instance James Chitsange, insist that even the dead should have been repatriated.[62] The blame remains long after the refugees returned to Mozambique. He claims that before the refugees arrived, there was enough grazing land, and they even had excess subsistence, but after 1992 there have been continued droughts, and pastures have dried up. Although locals identify the environmental destruction caused by refugees in the area, for instance the burning down of trees which also burnt grass and affected pastures, they argue that the recurrent droughts are not a result of climate change only. According to J Chitsange,

> Deforestation affected local sacred shrines, which are normally bushy areas. The refugees' graves, their dead bodies are also a problem. The spirits of the dead refugees cause continued periods of drought because they were people from different places, they are too mixed, and it is difficult to appease them or to repatriate their spirits. We cannot go to their gravesite because we did not know these people. Some of the graves are now open, and skeletons exposed. Those graves are a big problem.[63]

Moreover, among the refugees were the Barwe, an ethnic group that hosts from both villages believed to be cannibals. The Barwe embalmed their dead, and the locals believe they ate them.[64] Embalming a dead body is not acceptable among the Shangani and is associated with the ancestors' punishment of withholding rain.

From the above perspectives, it is clear that the Velemu villagers strongly subscribe to the idea that the disease outbreak was a curse from their ancestors over the loss of land and the presence of cannibals/witches in their village. The plausibility of this perspective is unimportant. It could as well be possible that the disease outbreak provided the Velemu villagers with the

61 Interview: Author with Livison Chikutu, 4 October 2020.
62 Interview: Author with James Chitsange, 1 October 2020.
63 Interview: Author with James Chitsange, 1 October 2020.
64 Interview: Author with James Chitsange, 1 October 2020.

opportunity to bring to the fore their simmering grievances on displacement and loss of land and an explanation drawn from their ancestral relationship with the land seemed appealing. Nonetheless, it is important to acknowledge that these alternative explanations of the disease have the power to influence long-term negative attitudes towards refugees.

5. CONCLUSION

Drawing from interviews, I examined the diverse attitudes and perspectives of the Chambuta and Velemu villagers on the disease outbreak that killed nearly 200 Mozambicans at Chambuta refugee camp in southeastern Zimbabwe in August 1992. Often, local voices are overshadowed by official perspectives from government officials and non-governmental organisations. In cases where hosts have been included in the literature, they are presented as a homogenous group with similar opinions and attitudes towards refugees. In this article, I emphasised the pertinent need to consider the diverse voices of hosts in humanitarianism studies and policy formulations. Engaging local voices allow us to disaggregate host communities and understand variations in the relationships between hosts and those in need of assistance, as well as formulate context-specific strategies that encourage social cohesion.

Governments and organisations involved in refugee settlement adopt several measures to ensure peaceful coexistence between the refugees and their host communities, particularly settling refugees in “uninhabited” or sparsely populated areas as well as ensuring that both populations benefit from the different services available. The provision of shared facilities in healthcare and education, particularly as in the Chambuta case, has encouraged mutual relationships between the refugees and their hosts, who, in most cases, had no access to quality education and healthcare prior to the arrival of refugees. However, the occurrence of epidemic disease in camps often disrupts this peaceful coexistence and leads to “othering”. Stigma, blame and hate take centre stage as host communities perceive refugees as bringing diseases and other misfortunes to them.

By paying attention to how the host community understand disease outbreaks in the Chambuta refugee camp, this article shows that although the community appeared undifferentiated and established mutual relations with the refugees before the disease outbreak, this was far from the case. Prior to camp establishment, the host community was differentiated along clan lines, each clan having access and jurisdiction over their own lands which were divided by a stream. The establishment of the refugee camp widened these divisions when the Chambuta village head allocated land that belonged to Velemu village to the camp without consultation. The Velemu village lost a

piece of their land which they used as grazing land, and ancestral shrines, whilst Chambuta villagers benefited from jobs and recognition. Consequently, the host community was further divided along socio-economic lines to the extent that when the disease outbreak occurred, those from Velemu village largely blamed refugee presence on their land. This highlights the importance of recognising the politics of host communities. Government authorities treated the local community as one harmonious unit without internal divisions or political cleavages. Receiving governments and local authorities should widely consult local traditional leadership to ensure that refugee camps are not established on disputed land. Whilst it is difficult to find '"uninhabited land", it is important to understand how land is allocated and used at a local level before embarking on large-scale projects leading to internal displacements. The internal displacement of locals, no matter how few the affected people are, encourages discontent among refugee hosts. In the Chambuta case, displaced families argue that they did not have time to communicate with their ancestors, and their link with the ancestors was broken as shrines and ancestral graves were destroyed, and this led to disease outbreaks and low rainfall.

Moreover, the spiritual explanations of disease that the Velemu villagers subscribe to point to the need for governments and partnering organisations to identify strategies that deal with alternative explanations of biomedical causes of disease. Such strategies may include public health awareness programmes among host communities before and after refugee settlement. Ensuring that hosts access clinics in refugee camps, as happened at Chambuta, is important but limits health interventions to curative medicine, yet there is a need to educate local communities about the possibilities of communicable disease epidemics among refugees. This may allay several etiological explanations, blame and stigma that threaten peacebuilding between the two communities. Wider consultation with host communities as well as public health and climate change awareness programmes, are important in ensuring a peaceful co-existence between refugees and their host communities.