

**THE RESPONSE OF THE ROMAN CATHOLIC,
ANGLICAN AND UNITED METHODIST CHURCHES
TO HIV and AIDS IN MANICALAND, ZIMBABWE
(1985-2007)**

BY

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26 November 2012

DECLARATION - PLAGIARISM

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As the Supervisor, I have agreed to the submission of this thesis.

Prof. Philippe Denis

Date

DEDICATION

**To my beloved parents John Nyazvita and Marian
Zvoitwawani, my bothers, sisters and friends who died
of the HIV and AIDS pandemic**

ABSTRACT

This study focuses on the history of the Roman Catholic, Anglican and United Methodist churches reaction to HIV and AIDS in Manicaland province, Zimbabwe between 1985 and 2005. It attempts to document and analyse what the three so called 'mainline' churches did and failed to do in responding to a new epidemic. The findings that culminated in this work were obtained mainly from primary written and oral sources that were collected between 2009 and 2011. These comprise oral testimonies of Christians from the Roman Catholic, Anglican and United Methodist churches including bishops and lay members of the churches. In addition, information from medical personnel serving at the churches' healthcare as well as that from officers serving in the National AIDS Council (NAC) and the Zimbabwe Association of Church-Related Hospitals (ZACH) were incorporated. Primary written sources include statements issued by the church leaders, the synod and annual conference resolutions, the minutes of parish council meetings, the *ad clerums*, reports by the church HIV and AIDS structures among others.

The study establishes that HIV and AIDS, which emerged in Zimbabwe in the early 1980s, definitely affected the church and also seeks to show that the churches' reactions in turn had an influence on the epidemic. The state came out to publicly acknowledge AIDS in Zimbabwe in 1985 and two years later the Zimbabwe Catholic Bishops' Conference became the first ecclesiastical body to issue a statement on HIV and AIDS in 1987. In 1989 the churches issued a collective statement under the Heads of Christian Denominations (HOCD) in Zimbabwe, which publicised their views on the Christian response to AIDS. The messages were largely moralistic in nature and the churches maintained this stance throughout the period of study. However, it has also been established that the church healthcare centres were involved in accessing condoms to people living with HIV (PLHIV) and other members of the public. Throughout the twenty-two years covered by this study the church healthcare system made an impact on the epidemic through offering treatment to PLHIV. The input of the church healthcare system underwent a three phased evolutionary process: the complementary stage between 1985 and 1994, the church paralleling of the state healthcare system from 1995 to 1999, and replacement of the responsibility of the

government in healthcare between 2000 and 2007. Generally, the responses have been subdivided into three phases, which were the early years: from 1985 to 1994, the middle years lasting between 1995 and 1999 and finally the later years falling between 2000 and 2007.

The individual churches appear to have been involved in responding to HIV and AIDS with the same motive of serving humanity starting with their followers and moving beyond. Within the Roman Catholic Church the intervention such as care of PLHIV and orphans and vulnerable children (OVC) became a national and diocesan priority that witnessed the birth of the Mutare Community Home Care project in 1992. The new initiative grew stronger over the years and expanded from nine to nineteen stations covering the province. The Anglican Church launched its institutional AIDS care initiatives between 1999 and 2006. The main thrust was on training of Anglicans in responding to the epidemic and the establishment of AIDS care and treatment centres in selected rural areas. Within the United Methodist Church, the thrust was on care of orphans and vulnerable children and home-care at the station, circuit and annual conference levels. All the three churches received donor funding for HIV and AIDS interventions and this became important at a time when the state healthcare and welfare systems were unable to provide care and support to people infected and affected by the epidemic.

The study argues that indeed HIV and AIDS like other earlier epidemics such as Black Death in Europe and influenza in Southern Africa is a historical phenomenon which received mixed responses from the community including Christians. It brought to light some of the negative reactions such as denial, stigma and discrimination and yet the epidemic also drew in Christian communities, individuals and institutions to show compassion by caring for people affected and infected by HIV and AIDS. At the institutional level bishops were in a dilemma of maintaining the moral teaching of the church on sexuality and yet they were also expected to be flexible in finding practical ways of preventing HIV. There were other dynamics such as culture, which prevented people from using condoms. The church followers made a very essential contribution in mitigating the effects of the epidemic by being the army of caregivers to people infected and affected by HIV and AIDS. Despite their unique dedication to caring for AIDS clients, women were the most affected by the epidemic because of the

patriarchal nature of the churches and the cultural perceptions of gender and sexuality. It is hoped that the churches will draw on this history to shape future HIV and AIDS interventions.

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LIST OF ABBREVIATIONS AND ACRONYMS

| | |
|---------|--|
| AIDS | Acquired Immuno-Deficiency Syndrome |
| ANC | antenatal clinic |
| ART | Antiretroviral Therapy |
| ARV | Antiretroviral |
| BACC | Bonda Art and Craft Centre |
| BEAM | Basic Education Assistance Module |
| CAPA | Council of Anglican Provinces of Africa |
| CCJP | Catholic Commission for Justice and Peace |
| CDM | Catholic Diocese of Mutare |
| COM | Council on Ministries |
| CPCA | Church of the Province of Central Africa |
| CPSA | Church of the Province of Southern Africa |
| CRS | Catholic Relief Service |
| DOMCCP | Diocese of Mutare Community Care Project |
| ESAP | Economic Structural Adjustment Programme |
| FACT | Family AIDS Caring Trust |
| FBO | Faith Based Organization |
| GBGM | General Board of Global Ministries |
| HIV | Human Immuno-Deficiency Virus |
| HOCD | Heads of Christian Denominations |
| IMBISA | Inter-regional Meeting of Bishops of Southern Africa |
| LATRIC | Lay Training, Relief and Information Centre |
| MCHC | Mutare Community Home Care |
| MOHCW | Ministry of Health and Child Welfare |
| MU | Mothers' Union |
| MUMC | Mubvuwi weUnited Methodist Church (UMC men's guild) |
| NAC | National AIDS Council, Zimbabwe |
| NACP | National AIDS Coordination Programme |
| NGO | Non-Governmental Organisation |
| NOCP | National Orphan Care Policy |
| OVC | Orphan and Vulnerable Children |
| PEPFAR | President's Emergency Programme for Aids Relief |
| PF ZAPU | Patriotic Front Zimbabwe African People's Union |
| PLHIV | People Living with HIV and AIDS |
| PMTCT | Prevention of Mother to Child Transmission |
| PSG | Project Support Group |
| RRW | Rukwadzano RweWadzimai (UMC women's guild) |
| SACBC | Southern Africa Catholic Bishop's Conference |
| SAfAIDS | Southern Africa HIV and AIDS Information Dissemination Service |
| SECAM | Symposium of Episcopal Conferences of Africa and Madagascar |
| STI | Sexually Transmitted Infections |
| TB | Tuberculosis |
| UK | United Kingdom |
| VCT | Voluntary Counselling and Testing |
| UMC | United Methodist Church |
| UNAIDS | Joint United Nations Programme on HIV/AIDS |
| UNICEF | United Nations International Children's Fund |

| | |
|---------|--|
| USA | United States of America |
| USAID | United States Agency for International Development |
| USPG | United Society for the Propagation of the Gospel |
| WCC | World Council of Churches |
| ZACH | Zimbabwe Association of Church-Related Hospitals |
| ZCBC | Zimbabwe Catholic Bishops' Conference |
| ZAC | Zimbabwe Annual Conference |
| ZANU PF | Zimbabwe African National Union Patriotic Front |
| ZCC | Zimbabwe Council of Churches |
| ZEAC | Zimbabwe East Annual Conference |

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CHAPTER ONE

INTRODUCING THE STUDY

1.1. Introduction: Outlining the Task

This research study seeks to explore responses to HIV and AIDS by the Roman Catholic, Anglican and United Methodist churches in Manicaland province of Zimbabwe. Manicaland is one of the ten provinces of Zimbabwe and is located in the eastern part of the country with Mutare being the provincial capital. Out of a total of 7,5 million inhabitants of Zimbabwe in 1982, the population of Manicaland was 1,1 million. This rose to a total of 1,5 million out of a total population of 10,4 million in 1992 and 1,6 million out of a total of population of 11,3 million in 2002.¹ The province of Manicaland shares the border with Mozambique. The province is subdivided into seven administrative districts namely Buhera, Chimanimani, Chipinge, Makoni, Mutare, Mutasa and Nyanga. Major urban areas include the city of Mutare, Rusape, Chipinge. Most of the inhabitants of Manicaland speak –Chimanyika” and –Chindau” all being dialects of the Shona language. Politically, Zimbabwe was colonised by the British at the beginning of the twentieth century as will be shown in Chapter two of this thesis.

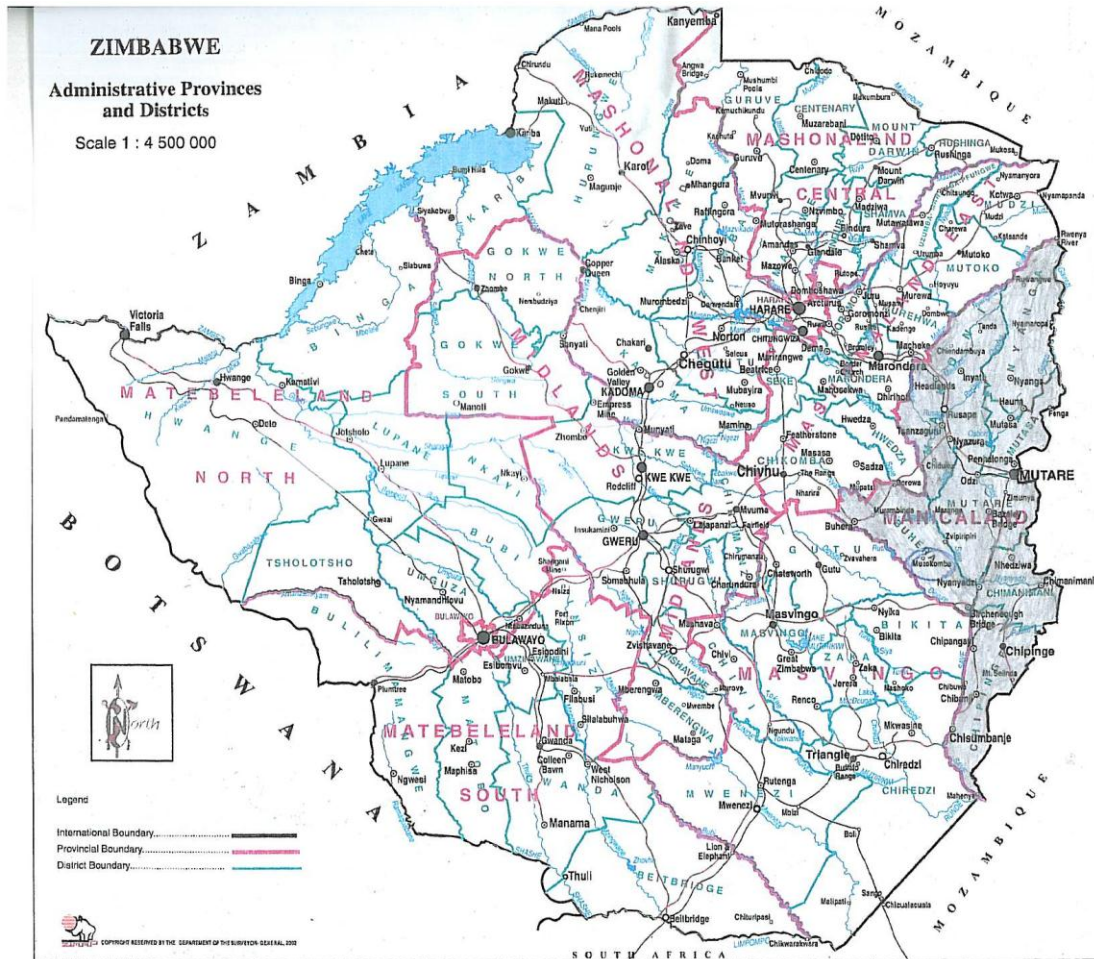
The province of Manicaland is home to some of the longest surviving established Western missionary-initiated churches in Zimbabwe.² The Roman Catholic, Anglican and United Methodist churches established mission centres at the dawn of the twentieth century.³ These three churches have a large contingent of healthcare centres and educational institutions as well as numerous parishes, mission stations, and circuits. The following (figure 1) is a geographical map of Manicaland province.

¹ Zimbabwe: Provinces, major cities and urban localities: Statistics and maps on city population, <<http://www.citypopulation.de/Zimbabwe.html>> [Accessed 25 June 2012].

² In this context churches refer to local Christian denominations constituted by members and have distinct leadership structures as found in countries such as Zimbabwe. The Roman Catholic, Anglican and United Methodist churches are examples.

³ For a discussion on this see chapter two of the study.

Figure 1: Manicaland province, Zimbabwe⁴



⁴ ZIMAP, "Mutare," *Atlas for Zimbabwe*, (Harare: Department of the Surveyor General, 2002), 39.

An overview of the AIDS scene in Zimbabwe in general indicates that after the first public case of HIV was acknowledged by the State in Zimbabwe in 1985.⁵ The critical task for this study is to trace what the three churches did or failed to do in responding to the pandemic. This research study will locate church responses to HIV and AIDS within the historical context of Zimbabwe (1985-2007).⁶ Generally, the HIV and AIDS landscape in Zimbabwe indicates that from the early 1980s there was a steep rise in HIV positive people, which reached 1,500,000 in 1999. In 2004 an estimated 2,300, 000 people were living with HIV.⁷ According to Theo Smart, HIV prevalence in Zimbabwe dropped from 32.1% in 2000 to about 20% in 2004.⁸ Estimates from the Zimbabwe country report for 2006-2007 showed even a further decline by stating that 1,300, 000 people were living with HIV.⁹ One of the tasks to be analysed by this study will be to establish whether or not church-led HIV prevention approaches by the Roman Catholic, Anglican and United Methodist churches were of any significance. For instance, the prevention of sexually transmitted HIV in Manicaland appears to have been undermined by cultural traditions as well as Christian beliefs and practices.

The present study is aware of the fact that generally, churches have been accused of not being safe spaces for discussing health, sexuality and AIDS because culturally, that was considered as taboo.¹⁰ This observation also applied to the churches in Manicaland and thus the present research study examines how church doctrines, beliefs and practices shaped their input on sexuality in the context of HIV. If the churches were to be effective agents in responding to HIV it was important for them to understand sexuality not only as an individual moral act, which can be right or wrong, but as a reality determined by social, economic and cultural factors.”¹¹ Thus

⁵ N. Zungu-Dirwayi *et al.*, *An audit of HIV/AIDS policies in Botswana, Lesotho, Mozambique, South Africa, Swaziland and Zimbabwe*, (Cape Town: Human Sciences Research Council, 2004), 10.

⁶ Response (s) refers to how churches reacted to the epidemic either positively or negatively.

⁷ Zungu-Dirwayi, *An Audit of HIV/AIDS Policies*, 10.

⁸ T. Smart, “Zimbabwe observes a reduction in HIV prevalence, but why?” <<http://www.aidsmap.com/en/news/90F01421-E63D-465A-BB79-4A44EEF6E9AE.asp>> [Accessed 10 March 2009].

⁹ UNAIDS, “Zimbabwe country report,” *United Nations General Assembly (UNGASS) report on HIV and AIDS: Follow-up to the declaration of commitment on HIV/AIDS, (January 2006-December 2007)*, 9.

¹⁰ B. Haddad, “We pray but we cannot heal:” Theological challenges posed by the HIV/AIDS crisis,” *Journal of Theology for Southern Africa* 125 (July 2006), 84.

¹¹ P. Denis, “Sexuality and AIDS in South Africa,” *Journal of Theology for Southern Africa* 115 (March 2003), 75.

the study draws attention to the way churches as religious bodies engaged with HIV in the realm of public health and sexuality.

The response of the churches in Zimbabwe cannot be divorced from the way society has always responded to other earlier epidemics. The response of the Roman Catholic, Anglican and United Methodist churches to the epidemic in Zimbabwe followed the pattern described by Charles Rosenberg as cited by Philippe Denis:

The gradual acceptance of epidemic, whose existence was denied by the principal social actors, constitutes the first act. The second act highlights the disorganised efforts of the authorities to conquer the disease. Act three sees the galvanisation of collective action which is better informed and more effective. The fourth and last act...shows the slow withdrawal of the epidemic.¹²

Zimbabwe is one of the countries in sub-Saharan Africa where the Western founded mission hospitals were not nationalised at independence and thus continued to serve the medical needs of citizens. The present research study will also explore ways in which the continued involvement of faith-based organisations (FBOs) in the sphere of public health including responses to HIV and AIDS could have undermined the State's obligation towards its citizenry and offered no vision of political activism or transformation of civil society.¹³ For example, Prince *et al.* in commenting on the study by Erica Bornstein which focused on World Vision in Zimbabwe, observe that its projects were a two-edged sword, in that, "while tackling poverty, they created new social inequalities and distinctions; their vision of economic development resembled neoliberal notions of individual responsibility."¹⁴ This present research study will show that HIV interventions carried out by the Roman Catholic, Anglican

¹² P. Denis, "Towards a social history of HIV/AIDS in sub-Saharan Africa," in P. Denis and C. Becker (eds), *The HIV/AIDS epidemic in sub-Saharan Africa in a historical perspective*, Online edition, October 2006), 20. <<http://www.sorat.ukzn.ac.za/sinomlando/publications/>> [Accessed 5 May 2009]. C. E. Rosenberg, *Explaining epidemics and other studies in the history of medicine*, (Cambridge: Cambridge University Press, 1992), 279.

¹³ R. Prince *et al.*, "Introduction to special issue: Engaging Christianities: negotiating HIV/AIDS, health, and social relations in east and southern Africa," in R. Prince *et al.* (eds), *Africa Today* 56, 1, (Fall 2009), x.

¹⁴ Prince, "Introduction to special issue," x. For a detailed discussion of this see E. Bornstein, *The spirit of development: Protestant NGOs, morality and economics in Zimbabwe*, (Stanford: Stanford University Press, 2005).

and United Methodist churches became critical amid socio-economic decline within the State especially between 2000 and 2007.

1.2. The Research Question and Hypotheses

The key research question that this study seeks to answer therefore is:

What was the response of the Roman Catholic, Anglican and United Methodist churches to HIV and AIDS in Manicaland province, Zimbabwe between 1985 and 2007?

The hypotheses are as follows:

- (i) Denial and stigmatisation by Christian communities influenced the churches' response to those infected and affected by HIV and AIDS thereby worsening the effects of the pandemic.
- (ii) The political history of Zimbabwe affected responses to HIV and AIDS by the Roman Catholic, Anglican and United Methodist churches in Manicaland.
- (iii) The presence of the HIV and AIDS pandemic in the public space affected church polity and influenced the way it did its theology.
- (iv) The Roman Catholic, Anglican and United Methodist churches' healthcare centres in Manicaland became critical centres in providing affordable HIV and AIDS-related treatment and care support.

1.3. Rationale for the Study

Manicaland province experienced a reported HIV decline between the years 2000 and 2005. A study by Simon Gregson *et al.* showed that behaviour change was one of the contributing factors. Notable changes such as women and men avoiding sex with non-

regular partners and increased condom use with non-regular partners were cited.¹⁵ In 2007, another study on Manicaland concluded that the decline in HIV was associated with poverty.¹⁶ These observations motivated the researcher to probe the part played by the Roman Catholic, Anglican and United Methodist churches in HIV prevention and AIDS mitigation in Manicaland between 1985 and 2007. Churches can make either a positive or negative contribution towards the pandemic through their responses. The researcher is convinced that writing a history of Roman Catholic, the Anglican and the United Methodist churches' HIV and AIDS interventions or lack of thereof in Manicaland is a step forward in responding to the pandemic. The insights drawn from this historical study could go a long way in enlightening church leaders and followers on the strengths and weaknesses of their responses to the pandemic. It is hoped that other churches from within and outside the province, country, region, continent and the world at large will draw lessons from this study.

1.4. Research Objectives

The overarching objective of this study is to critically analyse the responses of the Roman Catholic, Anglican and United Methodist churches to HIV and AIDS in Manicaland, Zimbabwe in the period 1985-2007. The main objective is broken down into four key objectives each of which has a number of related questions:

- i. To investigate the factors that informed the responses of the Roman Catholic, Anglican and United Methodist churches towards HIV and AIDS in Manicaland between 1985 and 2007.
 - a. Were church leaders from the Roman Catholic, Anglican and United Methodist churches aware of the presence of AIDS-related stigma in Manicaland between 1985 and 2007?

¹⁵ UNAIDS and WHO, *AIDS epidemic update*, (UNAIDS: Geneva, 2007), 16.

¹⁶ B. Lopman *et al.*, "HIV incidence and poverty in Manicaland, Zimbabwe: Is HIV becoming a disease of the poor?" (November 2007), <<http://www.pmbmedcentral.nih.gov/artclerender.fcgi?artid=2729486/>> [Accessed 27 September 2009].

- b. Did HIV and AIDS-related stigma and denial affect the way grassroots Christians belonging to Roman Catholic, Anglican, and United Methodist churches respond to the pandemic in Manicaland between 1985 and 2007?
 - ii. To find out what methods of HIV prevention the Roman Catholic, Anglican and United Methodist churches in Manicaland advocated for between 1985 and 2007.
 - a. What did the Roman Catholic, Anglican and United Methodist churches in Manicaland say and do about the use of condoms in the prevention of the sexual transmission of HIV between 1985 and 2007?
 - b. Was there any disharmony on HIV prevention between the three churches and their global bodies including the Lambeth Conference (Anglican Communion), the General Conference of the United Methodist Church and the Holy See in Rome (Roman Catholic) in the period 1985 to 2007?
 - iii. To investigate what AIDS treatment action was employed by the Roman Catholic, Anglican and United Methodist churches in Manicaland between 1985 and 2007.
 - a. What forms of AIDS-related treatment did the Roman Catholic, Anglican, and United Methodist churches in Manicaland use or recommend between 1985 and 2007?
 - b. What action was taken by the leadership of the Roman Catholic, Anglican and United Methodist churches in Manicaland in response to the Government of Zimbabwe's delay in providing affordable AIDS treatment to patients between 1985 and 2007?

- iv. To establish how the Roman Catholic, Anglican and United Methodist churches in Manicaland responded to the need to care for PLHIV, OVC, widows and widowers between 1985 and 2007.
 - a. What AIDS-related care strategies and programmes did the Roman Catholic, Anglican and United Methodist churches adopt and implement in Manicaland between 1985 and 2007?
 - b. What challenges emerged from the AIDS-related care programmes carried out by the Roman Catholic, Anglican and United Methodist churches in Manicaland between 1985 and 2007?

1.5. Theoretical Framework

This research study is based on the understanding that the public healthcare system in Africa cannot be understood without taking into account the influence of religion. The public healthcare system is not only a biomedical reality but also a social reality informed by religious beliefs and practices. Religion and health are inter-related and therefore influence each other. Christianity has been an important factor in healthcare in sub-Saharan Africa in general and Zimbabwe in particular since the establishment of the Western missionary-initiated medical systems. Thus, there can be no understanding of healthcare in Africa and indeed Zimbabwe without considering religion as an important factor. With specific reference to religion and HIV and AIDS in Africa, Ruth Prince has this to say:

...Christianity is becoming one of the most influential factors in the engagement with AIDS in some African countries. This special issue addresses the consequences of this rapidly expanding Christian engagement with AIDS and the questions it raises. These questions can be grouped into three main themes; first, those concerning the ways people are dealing with illness and death, treatment and care for the sick, and questions of morality, kinship, gender relations, and sexuality; second, those concerning the place of religion in the public sphere, in relation to civic society and Government, development and

public health; third, those concerning transformations within Christian practices and worldviews in Africa.¹⁷

This study is premised on the argument that an epidemic such as HIV and AIDS is a social phenomenon that affects society and in turn society has an influence on the epidemic. Religion explains the world and shapes how people make sense of their environment. HIV and AIDS as a pandemic is a social reality that changes over time and therefore it is not fixed. Within this understanding, a historical perspective is important because it documents the changes that occur over time regarding the HIV and AIDS pandemic by showing the way people have responded.

Within individuals, families, and communities, religion has an effect on the way people understand health and well-being. Christianity as a religion also influences the way patients understand issues of disease, treatment and healing. Within the context of HIV and AIDS, it is important to analyse societal attitudes towards those people infected and affected by the pandemic. Issues of blame, silence, denial and stigma might feature in the way people respond to an epidemic such as AIDS. Thus it is important to examine how Christianity has reinforced both negative and positive attitudes towards PLHIV and OVC through the churches' beliefs, teachings and practices. In Africa religion and in this case Christianity has a particular influence on the public sphere in the sense that church followers have a negative and positive input towards public perception of causes of disease and health in general.

The way churches understand and become involved in healthcare matters especially HIV and AIDS affects the contribution that they can make towards supporting or opposing State healthcare policies.¹⁸ This could be apparent at the church leadership level whereby the churches can support or undermine specific State policies on public health with respect to HIV and AIDS. Similarly, the churches can shape the public discourse on epidemics in both positive and negative ways. For example, Denis has noted that "religious institutions shape the discourse on HIV/AIDS in two ways: by

¹⁷ Prince, "Introduction to special issue," v.

¹⁸ For this see for example I. D. Campbell and A. Rader Campbell, "HIV/AIDS, stigma and religious responses: An overview of issues relating to stigma and the religious sector in Africa," (May 2005), <<http://www.heart-intl.net/HIVAIDSSigmaandreligiousresponses.htm>> [Accessed 11 June 2009].

individualising it and by moralising it.”¹⁹ The responses to HIV and AIDS by the churches cannot be ignored especially in a context where religion has a central function in a society. The positive input by the churches to public health can be manifest in the form of rolling out of HIV and AIDS interventions at church healthcare centres and other sites and the opposite can happen. Within the churches, the need to respond to HIV and AIDS can transform the ecclesiastical structures as “religious institutions create, or encourage their members to create, formal and informal HIV and AIDS organisations.”²⁰ Thus various role players including Christianity have input on public health. The present study made use of the perspectives by Michael Gelfand, Terence Ranger and Philippe Denis. The response of the churches to the pandemic in Manicaland, Zimbabwe in the period 1985-2007 will be analysed using the perspectives developed by these three authors.

First, the study will consider the argument by Gelfand that public healthcare formed an integral part of the early missionary enterprise in Zimbabwe,²¹ and thus the Western missionary-initiated churches inherited and continued with this legacy. The Western missionary-initiated churches in southern Africa, including Zimbabwe, lived with the notion that their presence in society was desirable because of what they perceived was their deep concern for the welfare of individual communities. Gelfand has argued that healthcare was one such concern:

When the first missionaries set up mission stations in the second half of the nineteenth century to help the African population, it is readily understandable that they wanted to alleviate suffering whenever it was encountered, especially as spiritual healing is part of Christian dogma.²²

While the purpose of this present research study is not to explore in detail the different debates around the motives of the Western missionary-founded medical institutions, it will nevertheless pursue the notion that healthcare services were generally perceived to have made a positive contribution to the lives of ordinary

¹⁹ P. Denis, “The church’s impact on HIV prevention and mitigation in South Africa. Reflections of a historian,” *Journal of Theology for Southern Africa* 134 (July 2009), 70.

²⁰ P. Denis, “HIV, AIDS and religion in sub-Saharan Africa: an Historical survey,” in B. Haddad (ed), *Religion and HIV and AIDS in Africa: Charting the terrain*, (Scottsville: UKZN Press, 2011), 59.

²¹ M. Gelfand, “Medicine and the Christian missions in Rhodesia, 1857-1930,” in A. J. Dachs (ed), *Christianity south of the Zambezi*, (Gweru: Mambo Press, 1973), 109.

²² Gelfand, “Medicine and the Christian missions in Rhodesia,” 109.

people. Hence, from the missionary times till the present the Roman Catholic, Anglican, and United Methodist churches and the other church denominations in Zimbabwe perceived that involvement in public healthcare or healing –was an integral part of the ministry of Jesus.”²³

This conviction was seen as being a key towards building bridges between the Western missionaries and the local communities and thereby assisted in the expansion of its so-called ‘Christian sphere of influence.’ Gelfand has observed: ‘Through the practice of medicine the missionary was gradually able to make friendly contact with Africans, who on the whole were ready to use the white man’s knowledge in this field.’²⁴ While the involvement of churches in healthcare can be seen as having popularised Christianity, the beneficiaries might have perceived this as part of Christian love and care. As with the other churches in Manicaland, the Roman Catholic, Anglican and United Methodist communions continued with the healthcare work initiated by the Western missionaries. In line with this assertion, Marian Burchardt *et al.* observed that ‘in many African countries, especially in those with a strong tradition of missionary Christianity, religious organisations have been pivotal to healthcare and education long before the arrival of HIV/AIDS.’²⁵ On that premise, the churches were therefore ‘expected’ by society to carry out HIV interventions and AIDS mitigation programmes.

During the colonial era in Southern Rhodesia, the churches offered healthcare services to the public. At times they did not have enough resources and the colonial authorities were unwilling to partner with them.²⁶ However, at the outbreak of epidemics, the medical missionaries drew the colonial administration’s attention to its responsibility for the healthcare of sick Africans. Hence, as Gelfand highlighted: ‘The missionaries also requested for material help from the government in the form of medicines and dressings for the sick. These they would be happy to dispense themselves.’²⁷ Later

²³ C. J. M. Zvobgo, *A history of Christian missions in Zimbabwe, 1890-1939*, (Gweru: Mambo Press, 1996), 202

²⁴ Gelfand, ‘Medicine and the Christian missions in Rhodesia,’ 114.

²⁵ M. Burchardt *et al.*, *Faith matters: Religion and biomedical treatment for HIV/AIDS in sub-Saharan Africa*, (Diemen: AMB Publishers, 2009), 2.

²⁶ See J. McCulloch, ‘The management of venereal disease in a settler society: Colonial Zimbabwe, 1900-30,’ in P. Setel *et al.*, (eds), *Histories of sexually transmitted diseases and HIV/AIDS in sub-Saharan Africa*, (Westport: Greenwood Press, 1999), 195-216.

²⁷ Gelfand, ‘Medicine and the Christian missions in Rhodesia,’ 120.

however, the colonial administration expressed its strong reservation at providing medical support to the majority of indigenous Africans through missionary healthcare facilities. Hence, it was only in June 1927 that grants were available to missionary societies providing medical attention in the reserves.”²⁸ Although the colonial administration was initially reluctant to work with mission authorities in the sphere of public healthcare, gradually a partnership was established. The church’s social institutions were also used by Western missionary agencies as tools for evangelisation. Hence, missionary involvement in providing healthcare using Western medicine was seen as a way of winning the hearts and minds of Africans to Christianity.²⁹ Efforts at HIV prevention and AIDS mitigation by the churches in Zimbabwe may also be seen in a similar light.

There is an important link between Gelfand’s assertion about the role played by the churches in public health in Zimbabwe³⁰ and Richard Elphick’s argument that Christianity formed an essential part in the public history of South Africa. In viewing the place of Christianity in the public sphere, Elphick has made the claim that, “long before Christians became an overwhelming majority, Christian ideas and institutions were prominent in the political history of the region.”³¹ This has inevitably drawn parallels with the situation in Zimbabwe whereby church-related healthcare facilities initially established by Western missionaries and later administered under local church structures continued to discharge medical services to the public.

Indeed, it is an established fact that following independence from colonial rule, many governments in Africa took over healthcare and other social services from the churches and thus responses to HIV and AIDS by faith organisations took on a different form. Consistent with this observation, Prince *et al.* have shown that following independence, “Scores of mission hospitals were nationalised. What we see today is a *return* to nongovernmental and faith-based healthcare, not through mission

²⁸ Gelfand, “Medicine and the Christian missions in Rhodesia,” 123. See also McCulloch, “The management of venereal disease in a settler society,” 200.

²⁹ G. L. Chavunduka, “Christianity, African religion and African medicine,” Paper published by the WCC, <<http://www.wcc-coe.org/wcc/what/interreligious/cd33-02.html>> [Accessed 26 May 2010]. See also Gelfand, “Medicine and the Christian missions in Rhodesia,” 114.

³⁰ Gelfand, “Medicine and the Christian missions in Rhodesia,” 109.

³¹ R. Elphick, “Introduction: Christianity in South African history,” in R. Elphick and R. Davenport (eds), *Christianity in South Africa: A political, social and cultural history*, (Oxford: James Currey, 1997), 1.

hospitals, but through FBOs and NGOs.”³² While this observation might be valid, the experience in Zimbabwe is that after gaining political independence in 1980, the church and State work in a cooperative partnership. This is shown by Zimbabwe’s newly elected Prime Minister Robert Mugabe inviting the churches to join hands with the State to fight ignorance, disease and general underdevelopment.³³

There has been a phenomenal expansion of Christianity in both South Africa and Zimbabwe since the missionary era. For example, as Elphick has observed, by 1997, some 72.6% of all South Africans ascribed themselves as being Christian, a figure that was up from about 46% in 1911.³⁴ Similarly, in Zimbabwe, Ambrose Moyo has indicated that by 1988, 50% of its citizens endorsed Christianity as an influential religious tradition in Zimbabwe.³⁵ In addition, according to the Bureau of Democracy, Human Rights and Labour, in 2001 between 60% and 70% of Zimbabweans were affiliated to the Christian religion.³⁶ While the statistics might need further interrogation, it is important for this study to note the increase in the number of followers of the Christian religion in Zimbabwe. This has made it even more important to consider the way Christianity may have shaped the socio-political landscape in the context of HIV and AIDS. Given this situation, it is particularly critical to focus on how the three Western missionary-initiated church denominations in this research study responded to the HIV pandemic within the realm of public health in Manicaland between 1985 and 2007.

This thesis is informed, secondly, by Ranger’s discussion on the effect of epidemics on mission bio-medical systems in Zimbabwe. Ranger described how missionaries felt “embarrassed” when missionary healthcare systems in colonial eastern and southern Africa—including Zimbabwe—failed to adequately address the 1918

³² Prince, “Introduction to special issue,” x.

³³ P. H. Gundani, “The Catholic Church and national development in Zimbabwe,” C. F. Hallencreutz and A. C. Moyo (eds), *Church and State in Zimbabwe*, (Gweru: Mambo Press, 1988), 216. Gundani’s original source is the “Prime Minister’s concluding address,” Zimbabwe Council of Churches International Five Year Development Plan Conference, 19 October 1983.

³⁴ Elphick, “Introduction: Christianity in South African history,” 1.

³⁵ A. M. Moyo, “Religion and political thought in independent Zimbabwe,” in Hallencreutz and Moyo, *Church and State in Zimbabwe*, 201.

³⁶ Bureau of Democracy, Human Rights and Labour, *Zimbabwe: International religious freedom report*, <<http://www.state.gov/g/drl/rls/irf/2001/5718.htm>> [Accessed 20 May 2009]. See also US State Department, *International religious freedom report 2002: Zimbabwe*, <http://atheism.about.com/library/irf02/blirf_zimbabwe.html/> [accessed on 6 May 2009].

influenza epidemic. According to Ranger, “challenges arose when official orthodoxies of public health broke down in periods of social, economic and political disorder, or when new diseases—or old diseases in the intensified form—overrode all control systems and devastating epidemics broke out.”³⁷ It appears that Christianity shared the ‘blame’ for western biomedicine’s failure to conquer the influenza epidemic of 1918. Within Christian healthcare systems, there was a tendency to project medical staff as ‘healers’ who could treat any disease successfully. As Ranger goes on to observe: “Missionaries came to put much emphasis upon the evangelical power of doctors and nurses whose dispensation of biomedicine was thought of as the modern continuance of the healing mission of Jesus.”³⁸ Gelfand and Zvobgo have also highlighted this in their study of Christian medical mission as already indicated above. Similarly, Willem Saayman argued that within Christian circles, healing is understood as a dimension of Christian mission, more specifically the involvement of Jesus of Nazareth in the victorious encounter of the reign of God with everything that diminishes people’s humanity.³⁹ These authors claim that Christian institutions are naturally inclined to be involved in healthcare. Thus the present research study takes the position that church responses to the HIV and AIDS pandemic can be viewed in that light.

The perception by members of the public that an epidemic constitutes a punishment from God was also highlighted in the case of the 1918 influenza epidemic in southern Africa. Public perceptions of this nature were indeed common among the Afrikaans-speaking Reformed churches as well as the Methodist and Anglican churches which held the perception that influenza was a natural calamity.⁴⁰ Ranger has also paid particular attention to Christian responses to the 1918 influenza epidemic in Southern Rhodesia (now Zimbabwe). When the medical healthcare system, including Christian hospitals, failed to stem the epidemic which arrived in Zimbabwe in October 1918, according to Ranger, “there was recourse to many traditional ways of responding to

³⁷ T. Ranger, “Plagues of beast and men; Prophetic responses to epidemic in eastern and southern Africa,” in T. Ranger and P. Slack (eds), *Epidemics and ideas: Essays on the historical perception of pestilence*, (Cambridge: Cambridge university Press, 1992), 242.

³⁸ Ranger, “Plagues of beast and men,” 263.

³⁹ W. Saayman, “AIDS, Healing and Culture in Africa: A Christian Perspective,” *Journal of Theology for Southern Africa*, 78 (March 1992), 41.

⁴⁰ Ranger, “Plagues of beast and men,” 264

epidemic, some of them once part of official orthodox systems of public health and some of them once part of popular counter systems.”⁴¹

The present research study will seek to illustrate that some of the Christian responses to HIV and AIDS in Manicaland were affected by public perceptions of AIDS as *runyoka* and the work of witches. Ranger has indicated that in Zimbabwe the credibility of the Christian public healthcare system was “humiliated” by the influenza epidemic: “It was, after all, Christian biomedicine which was most challenged by the pandemic. Influenza discredited mission public health among many African Christians.”⁴² Within Christianity, the failure of the Western-missionary initiated churches to contain the influenza epidemic led to the mushrooming of Christian prophetic and apostolic movements founded by local indigenous leaders. As Ranger has noted: “In Southern Rhodesia the pandemic gave a powerful impetus to the emergence of indigenous Christian prophetic churches—the Vapostori movements of Johane Maranke and Johane Masowe.”⁴³ This present research study brings to the fore a detailed analysis of the rise of a prophetic movement that claimed to cure HIV within the Anglican Church in Manicaland. It will also indicate that the church followers, affected and infected by HIV, often sought after the services of prophetic and traditional healers.

The third perspective is based on the work of Denis, in which religion is seen as pertinent to HIV and AIDS and that there are different levels at which church responses might occur. The present research study does not concern itself with a detailed analysis of ecclesiology. Generally, the Christian church could be understood as an ecumenical body, denominations, local congregations, worshipping communities, individual believers in their personal capacities, together with other persons, whether Christian believers or not, who were committed to the same cause.⁴⁴ Having defined the church as a gathering of people believing in Jesus Christ, Denis has argued that the church as a body has carried out a multi-faceted response to HIV and AIDS:

⁴¹ Ranger, “Plagues of beast and men,” 266

⁴² Ranger, “Plagues of beast and men,” 266.

⁴³ Ranger, “Plagues of beast and men,” 266.

⁴⁴ D. J. Smit, “Living unity? On the ecumenical movement and globalisation,” *Reformed World*, 24th General Council, Accra 2004, 53, 4, (December 2003), 198.

The social reality designated by the word [church], however is complex. As far as the response to HIV/AIDS is concerned, three components should be distinguished: the entire church body, either at the level of a denomination or all denominations taken together; the local congregations or parishes; and AIDS-related organisations directly or indirectly related to a denomination or a local congregation.⁴⁵

This perspective is critical in the sense that it acknowledges the organisational realities that exist within the various churches. Hence, the response of each church to HIV, together with its hierarchical structures, depends on which of the church components were involved.

Denis has further elaborated on HIV responses by different components of the church by observing that

...the church body as represented by a bishop, a synod or an assembly, plays a specific role in AIDS matters: the church authorities contribute, sometimes negatively, sometimes powerfully, to the discourse on the epidemic and in this way influence both policy-making and popular attitudes.⁴⁶

The present research study will concur with the position taken by Denis and will note that the leadership of all the three churches under this study were involved in passing joint or separate statements and/or messages in their response to the HIV pandemic. Denis also noted that local parishes or congregations form an important unit of a church's structure because at this level ordinary church members under the leadership of its clergy and elected lay officers have responded to the pandemic. Indeed, Denis has observed that the local parish or congregation was the most crucial in responding to HIV:

It is at this level that the fight against HIV/AIDS will or will not be successful by contributing to behaviour change, stigma reduction, higher levels of disclosure, care and treatment and ongoing support to people living with HIV/AIDS [PLHIV].⁴⁷

⁴⁵ Denis, "The church's impact on HIV prevention and mitigation," 68.

⁴⁶ Denis, "The church's impact on HIV prevention and mitigation," 69.

⁴⁷ Denis, "The church's impact on HIV prevention and mitigation," 69.

The present study has obtained its major findings in parishes and congregations belonging to Roman Catholic, Anglican and United Methodist churches in Manicaland. In this study, the voices of ordinary parishioners were critical to understand the churches' response to HIV. In addition, parish records and the minutes of church council meetings indicated an overall picture of the parish's response to the pandemic.

There is also a sense in which church-related HIV interventions transformed the ecclesiological landscape to a point of creating new specialised formal and informal structures that had not existed before. The church-founded FBOs involved in responding to HIV formed an important part of the multi-faceted approach undertaken by churches. In line with this assertion, Denis observed that: "FBOs constitute the third component of the church. They include any formal and informal organisation or initiative in the field of HIV/AIDS, initiated by churches themselves or some of their members."⁴⁸ This comment was an essential tool in analysing the establishment and work of AIDS-related FBOs that maintained connections with the churches that constituted this research study. In cases where AIDS-related FBOs spearheaded church-led HIV interventions, this increased the visibility of the particular church or churches involved, especially in cases where such organisations received foreign funding. Consistent with this observation, Prince *et al.* have stated: "Whatever the short-term fluctuations in funding for FBOs the move towards faith-based AIDS policies is contributing to the increased visibility of Christianity in the public space."⁴⁹

While each component had a role to play in responding to HIV, within a multi-faceted response to the pandemic, there are some internal dynamics that either create a sense of harmony or disharmony. Indeed, the church response to HIV mirrored the perceptions of the pandemic by its leaders and followers. As Daniela Gennrich has maintained:

The church can only begin to be effective in its fight against the HIV and AIDS epidemic when it recognises that AIDS is not confined to

⁴⁸ Denis, "The church's impact on HIV prevention and mitigation," 68.

⁴⁹ Prince, "Introduction to special issue," ix.

those outside the faith, and that people within the church community are infected and affected by HIV.⁵⁰

1.6. Literature Survey

While not much was written about the HIV pandemic in Africa prior to 2000, since that time there has been a steady increase in the literature. Studies on religion and HIV and AIDS in Africa and Zimbabwe in particular have however only recently begun to emerge. The literature survey will be discussed under three categories:

- i. The history of HIV and AIDS in Africa;
- ii. HIV and AIDS in Manicaland, Zimbabwe;
- iii. HIV and AIDS in the context of the Roman Catholic, Anglican and United Methodist churches in Manicaland.

1.6.1. The History of HIV and AIDS in Africa

The literature on HIV and AIDS in Africa is vast, and as such, this present study cannot exhaust it. That said, some important sources have been identified and sampled for their relevance to the present study. Although limited in scope, the work of anthropologist Robert Garner in a study of the influence of church membership on HIV outside of Pietermaritzburg, South Africa was crucial. Garner concluded that members of Pentecostal type churches were less prone to contracting HIV than those from the missionary founded churches including Roman Catholics, due to the fact that the former strictly adhered to the church's teachings on sexuality and the latter did not.⁵¹ In Malawi, the study by Jenny Trinitapoli and Mark Regnerus carried out

⁵⁰ D. Gennrich (ed), *The church in an HIV+ world: A practical handbook*, (Pietermaritzburg: Cluster Publications, 2004), 56.

⁵¹ R. Garner, "Safe sects? Dynamic religion and AIDS in South Africa," *Journal of Modern African Studies* 38, 1, (March 2000), 41-69.

between 1997 and 2000 drew similar conclusions.⁵² It should be noted however, that while both studies were carried out in southern Africa and involved individual churches, they did not focus on the church's response to the HIV pandemic. While their studies bring important insights, the present study is an attempt to document what the churches actually did or failed to do in responding to HIV with a specific focus on Manicaland in Zimbabwe.

Philip Setel *et al.* edited a volume entitled *Histories of sexually transmitted diseases and HIV/AIDS in sub-Saharan Africa* in which they linked the present HIV epidemic to the prevalence of earlier cases of sexually transmitted infections in African countries.⁵³ These countries include Ghana, Ivory Coast, Senegal, Uganda, Tanzania, Malawi, Zambia, Zimbabwe, Kenya and South Africa. In their introductory chapter, Setel *et al.* highlighted the fact that the comparative histories of sexually transmitted infections and AIDS in Africa had been characterised by factors such as ambiguity and diversity, cultural change, racism, gender, labour migration and economic instability, and the practice of biomedicine and epidemiology in African contexts.⁵⁴

The influence of religion in shaping people's responses to sexually transmitted diseases and subsequently the HIV pandemic appeared in a number of cases. In Ghana, Deborah Pellow highlighted the positive and negative influence of religious bodies in responding to HIV and AIDS. For example, while the Roman Catholic Church and religious fundamentalists —who do not want elementary school children to hear about sex,⁵⁵ Roman Catholic hospitals in Ghana were part of a team of Non-Governmental Organisations (NGOs) working under the national AIDS Control Programme.⁵⁶ This observation is relevant for the present study given a situation that while the healthcare centres belonging to the Roman Catholic, Anglican and United Methodist churches served PLHIV, the same churches remained reluctant to support the open use of condoms in their HIV prevention strategies.

⁵² J. Trinitapoli and M. D. Regnerus, —Religion and HIV risk behaviours among married men: Initial results from a study in rural sub-Saharan Africa,” *Journal for the Scientific Study of Religion* 45, 4, (2006), 505-528.

⁵³ Setel, *Histories of sexually transmitted diseases and HIV/AIDS*.

⁵⁴ P. Setel, —Comparative histories of sexual transmitted and HIV/AIDS in Africa: An introduction,” in Setel, *Histories of sexually transmitted diseases and HIV/AIDS*, 1-15.

⁵⁵ D. Pellow, —Sex, disease, and culture change in Ghana,” in Setel, *Histories of sexually transmitted diseases and HIV/AIDS*, 32.

⁵⁶ Pellow, —Sex, disease, and culture change in Ghana,” 34.

In Senegal, Charles Becker and René Collignon observed that religious leaders only became involved in HIV prevention and AIDS mitigation after a long period of little or no action. Change came when —moral and religious leaders who long stood back from debate and action have recently become involved.”⁵⁷ Although this observation might be relevant for the present study, it fails to locate the role of grassroots Christian communities in responding to the HIV pandemic. Their study did not give a detailed analysis of what the religious leaders of specific churches did or failed to do. In the case of Zimbabwe, Jock McCulloch noted that between 1900 and 1930 rural mission stations were involved in the treatment of venereal disease and received State support in the form of medical drugs.⁵⁸ McCulloch’s study focused on a period more than fifty years prior to the advent of HIV. However, the observations made by McCulloch brings out important insights in the way Western missionary-initiated church healthcare systems were involved in public health in Rhodesia (now Zimbabwe) especially in responding to venereal disease. Of importance was the fact that with State support, mission hospitals reduced the spread of syphilis and yet at the same time it —allowed missions to do good works and thereby attract Africans to their churches.”⁵⁹ Based on this observation, the present study will also seek to indicate the relationship between the State and the church-based healthcare systems in responding to the HIV pandemic within a historical perspective in Manicaland.

Jeremy Liebowitz’s work on HIV and religious responses in Africa has a particular focus on Uganda. The author defines FBOs as —.both places of worship and their members as well as any organisation affiliated with or controlled by these houses of worship.”⁶⁰ This definition is applicable to the present study in which the church’s response to HIV has included those initiatives involving grassroots Christians, church leaders as well as specialised church-based structures. Liebowitz’s work also found the negative input by churches in preventing and mitigating HIV and AIDS. This was

⁵⁷ C. Becker and R. Collignon, —History of sexually transmitted diseases and AIDS in Senegal: Difficulties in accounting for social logistics in health policy,” in Setel, *Histories of sexually transmitted diseases and HIV/AIDS*, 83.

⁵⁸ McCulloch, —The management of venereal disease in a settler society,” 199.

⁵⁹ McCulloch, —The management of venereal disease in a settler society,” 200.

⁶⁰ J. Liebowitz, —The impact of faith-based organizations on HIV/AIDS prevention and mitigation in Africa,” Paper prepared for the Health Economics and HIV/AIDS Research Division (HEARD), University of Natal, (October 2002), 5.

highlighted in –the resistance of religious leaders to condom use, the stigmatisation of AIDS as an immoral disease, and the way in which religion limits open discussion on sexuality, gender relations, and intergenerational relations.”⁶¹

On a positive note, and using the words of Robert Putman on social capital, the same study concluded that –religious institutions have demonstrated more effectiveness in combating AIDS than the government.”⁶² In this regard, social capital could include religious health assets as proposed by the African Religious Health Assets Programme (ARHAP).⁶³ Studies by ARHAP have further streamlined religious health assets into the two categories of tangible and intangible. By employing this approach, ARHAP brought another analytical angle to church responses to HIV and AIDS. ARHAP highlighted that –leading tangible factors comprise compassionate care, material support and health provision; leading intangibles are spiritual engagement, knowledge giving and moral formation.”⁶⁴ In 2004, Georges Tiendrebeogo and Michael Buykx in a desk review entitled *Faith-based organisations and HIV/AIDS prevention and impact mitigation in Africa*, also concluded that religion had both negative and positive effects on the HIV and AIDS pandemic.⁶⁵

John Iliffe in his 2006 publication, *The African AIDS epidemic: A history*,⁶⁶ has attempted to understand why the African continent has been the hardest hit by HIV. In his study, Iliffe not only highlights the discovery of HIV in the West, but also traces the history of the epidemic to the African continent describing it as a –silent

⁶¹ Liebowitz, –The impact of faith-based organizations on HIV/AIDS,” 5.

⁶² Liebowitz, –The impact of faith-based organizations on HIV/AIDS,” 17.

⁶³ For a detailed discussion on this see African Religious Health Assets Programme, Assets and Agency, Unpublished report, Pietermaritzburg Colloquium, (August 2003).

⁶⁴ African Religious Health Assets Programme. –Appreciating assets: The contribution of religion to universal access in Africa,” Report for the World Health Organisation, (Cape Town: ARHAP, October 2006), 3. See also G. Gunderson, –What do hospitals have to do with health? Exploring the relationship among religious disease care systems and other types of religious health assets,” in a collection of concept papers presented at ARHAP International Colloquium, March 13-16, 2007, Cape Town, 1-6. See also S. de Gruchy, –The value of religion in religious health assets,” in a collection of concept papers presented at the ARHAP International Colloquium, March 13-16, 2007, Cape Town, 15-20. See also B. Schmid, –What value does religion add to health services?” in a collection of concept papers presented at the ARHAP International Colloquium, March 13-16, 2007, Cape Town, 26-30.

⁶⁵ G. Tiendrebeogo and M. Buykx, *Faith-based organisations and HIV/AIDS prevention and impact mitigation in Africa*, (Amsterdam: Royal Tropical Institute, 2004). See also E. C. Green, *Faith-based organisations: Contribution to HIV prevention*, Report compiled for the Synergy Project, (September 2003). See also W. Parker and K. Birdsall, *HIV/AIDS, stigma and faith-based organisations: A review*, (Washington D C: DFID/Futures Group MSP, 2005).

⁶⁶ J. Iliffe, *The African AIDS epidemic: A history*, (Oxford: James Currey, 2006).

epidemic.” While this work indicates the fast rate of the spread of HIV in Africa including Zimbabwe, it gives limited space for a detailed analysis of responses to the pandemic in each country. Significantly, observations made by Iliffe in analysing Christian responses to the epidemic in Africa have relevance for the present study. Iliffe observes that religious moralists and medical pragmatists have been divided on sex education and the use of condoms with –Roman Catholic leaders generally denouncing them as contravening the divine purpose of procreation, encouraging promiscuity and actually fostering HIV.”⁶⁷ While acknowledging some of the findings by Iliffe, the present study will investigate and analyse in detail the responses of specific church leaders and their followers to HIV in a historical perspective. Rather than being a broad study, the research study will focus on specific responses to HIV by the three selected churches in one geographical province of Zimbabwe.

The work of Denis and Becker in the volume, *The HIV/AIDS epidemic in sub-Saharan Africa in a historical perspective* published in 2006,⁶⁸ was an attempt by historians, epidemiologists and anthropologists to present a history of the pandemic in selected African countries. The co-edited publication, which put together the work of fifteen specialists, has given limited attention to religious significance in relation to the HIV pandemic. For example, Paul Kocheleff’s chapter on AIDS in Burundi and South Africa points out that Burundi is largely a Roman Catholic country. In Burundi the church’s response to HIV has largely been characterised by denial, stigmatisation and resistance to the use of condoms.⁶⁹ Similarly, in the same volume, Elizabeth Colson’s study of responses to HIV in the Gwembe Valley, Zambia briefly highlights the fact that –the teaching especially of charismatic churches that HIV/AIDS is God’s punishment for sin or due to Satan, also affects how people view those ill with AIDS and their right to support.”⁷⁰ Apart from the brief focus on religion and HIV, this volume is also important in its periodisation of the AIDS epidemic in Africa as noted in the work of Michel Caraël,⁷¹ Colson,⁷² Kocheleff,⁷³ and Stephen van Houten.⁷⁴

⁶⁷ Iliffe, *The African AIDS epidemic*, 96.

⁶⁸ Denis and Becker, *The HIV/AIDS epidemic in sub-Saharan Africa*.

⁶⁹ P. Kocheleff, –AIDS in Burundi and South Africa: A day-to-day experience,” in Denis and Becker, *The HIV/AIDS Epidemic in sub-Saharan Africa*, 147.

⁷⁰ E. Colson, –The search for healing: The AIDS epidemic in Gwembe Valley,” in Denis and Becker, *The HIV/AIDS epidemic in sub-Saharan Africa*, 116.

⁷¹ M. Caraël, –Twenty years of intervention and controversy,” in Denis and Becker, *The HIV/AIDS Epidemic in sub-Saharan Africa*, 29-40.

⁷² Colson, –The search for healing,” 113-125.

While the insights of these contributors applied to contexts outside Zimbabwe, they were crucial and relevant in appreciating the periodisation of HIV and AIDS taken by this study in Manicaland.

In 2006, Jill Oliver, James Cochrane, and Barbara Schmid, from University of Cape Town and Lauren Graham from the University of the Witwatersrand mapped the critical sources that focus on religious responses to HIV and AIDS in Africa. Their collaborative work was subsequently published by ARHAP in the form of a comprehensive bibliography.⁷⁵ The volume was accompanied by a companion publication that focussed on a literature review,⁷⁶ the two pieces of work being complementary to one another. While some of the sources listed in the ARHAP bibliography were used in this study, the researcher drew important insights on church or religious responses to HIV and AIDS in Africa in general, and Zimbabwe in particular. One of the critical contributions made by Oliver *et al.* was to position religious responses to HIV in the context of their engagement with public healthcare issues. The authors noted that religion had a bearing on development that could not be ignored as observed, whereby, “Religions have long been involved in social transformation and development, but have rarely been recognised in this role by development policy makers.”⁷⁷

This present study is aware of the long history of the involvement in public healthcare by the Roman Catholic, Anglican and United Methodist churches in Manicaland. While this is a historical study, Oliver *et al.* have argued that a focus on religious entities was critical in a context whereby “systems fail and illnesses and diseases outstrip capacities for response, with high costs to many people, particularly those who cannot afford private care and services.”⁷⁸ The literature review by ARHAP also

⁷³ Kocheleff, “AIDS in Burundi and South Africa,” 143-154.

⁷⁴ S. Van Houten, “Historical trends in the HIV/AIDS training of healthcare workers in the Western Cape, South Africa, 1990-2003,” in Denis and Becker, *The HIV/AIDS Epidemic in sub-Saharan Africa*, 157-159.

⁷⁵ J. Oliver, J. R. Cochrane and B. Schmid, *ARHAP bibliography: Working in a bounded field of unknowing*, (Cape Town: African Religious Health Assets Programme, 2006).

⁷⁶ J. Oliver, J. R. Cochrane and B. Schmid, *ARHAP literature review: Working in a bounded field of unknowing*, (Cape Town: African Religious Health Assets Programme, 2006).

⁷⁷ Oliver, *ARHAP literature review*, 19.

⁷⁸ Oliver, *ARHAP literature review*, 22.

identified culture and religion as critical players in shaping the way people understand health and well-being within their local settings. As a result, the authors observed:

In Africa and other developing nations, however, religion and culture remain important elements of public and private life, and as such, they have a major impact on health ranging from health seeking behaviour to support structures, lifestyle, socialisation and access to healthcare.⁷⁹

The influence of culture and religion on responses of the three churches to HIV was manifest in a number of ways including patriarchal practices that exposed women to HIV and increased denial and stigma. Oliver *et al.* highlighted the existence of literature that focussed on stigma as a religious response by observing:

Many mainstream religious leaders are prominent as health advocates in the public arena—frequently taking centre stage and utilising public media channels to project their messages. There are also an amazing amount of ‘statements’ of intent released by mainstream religious organisations on the topic of HIV/AIDS.⁸⁰

Generally, while it appears that the attitude of church leaders towards PLHIV has changed over time, initially denial and stigma were the norm. Ian Campbell and Alison Rader thus noted: “Religious groups, in general, have a reputation for responding to the issue of HIV in negative terms. The religious sector has been largely unwilling to engage in any way that could imply dilution of moral standards.”⁸¹ This was critical to the present study as the researcher had to appreciate the way church leaders and members from the Roman Catholic, Anglican and United Methodist churches in Manicaland understood and responded to the HIV pandemic. As a consequence, this research study will hopefully dare to answer the question posed by Oliver *et al.*: “What role has the church played in mobilising access to treatment or supported HIV issues?”⁸²

The work by anthropologists in a volume edited by Felicitas Becker and Wenzel Geissler published in 2009 contributes greatly to appreciating the influence that

⁷⁹ Oliver, *ARHAP literature review*, 27.

⁸⁰ Oliver, *ARHAP literature review*, 41.

⁸¹ Campbell and Rader, “HIV/AIDS, stigma and religious responses.”

⁸² Oliver, *ARHAP literature review*, 31.

religious practice has on HIV and AIDS in Africa.⁸³ The present study has drawn upon valuable insights from the contributed essays by Felicitas Becker and Wenzel Geissler,⁸⁴ as well as Heike Behrend on the Roman Catholic Church in Western Uganda,⁸⁵ Ruth Prince on Christian salvation and Luo tradition in Western Kenya,⁸⁶ Catrine Christiansen on remaking of widow lives in Uganda,⁸⁷ and Isak Niehaus on Christian conceptions of AIDS in parts of South Africa.⁸⁸

While the work of Isak Niehaus on Christian perceptions of HIV and AIDS in South Africa is located in the field of anthropology,⁸⁹ the findings resembled traits that were similar to Christian responses to the 1918 influenza epidemic as indicated by Ranger. The fact that some Christians understood AIDS as the manifestation of biblical leprosy is an indication of the negative attitude maintained towards the HIV epidemic. As Niehaus has observed, there was much stigma expressed towards HIV in some churches including the Zionist Church of South Africa, which lead many Christian followers to –conceptualise AIDS as a new, deadlier kind of leprosy with all its overtones of divine punishment and horror.”⁹⁰ The connection between AIDS and leprosy is backed by three shared characteristics, whereby both conditions were seen as

...divine retribution for sin in a world that has gone astray morally. Villagers see the bodies of those with AIDS, like those of lepers, as tented with death. ...Like lepers, persons with AIDS are seen to be highly contaminating and are excluded from contact with other villagers.⁹¹

As a consequence, this led to a lot of secrecy about the AIDS pandemic: –Close kin usually shield terminally ill persons from public view and vehemently deny that they

⁸³ C. Becker and P. W. Geissler (eds), *AIDS and religious practice in Africa*, (Leiden: Brill, 2009).

⁸⁴ F. Becker and P. W. Geissler, –Introduction: searching for pathways in a landscape of death: Religion and AIDS in Africa,” in Becker and Geissler, *AIDS and religious practice in Africa*, 1-25.

⁸⁵ H. Behrend, –The rise of occult powers, AIDS and the Roman Catholic Church in western Uganda,” in Becker and Geissler, *AIDS and religious practice in Africa*, 29-47.

⁸⁶ R. Prince, –Christian salvation and Luo tradition: Arguments of faith in time of death in western Kenya,” in Becker and Geissler, *AIDS and religious practice in Africa*, 49-83.

⁸⁷ C. Christiansen, C, –The new wives of Christ: Paradoxes and potentials in the remaking of widow lives in Uganda,” in Becker and Geissler, *AIDS and religious practice in Africa*, 85-116.

⁸⁸ I. Niehaus, –Leprosy of a deadlier kind: Christian conceptions of AIDS in the South African Lowveld,” in F. Becker and P. W. Geissler, *AIDS and religious practice in Africa*, 309-332

⁸⁹ Niehaus, –Leprosy of a deadlier kind.”

⁹⁰ Niehaus, –Leprosy of a deadlier kind,” 311.

⁹¹ Niehaus, –Leprosy of a deadlier kind,” 311.

have AIDS. They often deflect blame by claiming that the sick persons are victims of witchcraft.”⁹² The study is thus aware that Christians also used euphemisms to avoid mentioning the words “HIV” and “AIDS” directly. While leprosy was a disease that had to be addressed by the Western missionary-initiated healthcare systems, the incurable nature of HIV gave way to mixed interpretations and responses by the Christian communities and thus demonstrated the churches’ perception of HIV and AIDS as being a form of pestilence.

The Western missionary-imitated churches including the Roman Catholic, Anglican and United Methodist churches in Manicaland were seen as sources of hope for the eradication of HIV and AIDS. As Ezra Chitando observed:

Missionaries who cared for social outcast illustrate the church’s legacy of compassion in Africa. Individuals who suffered from leprosy were traditionally barred from interacting with other members of society...Mission hospitals provided care to individuals who had been forsaken by society.⁹³

While the missionary churches in colonial Africa were at the forefront of responding to leprosy, there were also elements of ‘spiritualisation’ on the part of missionaries. As Niehaus has observed:

The misery of the leper epitomised the need of Africans for salvation from themselves and their culture. Invoking biblical images of leprosy, missionaries thereby helped establish it as a maximal and very contagious illness in the minds of their African converts and this representation of leprosy still resonates today.⁹⁴

Niehaus’ study indicates that some Christians understood AIDS as a product of witchcraft in which, “Christian healers interpret as evidence that the witches are trying to transform the sick person into a zombie.”⁹⁵ The failure of western medicine to adequately address the 1918 influenza epidemic as discussed by Ranger, and the Christian understanding of HIV as being the same as biblical leprosy, were relevant in

⁹² Niehaus, “Leprosy of a deadlier kind,” 313.

⁹³ E. Chitando, *Living with hope: African churches and HIV/AIDS* 1, (Geveva: WCC, 2007), 9.

⁹⁴ Niehaus, “Leprosy of a deadlier kind,” 318.

⁹⁵ Niehaus, “Leprosy of a deadlier kind,” 324.

conceptualising responses to HIV and AIDS by the Roman Catholic, Anglican and United Methodist churches in Manicaland.

In *Africa Today* published in 2009, the authors discussed Christian agendas in responding to HIV in east and southern Africa. Prince *et al.* explored “the place of Christianity in (inter)national AIDS programmes and initiatives, and the Christianisation of public discourse and debate about AIDS and its effects on other institutions, practices, and debates in African societies experiencing the AIDS epidemic.”⁹⁶ The observations made in the introductory chapter were relevant to Christian responses to HIV in Africa in general. The present study will use these insights in analysing church-led HIV interventions in Manicaland. The closest piece of academic work to the present study is Stephen Joshua’s doctoral thesis on the responses of the Roman Catholic Church to HIV and AIDS in KwaZulu-Natal, South Africa, 1984-2005.⁹⁷ In particular, Joshua’s work focused on reactions to HIV and AIDS mainly by the church’s hierarchy and dealt with a single church. The present thesis will focus on responses to the HIV pandemic by the Roman Catholic, Anglican and United Methodist churches within a geographical province of Zimbabwe.

1.6.2. The History of HIV and AIDS in Zimbabwe

While a number of publications on HIV and AIDS in Zimbabwe were available, few scholarly studies on HIV and religion exist. The work of the medical doctors, Mary Bassett and Marvellous Mhloyi, in an article entitled, “Women and AIDS in Zimbabwe: The making of an epidemic,”⁹⁸ traces the history of AIDS in Africa and Zimbabwe. The authors identified the role of trade, migrant labour, and urbanisation in fuelling the heterosexual spread of HIV in Africa. The findings were further discussed in the light of the political economy of family structures that exposed women to the risks of contracting HIV and the connection between AIDS and sexually transmitted infections in Zimbabwe. While the authors mentioned important

⁹⁶ Prince, “Introduction to special issue,” v.

⁹⁷ S. M. Joshua, “The Catholic response to HIV and AIDS in South Africa with special reference to KwaZulu-Natal (1984-2005): A historical critical perspective.” Unpublished PhD Thesis, University of KwaZulu-Natal, (2010).

⁹⁸ M. T. Bassett and M. Mhloyi, “Women and AIDS in Zimbabwe: the making of an epidemic,” *International Journal of Health Services* 21 (1991), 143-156.

dates in the history of the HIV pandemic in Zimbabwe and Africa, religious influence on women and AIDS in Zimbabwe does not receive prominence. The scope of the study was epidemiological but it also made reference to cultural practices such as patriarchy. While appreciating the critical issues being raised there, the present study will take the position that churches play a role in responding to the HIV pandemic, both positively and negatively. The present study will use the research findings from the Roman Catholic, Anglican and United Methodist churches in Manicaland to show that while religion has exposed churchwomen to the risks of contracting HIV, churchwomen were key players in rendering AIDS-related care to others.

In a similar way, Simon Gregson, a demographer, together with his colleagues working on the dynamics of the spread, effects and control of HIV pandemics in sub-Saharan has published extensively on HIV prevention in Manicaland, Zimbabwe. In a paper entitled “Recent upturn in mortality in rural Zimbabwe: Evidence for an early demographic impact of HIV?”⁹⁹ Gregson *et al.* focus on the demographic impact of HIV infection in the Rusitu Valley of Chimanimani district and Honde Valley of Mutasa district, located in Manicaland province. The study initiated in 1993, which indicates a connection between religious affiliation and HIV-related mortality, concluded that religious affiliation was a key factor. Apostolic Church members in Honde Valley were less prone to contracting HIV because they “follow a more restrictive behaviour code, which includes abstinence from drinking alcohol, extramarital relationships, medicines and modern methods of family planning.”¹⁰⁰ The inclusion of religious affiliation was of interest to the present study. Gregson *et al.* however, focus attention on the escalating mortality rate and not on church responses to HIV and AIDS in detail. The present study differs from that of Gregson *et al.* by drawing attention to what the Roman Catholic, Anglican and United Methodist churches have done and failed to do in responding to HIV and AIDS in the province of Manicaland.

⁹⁹ S. Gregson *et al.*, “Recent upturn in mortality in rural Zimbabwe: evidence for an early demographic impact of HIV?” *AIDS* 11, (1997) 1269-1280.

¹⁰⁰ Gregson, “Recent upturn in mortality in rural Zimbabwe,” 1273. See also a study by the Blair Research Institute/Oxford University, *The early socio-demographic impact of the HIV-1 epidemic in rural Zimbabwe* (Harare: Blair Research Institute 1996).

In 1999, Gregson *et al.* published another paper on the religious dynamics of HIV-related demographic changes entitled, “Apostles and Zionists: The influence of religion on demographic change in rural Zimbabwe.”¹⁰¹ Gregson *et al.* dedicated their time partly on Honde Valley whereby Apostolic and Zionist churches exist alongside Western missionary-initiated churches including the Roman Catholic, Anglican, and United Methodist Church. Using research targets from Honde Valley and Rusitu Valley, Gregson’s study concluded that HIV-related mortality was reportedly high among members of Western mission-initiated churches. This was connected to moral laxity whereby “avoidance of sin is largely a matter left to individual conscience and absolution can be obtained through confession and prayer.”¹⁰² In contrast, HIV-related mortality among members of Spirit-type churches was reportedly low. The main reason being that

...members of these churches are more likely than other people to follow church teachings on avoidance of pre-marital and extra-marital sex and are therefore at lower risk of acquiring HIV infection—despite the potential for rapid transmission posed by the multiple partner aspect of polygamous marriage systems.¹⁰³

Thus, Gregson *et al.* concluded that religion exerted both positive and negative influences on a person’s sexual behaviour. However, the observations fell short of precisely stating what actions the churches carried out in responding to the pandemic.

A number of papers published on HIV prevention in Manicaland make reference to behaviour change being a factor to the decline in HIV prevalence in the province. In a paper entitled “HIV decline associated with behaviour change in Eastern Zimbabwe,” Gregson *et al.* concluded that behaviour change translated in the decline in HIV prevalence in Manicaland from 23,0% in 1998-2000 to 20,5% in 2001 to 2003.¹⁰⁴ According to Gregson’s study, change of behaviour involves delay in sexual debut, reduction in multiple sexual practices, and consistent condom use in casual partnerships among the sample of participants. Whereas the study observes that a

¹⁰¹ S. Gregson *et al.*, “Apostles and Zionists: The influence of religion on demographic change in rural Zimbabwe,” *Population Studies* 53, 2 (1 February 1999), 179-193.

¹⁰² Gregson, “Apostles and Zionists,” 188.

¹⁰³ Gregson, “Apostles and Zionists,” 190.

¹⁰⁴ S. Gregson *et al.*, “HIV decline associated with behaviour change in eastern Zimbabwe,” *Science* 311 (3 February 2006), 644-646.

change in sexual behaviour could precede any observed decline in HIV prevalence, religion was not explicitly discussed in detail as a moderator of sexual behaviour either positively or negatively. The present research study will suggest that in the short term, the Roman Catholic, Anglican and United Methodist churches increased the risk of people contracting HIV by generally pursuing a moralistic stance against the use of condoms. This study will also take the position that in the long term, the moralistic messages passed on by the churches on prevention of HIV could have yielded positive results. The churches could have reduced the prevalence of HIV by preaching messages that focused on abstinence and delayed sexual debut among the youth and a reduction of casual sex among the married.

Halperin *et al.* were among those researchers whose studies sought to explain why Zimbabwe experienced a further decline in HIV prevalence in 2006. In a paper entitled, “A surprising prevention success: Why did the HIV epidemic decline in Zimbabwe,”¹⁰⁵ Halperin *et al.* arrived at the conclusion that several factors were responsible for the decline in HIV prevalence in Zimbabwe. Important for the present study was the observation made by Halperin *et al.* that the churches in Zimbabwe had been one of the channels responsible in making HIV prevention and AIDS information accessible to the general public. Other factors include a dramatic economic decline from 2000 onwards leading to reduced occurrences of casual sex, high levels of secondary education and marriage, and people’s direct witnessing of AIDS-related mortality under home-based care in homes as opposed to clinics.¹⁰⁶ While this study was national in scope and did not restrict itself to the situation in Manicaland province, its findings speak to the present study. There was however no mention of the specific churches and the way in which religious views on the use of condoms affected the findings. The present study was aware that churches, including the Roman Catholic Church, were generally conservative about the use of condoms in the prevention of HIV. This study therefore explored church-led HIV prevention messages by tracing the divergent views on the use of condoms emanating from the ecclesiastical hierarchy and grassroots members of the Roman Catholic, Anglican and United Methodist churches in Manicaland.

¹⁰⁵ D. Halperin *et al.*, “A surprising prevention success: Why did the HIV epidemic decline in Zimbabwe,” *Plos Medicine* 8, 2 (February 2011), 1-7.

¹⁰⁶ Halperin, “A surprising prevention success,” 4-5.

Further to the above, Gregson *et al.* sought to establish the extent to which national HIV prevention programmes led to a decline of HIV prevalence in Manicaland. Their study, published in 2011 and entitled, “Did national HIV prevention programmes contribute to HIV decline in eastern Zimbabwe? Evidence from a prospective community survey,”¹⁰⁷ explores the effect of national HIV prevention strategies on HIV prevalence in Manicaland. In Zimbabwe national HIV prevention programmes under the State’s Ministry of Health and Child Welfare (MOHCW) include abstinence, faithfulness to one sexual partner, safe sex or the use of condoms, prevention of mother to child transmission and voluntary counselling and testing.¹⁰⁸ Gregson *et al.* attribute the decline in HIV prevalence in Manicaland between 1998 and 2003 to the conduct of safe sex by women who attended public HIV prevention meetings, the increased exposure to relatives dying of AIDS-related diseases, and the unemployment of men leading to changes in social norms and HIV prevention programmes initiated in schools in the early 1990s.¹⁰⁹ Conclusions drawn from the study by Gregson *et al.* were quite similar to those of the 2006 publication mentioned above. A major concern however was the absence of any discussion of HIV prevention strategies undertaken by the various church bodies. It was therefore the intention of this present study to investigate the role played by the churches in their support or opposition to HIV prevention strategies initiated by the State in Manicaland.

Mandy Marshall and Nigel Taylor’s paper entitled, “Tackling HIV and AIDS with faith-based communities: Learning from attitudes on gender relations and sexual rights within the local evangelical churches in Burkina Faso, Zimbabwe and South Africa,”¹¹⁰ also has relevance to the present study. Using case studies from three African countries including Zimbabwe, their study indicated some shortcomings of the churches in the response to HIV. Marshall and Taylor could state: “It is not only

¹⁰⁷ S. Gregson *et al.*, “Did national HIV prevention programmes contribute to HIV decline in eastern Zimbabwe? Evidence from a prospective community survey,” *Sexually Transmitted Disease* 38, 12 (December 2011), 1-8. The term community refers to a society or people who live together and share a common life.

¹⁰⁸ MOHCW, *National HIV/AIDS policy for the republic of Zimbabwe*, (December 1999), 9, 10, 15, 16, 24-27. See also NACP, *AIDS: Questions and answers*, (Harare: UNICEF, 1993). See also NACP, *Living with HIV and AIDS*, (Harare: UNICEF, 1994).

¹⁰⁹ Gregson, “Did national HIV prevention programmes contribute to HIV decline,” 4-8.

¹¹⁰ M. Marshall and N. Taylor, “Tackling HIV and AIDS with faith-based communities: learning from attitudes on gender relations and sexual rights within local evangelical churches in Burkina Faso, Zimbabwe, and South Africa,” *Gender and Development*, 14, 3 (November 2006), 366-374.

in its lack of response to the crisis that the church is struggling. At the same time, it is failing to lead by example on matters of sex, gender relations and HIV and AIDS in its own behaviour.”¹¹¹ The observation that some of the mainline churches in Zimbabwe focus their attention more on evangelism and personal ethics and give little attention to developing life skills and issues of human sexuality is particularly relevant to the present study. The findings of Marshall and Taylor however were set within a particular theological tone and did not identify specific cases. In addition, they pointed to some of the inherent weaknesses of church-led HIV interventions. While taking note of some of their findings, the present study carried out further detailed investigations on the church responses to the HIV pandemic using as its study cohort three mainline churches in Manicaland.

According to UNESCO, culture is described in terms of “the ways of living, working and playing is often presented as a reason to resist change and people regularly hide behind it to justify negative behaviours for instance, promiscuity.”¹¹² Culture defines the way in which male and female members of the family, community and society at large are socialised and interact. In focusing on the effect of culture on HIV and AIDS in Zimbabwe, Jovonna Rodriguez has made the important observation that:

In Zimbabwean culture, the community is the priority. In order to maintain a sense of community, old traditions are followed. The issue of sex, marriage, polygamy and importance of fertility all dictate gender roles and expectations. These same issues need to be re-examined and modified in order to for improvement to occur regarding AIDS and other sexual transmitted diseases. Once sexual expectations change, the rate of infection will begin to decrease as social pressures weaken.¹¹³

In her study, Maureen Kambarami used a hermeneutic of culture, femininity and sexuality to argue that women in Zimbabwe have a great risk of contracting HIV because of the practice of patriarchy, which thrived on female subordination.¹¹⁴ The

¹¹¹ Marshall and Taylor, “Fackling HIV and AIDS with faith-based communities,” 368.

¹¹² V. Kernohan, “Interrogating culture in addressing HIV, gender and sexuality,” *Exchange on HIV and AIDS, sexuality and gender: Informing practice*, (Two-2010), 8.

¹¹³ J. Rodriguez, “AIDS in Zimbabwe: How sociopolitical issues hinder the fight against HIV and AIDS,” *Emory Endeavours in world history*, (March 2007), 6. Paper downloaded as pdf.

¹¹⁴ M. Kambarami, “Femininity, sexuality and culture: Patriarchy and female subordination in Zimbabwe,” Africa regional sexuality resource centre in collaboration with Health System Trust, South Africa and University of Fort Hare, (September 2006).

paper generates important insights that are useful to the present study, including how a religion such as Christianity can reinforce patriarchy. As Kambarami goes on to declare:

To exemplify, Eve's alleged creation from Adam's rib has made women to occupy a subordinate position in the church as well as in the family. Women are therefore viewed merely as second class citizens who were created as an afterthought.¹¹⁵

While Kambarami's findings are valid in appreciating the dilemma faced by churchwomen in the context of HIV, there remains a need to document the experiences of Christian women in their day-to-day engagement with the AIDS pandemic and thus gives valid grounds for the present study.

Similarly, Pascah Mungwini, in "Shona womanhood: Rethinking social identities in the face of HIV and AIDS,"¹¹⁶ has highlighted cultural understandings that undermine women's value and in turn make them vulnerable to HIV in the Zimbabwean context. The findings are relevant to the present study because they indicate that some Christian women in Zimbabwe have become their own oppressors. Such women are accused of being guilty of undermining laws that are meant to liberate them from cultural and religious tendencies that increase their vulnerability to contracting the HI-Virus. While HIV-positive women want to bear children as a way of expressing their need for survival, some members of society have always exerted pressure on women to be married and produce a child. Mungwini further argued:

As a result of these expectations numerous stories are told of women who have created illicit affairs (sexual) for the sake of having a child, affairs that stop immediately the woman realises she has fallen pregnant. Now in the face of HIV and AIDS pandemic the pressure that these traditional expectations place on women is not only constricting on what women can do but has become dangerous too.¹¹⁷

AIDS might have been responsible for male deaths leaving behind a trail of young widows and orphans. Based on personal experience, the researcher indicates that there

¹¹⁵ Kambarami, "Femininity, sexuality and culture," 4.

¹¹⁶ P. Mungwini, "Shona womanhood: Rethinking social identities in the face of HIV and AIDS in Zimbabwe," *The Journal of Pan African Studies* 2, 4 (June 2008), 203-214.

¹¹⁷ Mungwini, "Shona womanhood," 208.

has been a surge in numbers of single women in Zimbabwe and they are popularly known as “single mothers.” Douglas Feldman also observed that AIDS is a cultural phenomenon by noting:

The way in which we as a species handle AIDS is a measure of our changing times, of our deepest fears, of our varying values, and of our collective inspiration. It is impossible to truly understand the role of AIDS in our lives unless we consider the social and cultural contexts of AIDS-related behaviour.¹¹⁸

Paul Gundani’s essay entitled “Church, media, and healing: A case study from Zimbabwe,” that was published in 2001,¹¹⁹ was written at a time when HIV had already made strong inroads into the entire Zimbabwean nation. In this essay, Gundani highlights how Zionist and Apostolic churches use the media to advertise their promises to heal “all forms of ailments and suffering including cancer, hypertension, stomach problems, acute headaches, bad dreams, barrenness, unemployment, bad debts, and failure to prosper in life.”¹²⁰

In a time of AIDS, health seeking behaviours in Zimbabwe have prompted people to consult with Christian prophets, churches and traditional health practitioners. However, Gundani’s article avoids mentioning the words “HIV and AIDS” and yet its incurable nature has driven many individuals to seek places of healing. Gundani’s observations are reminiscent of the spiritual healing carried out by Livingstone Nerwande in the Anglican Church in Manicaland in the mid-1990s as will be discussed later. Some healing prophets have reportedly claimed to cure AIDS. In Zimbabwe, some traditional healers have also discouraged PLHIV from taking ARVs and instead have assured their clients of complete healing. Media reports in Zimbabwe often carry incidences of some prophets who “use unprotected sex as a form of internal cleansing thereby increasing the risk of spreading HIV and AIDS.”¹²¹

¹¹⁸ A. Feldman. *Culture and AIDS*, (New York: Praeger, 1990), vii.

¹¹⁹ P. H. Gundani, “Church, media, and healing: A case study from Zimbabwe,” *Word and Word* XXI, 2 (Spring 2001), 135-143.

¹²⁰ Gundani, “Church, media, and healing,” 136.

¹²¹ E. Siamonga, “Hundred of worshippers dying as churches ban HIV and AIDS medication,” *Newsday, Zimbabwe*, (13 March 2011)).

Elesinah Chauke's article, "Theological challenges and ecclesiological responses to women experiencing HIV/AIDS: A south eastern Zimbabwe context,"¹²² also has relevance for this study. The paper published in 2003 made use of the methodology of oral history on women's experience of culture in relation to the HIV pandemic in south eastern Zimbabwe. The fact that culture is highlighted as being responsible for exposing women to the risks of contracting HIV, and that the Christian churches have done little to address this problem, is particularly relevant. However, this paper focuses on what the churches can do to assist women who have the potential of being infected and affected by HIV. The present research study differs from that of Chauke in the sense that it deals with how the three specific churches in Manicaland responded to HIV and AIDS from 1985 to 2007. Indeed, the present study is aware that all human societies, past and present, have suffered from infectious diseases and that the belief systems of many traditional societies contain elements that are compatible with the notion of contagion.¹²³ A dynamic relationship between religion and HIV and AIDS exists. First it is critical understand how religion and public health can contribute to a fuller understanding of the epidemic. Second, it has to be established whether or not religion has a positive or negative influence on HIV prevention and mitigation.

Sophie Chirongoma's essay entitled, "Women, poverty, and HIV in Zimbabwe: An exploration of inequalities in healthcare,"¹²⁴ focuses on rural women's anguish and struggle with access to healthcare facilities in the context of HIV. Insights on the decline of the public health sector in Zimbabwe caused by the introduction of economic reform programme (ESAP) in 1991 were of significance to the present study. The programme placed people under pressure and stress, which leads to their adoption of risky survival strategies. This makes them highly vulnerable to HIV infection and AIDS.¹²⁵ Chirongoma mentioned the Roman Catholic Church in Zimbabwe and the Catholic Relief Services (CRS) for their support in AIDS-related

¹²² E. Chauke, "Theological challenges and ecclesiological responses to women experiencing HIV/AIDS: A south eastern Zimbabwe context," in I. Phiri *et al.*, (eds), *African women, HIV/AIDS and faith communities*, (Pietermaritzburg: Cluster Publications, 2003), 128-148.

¹²³ C. S. McCombie, "AIDS in cultural, historic, and epidemiological context," in D. A. Feldman (ed), *Culture and AIDS*, (New York: Praeger, 1990), 9-27.

¹²⁴ S. Chirongoma, "Women, poverty, and HIV in Zimbabwe: An exploration of inequalities in health Care," in I. Phiri and S. Nadar (eds), *African women, religion, and health: Essays in honour of Mercy Amba Ewudziwa Oduyoye*, (Pietermaritzburg: Cluster Publications, 2006), 173-186.

¹²⁵ Chirongoma, "Women, poverty, and HIV in Zimbabwe," 180.

community and home-based care programmes.¹²⁶ In another essay, Chirongoma discusses the issue of women and children's rights in a time of HIV and AIDS in which the paper acknowledges the work of churchwomen's organisations in providing care to those infected and affected by HIV in Bulilamangwe District.¹²⁷ Chirongoma's study does not make an attempt to give a detailed historical analysis of what the churches have done in responding to HIV in Zimbabwe; a fact that accounts for the brief mention of the Roman Catholic Church and CRS. The present study will seek to investigate and comparatively analyse HIV and AIDS responses by three church denominations in Manicaland within a historical perspective.

In 2006, Herbert Moyo followed a similar theological theme and argued that there is a great need for the churches to exercise a pastoral ministry to the PLHIV and OVC. Moyo's Master's dissertation completed in 2006 was entitled, "Jesus is HIV Positive: Listening with compassion to the HIV positive people through clinical pastoral counselling."¹²⁸ Based on the reality that church members infected and affected by HIV are members of the body of Christ, Moyo argues that the churches could use clinical pastoral education as tool to —help set up support groups for people living with AIDS in rural areas...as ignoring these communities is detrimental in the fight against HIV."¹²⁹ Moyo's study provides a 'theological voice' calling churches to be active listeners and providers of tangible material support to people infected and affected by HIV. It raises the issue of what the Evangelical Lutheran Church in Matabo, Zimbabwe ought to do in responding to the needs of PLHIV because they are members of the body of Christ. The present study benefited from Moyo's insights that highlight the fact that churches were guilty of stigmatising PLHIV and seeks to provide further analysis of HIV interventions carried out by the three churches in Manicaland.

¹²⁶ Chirongoma, "Women, poverty, and HIV in Zimbabwe," 183-184.

¹²⁷ S. Chirongoma, "Women's and children's rights in the time of HIV and AIDS in Zimbabwe: An analysis of gender inequalities and its impact on people's health," *Journal of Theology for Southern Africa* 126 (November 2006), 61-63.

¹²⁸ H. Moyo, "Jesus is HIV positive: Listening with compassion to the HIV positive people through clinical pastoral care," Unpublished Master of Theology thesis, University of KwaZulu-Natal, (2006).

¹²⁹ Moyo, "Jesus is HIV positive," 160.

Although not a historical study and without mentioning particular churches in Zimbabwe, Stan Nussbaum's article, "Evangelicals and AIDS,"¹³⁰ makes important observations about problems experienced by churches in responding to HIV and AIDS. In a studied analysis of the Zimbabwean situation, Nussbaum's article is helpful in that while churches tend to informally use their social and moral capital in responding to HIV and AIDS, national governments and major secular donors will find it difficult or impossible to give money directly to church congregations to fund their activities."¹³¹ Albeit this might be the case, the present study explored ways in which church responses to HIV were affected by access to donor funding and State support or the lack of thereof. Nussbaum's findings were of relevance given the fact that the churches in Manicaland carried out HIV interventions under adverse socio-economic conditions. Apparently, church-related HIV interventions in Manicaland could have been affected by the capacity of the churches to obtain foreign donor funding as well as State grants. Between 2000 and 2007 the churches became important conduits of external donor funded healthcare programmes including HIV interventions (see later discussions in chapter 5 sections 5.2.1, 5.2.2.1, 5.2.2.2, 5.3.2, 5.3.4, 5.3.5, 5.4.1, 5.4.2 and 5.4.3). This study brings to the fore social and moral capital from the Roman Catholic, Anglican and United Methodist churches as they responded to HIV in Manicaland.

1.6.3. The History of HIV and AIDS in Manicaland

In 1989, the Heads of Christian Denominations, an informal forum constituted by the Zimbabwe Catholic Bishops Conference (ZCBC), the Zimbabwe Council of Churches (ZCC) and the Evangelical Fellowship of Zimbabwe issued a publication entitled *AIDS: The Christian response*.¹³² This resource was quite popular to the extent that a second revised edition appeared in 1995. At that time, AIDS was still fairly new in

¹³⁰ S. Nussbaum, (ed), "The contribution of Christian congregations to the battle with HIV/AIDS at the community level," A seven-country report prepared for the Summer Mission Briefing at the Oxford Centre for Mission Studies, 7-9 June 2005 (Colorado Springs: Global Mapping International, 2005), pdf. See also S. Nussbaum, "Evangelicals and AIDS," in R. Gill (ed), *Reflecting theologically on AIDS: A global challenge*, (London: SCM Press, 2007), 121-138.

¹³¹ Nussbaum, "Evangelicals and AIDS," 134.

¹³² HOCD, *AIDS: The Christian response*, (Harare: ZCC, 1989). An electronic manuscript copy of this booklet was sent to the researcher by Edward T. Rogers in April 2011.

Zimbabwe and therefore national church leaders took the opportunity to inform their constituencies about an impending pandemic. The contents of the publication included a brief historical overview, a definition of AIDS, the mode of HIV transmission, data on national prevalence, the effects of HIV on the economy and a call for upholding Christian morality as a key HIV prevention tool. The church leaders articulated that HIV was not a punishment from God and condoms were not the answer. Instead, the solution was –eashty before marriage and fidelity to one’s partner after marriage.”¹³³ This publication was written in the early years of the epidemic in Zimbabwe and reflected the views of senior church clerics at a national level. The relevant insights on responses to HIV and AIDS by churches constitute an integral part of the input by the grassroots structures of each denomination analysed for twenty-two years.

In 1993, the Heads of Christian Denominations published a statement on the HIV epidemic, which became known as the Kadoma Declaration because it was produced after a meeting of national senior clerics in the town of Kadoma, west of the capital, Harare. The statement, only three pages in length, was the first interdenominational HIV and AIDS policy that was to emerge from church leaders in Zimbabwe.¹³⁴ In brief, the policy expressed the stance taken by church leaders on HIV prevention and covered areas including human sexuality, AIDS and Christian morality, traditional values, a message to youth, a message to parents, and attitudes towards PLHIV.¹³⁵ It is important to note that while the State did not have a national HIV and AIDS policy until 1999, what the churches offered was a moral position on HIV prevention.

In 2005, the Heads of Christian Denominations also published a second HIV and AIDS policy document. The new and expanded policy contained aspects such as HIV prevention, AIDS-related care and support, the treatment of AIDS-related diseases, stigma and discrimination, the property rights of widows and orphans, and traditional and cultural practices in the context of HIV.¹³⁶ In 2006, some of the churches in Manicaland collectively advocated for increased responses to HIV and AIDS by

¹³³ HOCD, *AIDS: The Christian response*, 7.

¹³⁴ HOCD, –Conference statement on AIDS: An appeal by church leaders for behavioural change to combat AIDS,” Interdenominational AIDS Conference, Kadoma Ranch Motel, (20-23 April 1993). S. A. Farag (ed), *Interdenominational AIDS Conference: A compilation of selected presentations made at the conference*, (July 1994), 2.

¹³⁵ HOCD, –Conference statement on AIDS.”

¹³⁶ HOCD, *HIV and AIDS policy*, (Harare: HOCD, 2005).

churches and the general public. In a publication entitled, *The truth will make you free: A compendium of Christian social teaching*, the authors urged the churches and communities in general to support those living with HIV, to practice Christian morality, and offer support to AIDS-related orphans and vulnerable children.¹³⁷

The statements on HIV and AIDS expressed by the churches in Manicaland including the Roman Catholic and Anglican churches were meant to highlight their theological position. The publication indicates what the churches believed Christians ought to be doing in responding to the needs of those living with HIV as well as AIDS-related orphans and vulnerable children. Interestingly, the concluding statements of the book located the HIV epidemic in the wider context of the deplorable living conditions of the poor, caused by escalating unemployment levels and the high cost of living in Manicaland in particular and Zimbabwe in general:

HIV/AIDS is not a health issue that stands alone. It is related to the social and economic environment in which we live. ...These conditions add fuel to the fire of HIV/AIDS; the greater the social disintegration, the greater the prevalence of the virus.¹³⁸

While the present study acknowledges this work, its focus was on the history of actual responses to the HIV pandemic by the three churches. In 2007, the national church leaders' forum acting in collaboration with the ZACH published a training manual for use by clergy and pastors in pastoral care and counselling of PLHIV.¹³⁹ Briefly, the association was formed in 1974 as a medical arm of the Christian churches in Zimbabwe and reports to the Heads of Christian Denominations. By 2007 a total of 126 church hospitals and clinics were registered members of the association. The following map of Zimbabwe shows some of ZACH's HIV and AIDS interventions activity sites as of 2008.

¹³⁷ Churches in Manicaland, *The truth will make you free: A compendium of Christian social teaching*, (Mutare: Churches in Manicaland, 2006), 44-47.

¹³⁸ Churches in Manicaland, *The truth will make you free*, 47.

¹³⁹ S. Mpofu (ed), *A Guide to HIV and AIDS pastoral care and counselling*, (Harare, HOCD and ZACH, 2007).

This ecumenical medical body established HIV and AIDS programmes that —. aimed at supporting member institutions to develop strategies for mitigating HIV and AIDS especially in the rural areas using community initiatives.”¹⁴¹ These documents reveal ecumenical collaboration at the national level and fall short of indicating responses to HIV and AIDS by the individual churches in Manicaland. Prior to 1999, ZACH provided financial aid towards HIV and AIDS interventions at church healthcare centres.¹⁴²

The publication by Ted Roger entitled, *Jesuit, social pioneer and AIDS activist: A memoir* provides important insights into the beginnings of church responses to HIV and AIDS in Zimbabwe in the mid-1980s, especially the Roman Catholic Church of which the Rogers was a member.¹⁴³ In his chapter entitled, “Hijacked by AIDS,” Rogers chronicled his involvement in HIV and AIDS interventions with the Roman Catholic Archdiocese of Harare in 1986 and a year later set up the ZCBC’s HIV and AIDS Committee. AIDS-awareness seminars organised by Rogers involved all the church’s dioceses in Zimbabwe. Ambrose Vinyu, a Roman Catholic priest from Mutare and other delegates from Manicaland used to attend.¹⁴⁴ Rogers’ memoirs were of importance in highlighting his input to an ecumenical response to HIV and AIDS in Zimbabwe especially through the Heads of Christian Denominations. This said, Rogers’ work focuses on interactions at the highest level of church structures and did not reflect the responses to HIV and AIDS by Christian communities on the ground. Since the book comprised of memoirs, its focus was limited to Rogers’ personal experiences rather than being devoted to the wider scope of the churches and the HIV pandemic in Zimbabwe or Manicaland. This study made use of Rogers’ work in tracing the humble beginnings of Christian responses to HIV in Zimbabwe.

Jill Ruchala, in *Zimbabwe: A guide to humanitarian and development efforts of interaction member agencies in Zimbabwe*, highlights the contribution of the CRS towards meeting the material needs of people in infected and affected by HIV starting from

¹⁴¹ ZACH information brochure, 2008.

¹⁴² V. Chitimbire, interview conducted by M. Mbona, ZACH office, Harare, 5 October 2010.

¹⁴³ T. Rogers, *Jesuit, social pioneer and AIDS activist: A memoir*, (Pietermaritzburg: Cluster Publications, 2011), *Forthcoming*.

¹⁴⁴ Rogers, *Jesuit, social pioneer and AIDS activist*.

1989 and onwards.¹⁴⁵ Although relatively brief, the overview is relevant to the present study because it mentions the work of the CRS, a funding organisation of the Roman Catholic Church in the United States of America (US). Since the early 1990s, the same organisation funded HIV and AIDS interventions in the Roman Catholic Diocese of Mutare. In a study by the Joint United Nations Programme on HIV/AIDS (UNAIDS) conducted in 1999, the reviewers identified a Christian community at Regina Coeli mission, Nyanga in Manicaland, as having mobilised a support group for PLHIV in 1994. Such support groups established income generating projects as well as providing emotional support to those infected and affected by HIV and AIDS.¹⁴⁶ While it only provided a brief overview of the projects then in hand, the report hinted on HIV interventions established by grassroots communities associated with a Roman Catholic institution in Manicaland. The report connects well with HIV interventions established under the diocesan AIDS-related care project in 1992 and the present study made important use of this work.

Edwin Kaseke and Jotham Dhembha co-authored the “Zimbabwe country report” as part of a five-country study on service and volunteering in southern Africa, commissioned by the “Voluntary and Service Enquiry of southern Africa” in July 2006. The purpose of the study was “to document and analyse civic service and volunteering in Zimbabwe.”¹⁴⁷ The findings reported on two faith-based organisations from Manicaland, the Family AIDS Caring Trust (FACT) and the Diocese of Mutare Community Care Project (DOMCCP). This is of interest to the present study because FACT is the earliest FBO to pioneer HIV interventions in Manicaland since 1987. The latter previously known as Mutare Community Health Care (MCHC) is a faith-based AIDS service organisation established by the Roman Catholic Diocese of Mutare in 1992. The study focuses on orphan care within families following traditional community principles.¹⁴⁸ The underlying principle is that of encouraging community ownership of care of AIDS-related OVC that was aided by financial

¹⁴⁵ J. Ruchala, “Zimbabwe: A guide to humanitarian and development efforts of inter action member agencies in Zimbabwe,” (February 2008), 18-20.

¹⁴⁶ G. Mutangadura, D. Mukurazita and H. Jackson, *A review of household and community responses to the HIV/AIDS epidemic in rural areas of sub-Saharan Africa*, (Geneva: UNAIDS, June 1999), 61.

¹⁴⁷ E. Kaseke and J. Dhembha, “Zimbabwe country report,” in *Five-country study on service and volunteering in southern Africa, under the Volunteer and service enquiry southern Africa*, (July 2006), 6.

¹⁴⁸ Kaseke and Dhembha, “Zimbabwe country report,” 26.

support from diocese through its FBO's programme. While the study highlights the importance of community volunteerism for AIDS-related orphan care, its scope did not explore in full detail other HIV and AIDS interventions carried out by the Roman Catholic Church in Manicaland. The present research study will therefore benefit from the work of Kaseke and Dhemba.

Martha Chinouya, Livingstone Musoro and Eileen O'Keefe's publication entitled, *The Anglican Diocese of Manicaland: Capacity building and policy response to the HIV/AIDS crisis in Zimbabwe*,¹⁴⁹ focuses on the challenges faced by the Anglican Church's healthcare centres. While the effects of the migration of medical personnel to other countries on HIV and AIDS intervention were discussed by Chinouya *et al.*, there is no attempt to trace the history of the church's response to the pandemic. Instead, the scope of the publication was to facilitate future responses to HIV and AIDS by the Anglican Church in Manicaland. Martha Chinouya in, *TAURAI! (Communicate!): A dialogue of hope between church leaders and HIV-positive Christians in the Anglican Diocese of Manicaland, Zimbabwe*,¹⁵⁰ focuses on the importance of dialogue in reducing stigma. The findings of this report published in 2007 reflect on support groups as spaces for HIV disclosure within the Anglican Church in Manicaland. The word *taurai*, which in the Shona language translates as "let us talk" or simply "let us hold a conversation," was meant to encourage dialogue between people infected and affected by the HIV pandemic and church leaders. The intention of the study is the provision of hands-on training in reducing denial and stigma of HIV among the Anglican Church clergy in Manicaland. Chinouya's work makes a positive step in HIV prevention and AIDS mitigation but falls short of accounting for the Anglican Church's responses to the epidemic within given specific time periods.

In another publication, Martha Chinouya discusses the role of the Mothers' Union guild in the provision of care to those infected and affected by HIV and AIDS in

¹⁴⁹ M. Chinouya *et al.*, *The Anglican Diocese of Manicaland: Capacity building and policy response to the HIV/AIDS crisis in Zimbabwe*, (London: Human Rights and Social Justice Institute, 2003).

¹⁵⁰ M. Chinouya, *TAURAI! (Communicate!), A dialogue of hope between church leaders and HIV-positive Christians in the Anglican Diocese of Manicaland, Zimbabwe, A report compiled on behalf of the Taurai project* (London: London Metropolitan University, 2007).

–*Ubuntu* and the helping hands for AIDS.”¹⁵¹ Chinouya observes that the members of this guild are a leading group among those playing a role in responding to the challenges posed by HIV and AIDS within the church and in the wider community. Generally, the same observations were valid for members of the married churchwomen’s guilds including those from the Roman Catholic and United Methodist Church in Zimbabwe. Chinouya’s argument that there was a general lack of proper resources and funding in harnessing such religious assets for AIDS-related caring work is a relevant key point. As she noted:

Small groups of ordinary community members, caring for orphaned and vulnerable children and in urgent need of financial support, do not receive international funding, as many obstacles exist that prevent the resources from reaching grassroots communities.¹⁵²

Apart from making use of Chinouya’s findings, this study documents not only AIDS-related caring work carried out by Christian women but indicates the way HIV affected them.

Gladys Mutangadura’s article entitled: “How communities help families cope with HIV and AIDS in Zimbabwe,” mentions church responses to AIDS-related orphan care needs in Manicaland.¹⁵³ Mutangadura’s study focuses on 215 households selected from Marange district (rural) and Mutare (urban), in Manicaland. An important observation from the study is that at community level, people infected and affected by HIV including orphans identified clubs, burial societies, and churches as providers of essential financial and other material support. Mutangadura noted:

Of the three types, church-based support offered the most help by providing food, funeral expenses, clothing, and school fees to orphans. However, support from the churches is limited to church members, and

¹⁵¹ M. Chinouya, “–*Ubuntu* and the helping hands for AIDS,” in O. Wambu (ed), *Under the tree of talking: Leadership for change in Africa*, (London: Counterpoint, 2007), 101-111. The Mothers’ Union is a guild of church married women in the Anglican Church founded by Mary Sumner in England in 1876. The guild seeks to uphold Christian teachings on marriage and family life.

¹⁵² Chinouya, “–*Ubuntu* and the helping hands for AIDS,” 105.

¹⁵³ G. Mutangadura, “How communities help families cope with HIV and AIDS in Zimbabwe,” in A. Singhal and S. Howard (eds), *The Children of Africa confront AIDS: From vulnerability to possibility*, (Athens: Ohio University Press, 2003), 159-168.

those who benefit from it indicate that the assistance from it is inadequate and not consistent.¹⁵⁴

The study is crucial in that it acknowledged a positive contribution to AIDS-related orphan care by church communities in Manicaland and also highlighted shortcomings like favouritism. Although not referring to specific church denominations, the findings provide important insights on the strengths and weaknesses of church led AIDS-care interventions in Manicaland province.

Nancy Carter highlights the work of the United Methodist Church in Zimbabwe in an article entitled, "United Methodists help save girls and women's lives through school and literacy programmes."¹⁵⁵ The major focus of this report is to indicate the church's initiatives at fund-raising towards meeting the material needs of women infected and affected by HIV and AIDS in sub-Saharan Africa, particularly in Zimbabwe. Carter notes that since 1995 the United Methodist Church in Zimbabwe has assisted thousands of AIDS-related cases, assisted by the General Board of Global Ministries (GBGM), particularly through the health and welfare ministries and the United Methodist Committee on Relief.¹⁵⁶ Brenda Wilkinson also pays tribute to efforts by the church in reaching out to the youth by reporting on a Zimbabwe Youth AIDS Conference held at the Chinhoyi Technical College in 2000. This became a national event which sought to provide an opportunity for youth to dialogue with the church's leadership, government officials, and health professionals about HIV infections and AIDS for the first time in a peer setting.¹⁵⁷ While these submissions are acknowledged, the articles only highlight a few things done by the United Methodist Church in responding to HIV. Nevertheless, the reported events and programmes were helpful to this study.

¹⁵⁴ Mutangadura, "How communities help families cope," 163-164. See also G. B. Mutangadura, "Women and AIDS in southern Africa: The case of Zimbabwe and its policy implications," *Jenda: A journal of culture and African women studies* 1, 2 (2001), 1-11.

¹⁵⁵ N. Carter, "United Methodist help save girls and women's lives through school and literacy programmes," (2004), <<http://new.gb-gm-umc.org/work/health/aids/archives/literacyprograms/>> [Accessed 8 July 2009].

¹⁵⁶ Carter, "United Methodist help save girls and women's lives."

¹⁵⁷ B. Wilkinson, "HIV/AIDS conference for the United Methodist youth in Zimbabwe," 2 October 2000, <<http://gb-gm-umc.org/mission/news2000-2/gb-gm100300bwbm.html/>> [Accessed 8 July 2009]. See also B. Wilkinson, "General Secretary of the GBGM praises Zimbabwe youth initiatives on HIV/AIDS," <<http://gb-gm-umc.org/mission/news2000-2/gb-gm092800bwbm.html/>> [Accessed 8 July 2009].

1.7. Limitations and Delimitations of the Study

This section will deal with the limitations and delimitations of the present study. An appreciation of the limitations of the study is important in that it indicates the constraints faced and how they will be dealt with. In particular, delimitations explain the reasons for focusing on responses to HIV and AIDS by the Roman Catholic, Anglican and United Methodist churches in Manicaland.

1.7.2. Limitations of the Study

This study does not provide detailed coverage of responses to HIV and AIDS by the other churches, traditional healers, the government and non-governmental organisation. However, wherever possible the study acknowledges any interactions between the Roman Catholic, the Anglican and the United Methodist Church and others that responded to the epidemic within the same period. This is not meant to undermine any important work done by other players in responding HIV and AIDS. The focus of the present study is not to provide a detailed analysis of the history of the three churches as such but to examine their response to HIV and AIDS between 1985 and 2007. Access to the churches' regional, continental, and world bodies' response to the pandemic has been accomplished via the Internet and other publications. The major findings of the study were limited in a sense because they were drawn from samples of carefully, selected Roman Catholic, Anglican, and United Methodist parishes or congregations, church leaders and followers from Manicaland. It is practically impossible for this study to reach out to every parish, congregation, mission, district, school or church administrative unit. That being the case, the findings of the study have the likelihood of suffering from limitations linked to these and other practical constraints.

1.7.3. The Delimitations of the Study

The present study focused on the response of the Roman Catholic, Anglican and the United Methodist Church to HIV and AIDS in Manicaland from 1985 to 2007.

Historically, the three churches were among the oldest and largest Western missionary founded churches in Zimbabwe. Statistics on religious affiliation for 2001 indicated that over 70% of the population of Zimbabwe was Christian with 8.7% being Roman Catholics and 3% being Anglicans.¹⁵⁸ The United Methodist Church had an estimated membership of 100 000 followers in 2009 countrywide with the majority coming from Manicaland.¹⁵⁹ In 2004 the Roman Catholic Diocese of Mutare had an estimated membership of 128, 120.¹⁶⁰ It has to be noted that these statistics might not very accurate though they give a general picture of church membership. The main task of the present study is not to focus on church membership but analyse responses to HIV and AIDS holistically by these three churches. The researcher is aware that there are several other churches in Manicaland including the Seventh Day Adventist, United Church of Christ in Zimbabwe, Salvation Army, Presbyterian, Dutch Reformed, Methodist Church in Zimbabwe, African Methodist Episcopal, Zimbabwe Assemblies of God, and numerous African initiated churches and religious sects.¹⁶¹

While the present study is aware of responses to HIV by Pentecostal churches in Zimbabwe, the present focus is restricted to the three identified churches. The response of Pentecostal churches to HIV and AIDS appeared much later than that of the Roman Catholic, Anglican and United Methodist churches in Manicaland in particular and Zimbabwe in general. This trend is not unique to Zimbabwe. Prince *et al.* observed that mainline churches took up the challenge earlier, Pentecostal churches only began to revise their theology concerning HIV and AIDS from about 2001.¹⁶² Generally, in Zimbabwe Pentecostal and Apostolic churches started to officially respond to HIV and AIDS from 2004 onwards. For example, in September 2005, leaders of Apostolic churches launched a national HIV and AIDS policy.¹⁶³ Apart from banning polygamy, Bishop Xavier Chitanda of the Johane Masowe

¹⁵⁸ Demographics of Zimbabwe, <http://en.wikipedia.org/wiki/Demographics_of_Zimbabwe/> [Accessed 8 July 2009]. See also *General Facts on Zimbabwe*, (circa 1995); *International Religious Freedom Report 2002: Zimbabwe*, US State Department, <http://atheism.about.com/library/irf02/blirf_zimbabwe.html/> [Accessed 6 May 2009].

¹⁵⁹ —“AIDS in Zimbabwe and the United Methodist Church’s response,” <<http://gbgm-umc.org/health/AIDSAfrica/zimaida.cfm/>> [Accessed 22 February 2009].

¹⁶⁰ Diocese of Mutare, <<http://catholic-heirarchy.org/diocese/dmutr.html/>> [Accessed 4 June 2009].

¹⁶¹ T. L. Presler, *Transfigured night: Mission and culture in Zimbabwe’s vigil movement*, (Pretoria: Unisa Press, 1999), 289-290.

¹⁶² Prince, “Introduction to special issue,” xii.

¹⁶³ S. Tikiwa, “Vapostori sects ban polygamy,” 19 September 2005, <<http://www.religionnewsblog.com/1240/vapostori-sects-ban-polygamy/>> [Accessed 20 June 2009].

Church admitted that church members also experienced the scourge of HIV and AIDS and thus new theology was needed.¹⁶⁴ In 2006, the Evangelical Fellowship of Zimbabwe launched an HIV and AIDS policy. Key areas addressed by the policy were HIV prevention and the care of vulnerable groups including orphans and widows.¹⁶⁵ A possible reason may be that previously, members of Pentecostal churches were less infected and affected by the pandemic compared to those from the mainline churches. Consistent with this assertion, Gregson *et al.* observed: “This could be because members of these churches were more likely than other people to follow teachings on avoidance of pre-marital sex and extra-marital sex and are therefore at lower risk of HIV infection.”¹⁶⁶ At this present time, this research study may be one of a few that will provide a detailed analysis of HIV and AIDS-related responses by the Roman Catholic, Anglican and United Methodist churches in Manicaland province in Zimbabwe within a historical perspective.

1.8. Research Methodology and Design

As a historical study, this research study will utilise the interpretive paradigm. This methodology will be used because the findings will be greatly influenced by subjectivity arising from understandings and views expressed by the participants under study. According to Martin Blanche and Kevin Durrheim, the interpretive paradigm is suitable in a situation whereby:

...the reality to be studied consists of people’s subjective experiences of the external world... and use of methodologies such as interviewing or participant observation that rely on subjective relationship between researcher and subject. This is characteristic of the interpretive approach, which aims to explain the subjective reasons and means that lie behind social action.¹⁶⁷

¹⁶⁴ G. Ngwa, “Zimbabwe indigenous Christian churches make an about turn on HIV prevention,” 26 May 2006, <<http://www.unfpa.org/news/news.cfm?ID=786/>> [Accessed 20 June 2009].

¹⁶⁵ Xinhua, “Church group launches AIDS policy in Zimbabwe,” <http://english.peopledaily.com.cn/200602/15/print20060215_242792.html/> [Accessed 20 June 2009].

¹⁶⁶ Gregson, “Hostles and Zionists,” 189-190.

¹⁶⁷ M. T. Blanche and K. Durrheim, “Histories of the present: Social science research in context,” in M. T. Blanche *et al.*, (eds), *Research in practice: Applied methods for the social sciences*, 2nd Edition, (Cape Town: University of Cape Town Press, 2006), 7.

The use of archival documents and oral interviews will be critical historical methods relevant in answering the research question. Archival documents and views expressed by interviewees were not to be taken at face value. This is because what has been written or spoken is subjected to selectivity and interpretation. As Jan Vansina has observed, “every person who speaks or writes chooses information, orders it, [and] colours it.”¹⁶⁸ It was therefore important to obtain relevant documents, analyse interviews, and use the corroborative approach in the evaluation of all historical evidence.

This descriptive ethnographic study was located in the broad field of empirical qualitative research methodologies. Durrheim has argued that the qualitative research methods enables data to be collected in written or spoken language, and is analysed by identifying and categorising themes and thus states: “Qualitative methods allow the researcher to study selected issues in depth, openness, and detail as they identify and attempt to understand the categories of information that emerge from the data.”¹⁶⁹ The present research study has involved extensive travel in order to interview research subjects in their ordinary settings or home and work environment. In the same vein, archival research was carried out physically at selected research sites. Another key tenet of qualitative research methodology is its attachment to the real world where it takes place. Snape and Spencer stated: “...qualitative research is a naturalistic, interpretative approach that is concerned with understanding the meanings which people attach to phenomena including actions, decisions, beliefs, values, etc. within the social world.”¹⁷⁰

The present study understands that HIV and AIDS is one of the major current health issues that deeply affects the lives of many Zimbabweans and thus such research is duly warranted. Research on responses to the HIV pandemic by church leaders and lay members from the Roman Catholic, Anglican and United Methodist churches in Manicaland is a way of understanding meanings that people attach to the pandemic. Qualitative research methods are suitable for this study because of the descriptive nature of analysis that is based on the narratives of church leaders, their followers and

¹⁶⁸ J. Vansina, *Oral tradition as history*, (London: James Currey, 1985), 191.

¹⁶⁹ K. Durrheim, “Research design,” in Blanche, *Research in practice*, 47.

¹⁷⁰ D. Snape and L. Spencer, “The foundation of qualitative research,” in J. Ritchie and L. Lewis (eds), *Qualitative research in practice*, (London: Sage Publications, 2003), 2.

others who framed their stories of how the churches responded to the HIV pandemic. In line with this assertion, Linda Kalof *et al.* observed: “The emphasis in qualitative research is on individuals’ own interpretations of their experiences and studying what they say in detail.”¹⁷¹ While such personal experiences often possess strands of subjective material, the task is to carefully select and process those materials found relevant in addressing the research question. The combination of a literary study of church papers found in archives of selected churches and the use of interviews will enable the researcher to write a detailed description of church responses to HIV. Such studies were often affected by the biases of the researcher who needs to be aware of the fact that “own’s biases also cloud the picture, making impartial judgment extremely difficult.”¹⁷² It is indeed possible that the researcher’s analysis of findings might have been affected by his identity as an Anglican priest from Manicaland. The researcher is an insider to the Anglican Church, and an outsider to the Roman Catholic and United Methodist Church. In the researcher’s analysis of church responses to HIV and AIDS in Manicaland there is always a deliberate attempt to remain aware of the need to “take these biases into account when weighing the reliability of evidence.”¹⁷³

Within the Manicaland province, in 2004 the Roman Catholic diocese had twenty-six parishes including its mission stations,¹⁷⁴ the Anglican Church had twenty-seven ecclesiastical units which, included parishes, mission districts and chapelries,¹⁷⁵ and the United Methodist Church had five ecclesiastical districts with each having an average of twelve circuits.¹⁷⁶ Samples were drawn from all the three churches because they were the object of the study and formed the “...unit of analysis.”¹⁷⁷ Six archival research sites were identified for data collection and these were chosen with the assistance of gatekeepers as well other logistic considerations. The map reproduced in figure 3 shows Mutare and some parts the province of Manicaland.

¹⁷¹ L. Kalof *et al.*, *Essentials of social research*, (Berkshire: Open University Press, 2008), 80.

¹⁷² J. R. Benjamin, *A student’s guide to history*, 6th edition, (New York: St. Martin’s Press, 1994), 7.

¹⁷³ Benjamin, *A student’s guide to history*, 8.

¹⁷⁴ Information was obtained from the Catholic Diocese of Mutare office at Drumfad in Mutare, 7 May 2010.

¹⁷⁵ M. Mbona, private archives, Rusape, (MM), Diocese of Manicaland, “Appendix B: List of ecclesiastical divisions,” Acts of the Diocese, (2004).

¹⁷⁶ Information was obtained from the United Methodist office, Zimbabwe East Annual Conference, Mutare on 11 May 2010.

¹⁷⁷ Durrheim, “Research design,” 41.

Figure 3. Map of Mutare and parts of Manicaland¹⁷⁸



¹⁷⁸ ZIMAP, *Atlas for Zimbabwe* (Harare: Department of the Surveyor General, 2002), 12.

A letter of introduction issued by the researcher's supervisor on behalf of the University of KwaZulu-Natal became instrumental in obtaining gatekeepers' permission to carry out the study (see Appendix VI). Three gatekeepers issued letters appealing to the clergy and laity to support the project, these being: Bishop Alexio Muchabaiwa of the Roman Catholic Church (see Appendix VII), Reverend Teddy Chigwanda on behalf of Bishop Julius Makoni of the Anglican Church (see Appendix VIII), and Reverend Saphirina Sign on behalf of Bishop Eben Nhwatiwa of the United Methodist Church (see Appendix IX). Within the Roman Catholic Church's Diocese of Mutare the following sites were chosen: the Cathedral of the Holy Trinity, St. Joseph's mission, Sakubva, St. Paul's Dangamvura, Triashill mission, Kriste Mambo and Nyahukwe and St. Simon Stock and St. Joseph's mission in Rusape. Within the Anglican Diocese of Manicaland research was conducted at: St. Cuthbert's Denzva, St. Matthew's Vengere, Holy Name Sakubva, St. Agnes Chikanga, St. Joseph's Samanga, St. David's Bonda and St. Bartholomew's Rusape. Data from the United Methodist Church was collected from Rukweza, Honde Valley, Old Mutare mission Centre, Africa University, Tsonzo, Hilltop and Rusape. Six archival research sites were identified for data collection and these were chosen with the assistance of gatekeepers as well other logistic considerations.

1.8.2. Primary Written Sources

Primary written sources in the form of unpublished church papers formed a critical part of the data used in this study. According to William Simpson, primary written sources are important in appreciating the past and thus define primary written sources as –simply the tracks left by our predecessors, and they are the raw materials out of which historians construct their accounts of the past. Without such sources there can be no History.”¹⁷⁹ While this might be a valid observation for this study, there is also a need to be cautious when utilising written church documents as primary sources. The advice of Edward Carr to be aware of the subjectivity of written documents including church papers and other documents is critical to this research. Carr stated:

¹⁷⁹ W.O. Simpson, *Working with sources: Case studies in twentieth-century history*, (Leckhamton: Stanley Thornes Publishers, 1988), 1.

No document can tell us more than what the author of the document thought—what he thought had happened, what he thought ought to happen or would happen, or perhaps only what he wanted others to think he thought, or even what he himself thought he thought.¹⁸⁰

While every effort was taken to ensure that documents were exposed to a rigorous process, the possibility of subjectivity cannot be ruled out. Each document will be scrutinised by looking for any statements or references that mention AIDS, HIV, HIV/AIDS and HIV and AIDS. All the documents used in the research have been acknowledged in the footnotes and for practical purposes it has not been possible to do the same in the bibliography. In the bibliography, the researcher grouped all the documents from the same archives together in one list, a method that is by no means a deliberate deviation from the norm.

The condition of church archives in Zimbabwe indicated that the systematic keeping of documents was a skill and practice that the churches still had to learn. Church papers such as minutes of parish council meetings, synod reports, annual conference reports, statements by church leaders and others are critical in tracing the responses to HIV. Matters of particular importance to the churches usually receive attention at parish or circuit council meetings, synods and annual conference sessions. Such documents become critical sources of data because they indicate the nature of responses to HIV at different levels of church structures. At Africa Synod House, Harare, the pastoral statements and letters issued by the ZCBC that mentioned AIDS, HIV, HIV/AIDS or HIV and AIDS were gleaned. In the early period (1985-1994) the number of statement was four. This was followed by the same number of statements in the middle period (1995-1999) and the statements increased to ten in the later period (2000-2007).

In the pastoral statements, the Zimbabwean Catholic bishops communicated their views on HIV and AIDS with members of the Roman Catholic Church and Zimbabweans in general. Reports on the work of the Roman Catholic Church diocesan HIV and AIDS project were obtained from St. Joseph's mission, Mutare and others from St. Joseph's mission, Rusape. Since 1992, the church's Diocese of Mutare

¹⁸⁰ E. H. Carr, *What is history*, 40th Anniversary edition with a new introduction by R. J. Evans, (Basingstoke: Palgrave, 2001), 10.

launched an AIDS service organisation. This FBO became a specialised arm of Roman Catholic Church in responding to HIV and AIDS in Manicaland. Two weeks were also spent in the archives of the Cathedral of the Holy Trinity, Mutare and St. Simon Stock, Rusape scrutinising minutes of parish council meetings for the period 1985-2007.

The study also relied on archives of the Anglican Church, where the researcher spent two weeks at Holy Name parish church located in Sakubva, Mutare. The diocesan archives disappeared in 1998 when Bishop Elijah Masuko retired.¹⁸¹ When the researcher visited Holy Name, the current parish council had resolved to burn all the old church papers and the current rector spared contents of four old files that contained rich archival material. At Holy Name the researcher went through samples of minutes of parish council meetings held between 1985 and 2007 looking for the words AIDS, HIV, HIV/AIDS and HIV and AIDS. The researcher carefully extracted the statements made at parish council meetings in response to HIV. These were duly analysed and used in the present work. Written correspondences between the parish and the diocese were accessed and include diocesan synod agendas, synod resolutions and reports, minutes of diocesan standing committee meetings, health commission reports, and bishop's circulars or *Ad-Cleriums*. The same process was applied at the archives of St. Matthew's parish church, Rusape where the researcher spent twelve days. The researcher's personal archives also contained papers issued by the diocesan office including synod agendas, Acts of the Diocese of Manicaland, circulars from the bishop, reports and programmes from the diocesan Lay Training Relief and Information Centre, and the Mothers' Union guild. The documents covering the period 1985-2007 were also scrutinised using the same approach as mentioned above.

The official journals of the United Methodist Church in Zimbabwe are published annually and formed a critical resource in appreciating the denomination's response to HIV. The journals usually contain the Episcopal address, a joint report by the district superintendents, annual conference resolutions, and reports by various church committees. Prior to 2000 the journals covered proceedings of the church's single

¹⁸¹ S. Bakare, interview by M. Mbona, Murambi East, Mutare. 16 August 2010. As a member of the Anglican Church in the Diocese of Manicaland since 1980 the researcher is aware of this reality from the time Bishop Masuko retired in 1998.

annual conference in Zimbabwe including Manicaland. Thereafter, journals have been issued for the Zimbabwe East Annual Conference (ZEAC) that mainly covers Manicaland. The visit by the researcher to the church archives at Africa University yielded only four journals for the years 1985, 1987, 1988 and 1990. The researcher networked with the church's clergy including Reverend Andrew Mhondoro of Rusape who provided copies of the church's journals covering 1983, 1984, 1989, 1991, 1992, and 1995. Also Reverend Samson Muzengeza of Rusape assisted the researcher with journals for 1993 and 1996, annual reports for 2000 and 2002 and other papers. The United Methodist Church's Makoni-Buhera office in Rusape provided journals for 1994 and 2006 and various circuit reports that contained responses to HIV and AIDS. Hilltop Centre in Mutare is another research site where the researcher accessed a journal for 2004, a special "Centennial Session Report for 1997," an annual conference report for 2000 and several other papers. A journal for 2007 was obtained from the church's Mutasa-Nyanga district superintendent's office in Mutare. Five weeks were spent gleaning journals, annual conference reports, and circuits' minutes and reports.

The archives of FACT in Mutare and Rusape were also a focal point of this study. This became one of the earliest faith-based organisations to pioneer responses to HIV and AIDS in its work with churches. Data collected was not to be used to evaluate the FBO's work, but to establish some idea of the collaboration or lack thereof between FACT and the Roman Catholic, Anglican and United Methodist churches in Manicaland. While archival research generated much of the data for the study, secondary published sources such as journals and books on HIV were also used. Publications with a focus on religious responses to HIV in Zimbabwe and Africa were read and used in writing the present study. Written sources on the Government of Zimbabwe's response to HIV between 1985 and 2007 were seen as crucial in locating church responses to the pandemic. Some of the documents in this category include the *National HIV/AIDS Policy for the Republic of Zimbabwe*, (December 1999), publications by UNAIDS on HIV in Zimbabwe and many others as acknowledged in this present study. The World Wide Web (Internet) also proved to be a very useful tool in accessing some key documents and other valuable information that was instrumental in shaping the findings of the present study. Having established the

existence of written primary and secondary sources, the next challenge was that of selecting suitable information.

1.8.1. Primary Oral Sources

Primary oral sources in the form of semi-structured or in-depth interviews formed a crucial component of the present study in that they provide essential data in order to answer the research question and fulfil set objectives. An interview has been defined as “a conversation, usually between two people. But it is a conversation where one person—the interviewer—is seeking responses for a particular purpose from the other person: the interviewee.”¹⁸² In a historical study such as the one carried out by the researcher, interviews “can allow researcher’s access to the past,”¹⁸³ and thus can be used as oral history research tools. Denis has observed:

Oral history, as we understand it, is the complex interaction between an interviewer and an interviewee about events of the past, which requires questioning, as well as listening, on the part of the interviewer. This encounter shapes the story.¹⁸⁴

Apart from a few interviews carried out by others as acknowledged in the thesis, the researcher personally conducted the rest of the interviews. While the researcher knew some of the interviewees, with others it was a first encounter. The ‘insider’ and ‘outsider’ dynamics of research in conducting interviews is critical for the interview process. Norman Blaikie warned of this challenge among social science researchers and advised: “The choice is between either maintaining a ‘professional’ distance from the research participants or becoming thoroughly immersed in their social world.”¹⁸⁵ With the researcher being the interviewer, the success of each interview process rested on the researcher’s ability to control the interview situation in order to elicit

¹⁸² B. Gillham, *The research interview*, (London and New York: Continuum, 2000), 1. See also S. Dunne, *Interviewing techniques for writers and researchers*, (London: A and C Black, 1995), 30.

¹⁸³ D. Scott, “Qualitative approaches to data collection and analysis: Examinations and schools,” in G. Mckenzie *et al.*, (eds), *Understanding social research: Perspectives on methodology and practice*, (London: The Falmer Press, 1997), 165.

¹⁸⁴ P. Denis, “Introduction,” in P. Denis and R. Ntsimane (eds), *Oral history in a wounded country: Interactive interviewing in South Africa*, (Scottsville: UKZN Press, 2008), 3.

¹⁸⁵ N. Blaikie, *Approaches to social enquiry*, 2nd edition, (Cambridge: Polity Press, 2007), 11.

data. Such crucial data has been used to fill in gaps of information that were not addressed by the written sources.

Data generated from interviews has flaws because perceptions vary with each interviewee's memory. It became crucial for the researcher to be aware of the reality that interviewees as individuals are also social beings, formed in interaction, reproducing and also altering the societies of which they are members. Literate or illiterate, we are our memories."¹⁸⁶ As a consequence, the views expressed by interviewees cannot be taken as objective reality but as a narrative of what people chose to speak about including the way they said it. There are dangers in treating interviewees as mere objects without feelings or memory. According to Elizabeth Tonkin, interviewees should be regarded as individual tellers, who have to remember, reconstruct, order and direct their own recollection and sometimes do so with better or worse success."¹⁸⁷ Psychologically, interviewees might be confronted with questions of what information is important for the interviewer and thus selectively divulge what they said. During research interviews, people remember what they think is important, not necessarily what the interviewer thinks is most consequential."¹⁸⁸ The researcher's task has been that of probing interviewees to tell their experiences of church responses to the HIV pandemic mainly in local area settings and within the Manicaland province.

The study uses purposive sampling in which sampling depends not only on availability and willingness to participate, but that cases that are typical of the population are selected."¹⁸⁹ Church leaders and their followers, including a few other informants, were selected after the researcher established that they were likely to possess relevant insights on how the churches responded to HIV and AIDS in Manicaland (1985-2007). Kevin Durrheim and Desmond Painter suggest that purposive sampling is a suitable method for use in a qualitative study whereby

¹⁸⁶ E. Tonkin, *Narrating our past: the social construction of oral history*, (Cambridge: Cambridge University Press, 1992), 1.

¹⁸⁷ Tonkin, *Narrating our past*, 101.

¹⁸⁸ D. A. Ritchie, *Doing oral history: A practical guide*, 2nd edition, (Oxford: Oxford University Press, 2003), 32.

¹⁸⁹ K. Durrheim and D. Painter, "Collecting quantitative data: sampling and measuring," in Blanche, *Research in practice*, 139. For this see also Durrheim, "Research design," 50. Though discussed under quantitative sampling techniques, the researcher contends that purposive sampling fits well in the study.

researchers —typically work with—and actually prefer—small non-random samples of information rich cases that they study in depth.”¹⁹⁰ The snowballing method of sampling was then used in conjunction with leads from gatekeepers and other respondents.¹⁹¹ In the second phase, formalities of explaining the purpose of the study and the value of the interview were discussed.¹⁹² The researcher had to discuss with each one of the interviewees the use of the following documents: the Interview Themes Guide (see Appendix I), the Interview Guiding Questions or Schedule (see Appendix II), the Consent Form (see Appendix III), and the Interview Release Agreement Form (see Appendix IV). Interview themes and the interview research questions served as guides. Some flexibility was often made in order to deliberately accommodate each of the interviewees’ experiences.¹⁹³

Between August 2010 and April 2011, the researcher conducted fifty-six interviews all of them being with adult male and female respondents (see list in the section on Bibliography of this study). There were twenty-seven male and twenty-nine female participants whose age range was between thirty and seventy-eight years. A total of fifteen participants were drawn up from the Roman Catholic Church in Manicaland and has been constituted by a bishop, two priests, and twelve laity. The interviewees were chosen from the Cathedral of the Holy Trinity, St. Joseph’s mission, Sakubva, St. Paul’s Dangamvura, Triashill mission, Kriste Mambo with St. Thomas Nyahukwe, and St. Simon Stock. Within the list of lay people one was a nurse-in-charge at St. Joseph’s mission hospital in Mutare. Two females and one male had been involved in AIDS-related home-based care. Outside Manicaland the researcher also interviewed Ted Rogers, a Jesuit priest, who was one of the pioneers in spearheading church responses to HIV in the Roman Catholic Church in Zimbabwe and southern Africa. Rogers also led national ecumenical HIV interventions between the late 1980s and mid-1990s.

The highest number of interviewees has been drawn up from the Anglican Diocese of Manicaland. The nineteen participants include a retired bishop and his wife, four

¹⁹⁰ Durrheim and Painter, “Collecting quantitative data,” 139.

¹⁹¹ For this see also B. Carton and L. Vis, “Doing oral history,” in Denis and Ntsimane, *Oral history in a wounded country*, 43, 47. See also Durrheim and Painter, “Collecting quantitative data,” 139.

¹⁹² Carton and Vis, “Doing oral history,” 48.

¹⁹³ For this see Gillham, *The research interview*, 3-4.

priest and thirteen laity. Bishop Sebastian and Ruth Bakare were leaders of the Anglican Church in Manicaland between 1999 and 2006 and were therefore critical for the study in appreciating HIV interventions at leadership level. An interview transcript for Ruth Bakare has been included in the appendices (See Appendix V). The four clergy were all male since the Church of the Province of Central Africa (CPCA) of which the Anglican Diocese of Manicaland was part did not ordain females to the priesthood. One of the clergy worked in the church's relief and development office since 1985 and thus could have been familiar with how the diocese responded to HIV during the entire period covered by the study. Within the sample, the other participants included eight women and four males. One of the eight women has worked as a senior matron at the church's St. David's Bonda mission hospital since 1980. Three of the women interviewees were involved in home-based care within the communities where they lived. Interviewees were identified from the following sites: Holy Name Sakubva, St. Matthew's Vengere and St. Bartholomew in Rusape, St. Cuthbert's Denzva, St. Agnes Chikanga, St. Joseph's Samanga, St. David's Bonda mission, and the Cathedral of St. John the Baptist. The contingent of interviewees from the Anglican Church was more than the others because of the existence of gaps of information not addressed by data from archival sources.

A total of fourteen interviewees were solicited from the United Methodist Church in Zimbabwe all of them from Manicaland. One ordained senior female pastor represented the church's bishop. Two of the interviewees are senior male pastors who were already in the ordained ministry of the church by 1985. Out of the four remaining males, one is a medical doctor serving at Old Mutare mission hospital since the mid-1990s. Two out of the seven laywomen participants had been involved in home-based care and one worked with the church's youth, and OVC. All the interviews were conducted at the participants' places of either work or residence. Interviewees were drawn up from the following centres: Hilltop United Methodist centre, Mutare urban, Old Mutare mission, Tsonzo circuit (Mutasa), Rukweza (Makoni), Vengere in Rusape, and Chitombo in Honde Valley (Mutasa).

It was also important for the study to enlist the voice of Dr. Geoff Foster, founder of FACT whose insights from working with churches in Manicaland could enrich the findings. Similarly, an officer from the same FBO but based in Rusape was

interviewed. An interview was also conducted with Vuyelwa S. Chitimbire the executive director of ZACH. The researcher chose to interview senior medical personnel one each from St. Joseph's mission hospital (Roman Catholic in Mutare urban), Old Mutare mission hospital (United Methodist and peri-urban) and St. David's Bonda mission hospital (Anglican and rural) all being affiliates of ZACH. Three officers from the National AIDS Council (NAC) with one based at the Manicaland provincial office in Mutare and two serving at Mutare urban and Makoni district offices respectively were interviewed for their input (see Appendix X). Finally one medical doctor from Rusape had to be interviewed as a way of eliciting insights on an overview of State and church responses to HIV in Zimbabwe in general and Manicaland in particular. Information that is relevant to the study was also obtained informally through other oral sources and email communication as acknowledged in the thesis.

It has not been intention of the study to intentionally interview HIV positive people as a way of avoiding the probability of causing possible harm. The focus of the present research study is not to seek HIV and AIDS status of participants but to concentrate on the response of Christian communities particularly from the Roman Catholic, Anglican and United Methodist churches. Interviewees were informed of the use of a digital recorder and given the option to have the interview in English or Shona. The researcher is conversant in both English and Shona languages and is familiar with the geography of Manicaland from which he hails. On the day of conducting each of the interviews the researcher had to carefully go through the interviews themes for a second time as well as the consent and interview release agreement forms. Before the commencement of the interview session, interviewees voluntarily signed the consent form as a way of authorising the interview process to ensue. By giving consent the interviewee also authorised the use of the interview by the researcher and as well as others thereafter. At the end of each interview session the interviewee also signed a release agreement form authorising the researcher to use the interview responsibly and deposit it in a safe place where it will be used by other researchers.¹⁹⁴

¹⁹⁴ P. Denis, "The ethics of oral history," in Denis and Ntsimane, *Oral history in a wounded country*, 74.

The researcher made all the interviewees aware of the regulations and also informed them that based on signing a release agreement form the digitally recorded interviews were to be taken to the University of KwaZulu-Natal, South Africa. In oral history if there are no anticipated chances of possible harm, after giving their consent, the participant's names may be mentioned and acknowledged in the text unless they have requested that it should be otherwise. Consistent with this practice, Paul Thompson has observed: "Perhaps more importantly, a licence to quote the informant is implied by the consent to be interviewed."¹⁹⁵ None of the participants declined to have their names stated in the text and all proudly expressed the opinion that their names be mentioned and openly acknowledged in the present study. It is under these circumstances that names of interviewees have not been hidden in the text of the present work. The digitally recorded interviews have been deposited at the Alan Paton Centre and Struggle Archives that houses the Sinomlando Interview Catalogue at the University of KwaZulu-Natal, Pietermaritzburg campus.

1.8.2. Data Analysis

Following the collection of large volumes of data generated from primary written and primary oral sources, the researcher analysed the data qualitatively. Data analysis has been done with the purpose "...to transform information (data) into an answer to the original research question."¹⁹⁶ The study seeks to answer the research question by analysing all relevant data as it came in and gradually build up into a volume of substantial size. This is in line with the observation that qualitative analysis of data is "...an on going process starting from the time that the field work begins."¹⁹⁷ Similarly, Sotirios Sarantakos has also observed that qualitative analysis "occurs in a cyclical continuous process that goes through data reduction, data organisation and interpretation."¹⁹⁸ The approach is suitable for the present study because each unit of data obtained from either primary written and primary oral sources could be analysed. Another reason for the researcher's use of this approach is that data collection and

¹⁹⁵ P. Thompson, *The voice of the past: Oral history*, 3rd edition, (Oxford University Press, 2000), 253.

¹⁹⁶ Durrheim, "Research design," 52.

¹⁹⁷ G. D. Bouma and G.B.J. Atkinson, *A handbook of social science research: A comprehensive and practical guide for students*, New revised and expanded edition, (Oxford: Oxford University Press, 1995), 213.

¹⁹⁸ S. Sarantakos, *Social research*, (London: Macmillan, 1993), 300.

data analysis occurred simultaneously. This approach has also been supported by Kalof *et al.* when they made the following observation: “Since the goals of qualitative research are often to understand underlying meanings or describe experiences or phenomena in-depth, data collection, sampling, analysis and interpretation are typically done simultaneously.”¹⁹⁹

The present study used the interpretive analysis strategy in which data analysis depends on the researcher’s ability to develop a deep understanding and sound knowledge of the available data. Blanche *et al.* observed that, “the key to doing a good interpretive analysis is to stay close to the data, to interpret it from the position of empathic understanding.”²⁰⁰ While a number of interpretive styles existed, the study adopted the immersion or crystallisation style. This style requires the researcher to become “thoroughly familiar with a phenomenon, carefully reflecting on it, and then writing an interpretation by relying on one’s intuitive grasp of what is going on rather than any particular analytic techniques.”²⁰¹ In order to answer the research question, the researcher had to be familiar with what emerged from primary written and oral sources. Furthermore, the researcher reflected on the themes and patterns of response that developed within each church and compared this data with the other churches. While Sarantakos has identified three steps in interpretive data analysis: data reduction, data organisation and finally, interpretation,²⁰² a comprehensive approach as discussed by Blanche *et al.* was finally used. The latter identified and discussed five steps to be followed in interpretive data analysis: familiarisation and immersion, inducing themes, coding, elaboration, and finally, interpretation and checking.²⁰³

Firstly, the researcher critically scrutinised field notes by reflecting on the data to understand what took place in relation to church responses to HIV and AIDS. This was followed by the researcher having to develop deep knowledge of intricate details of the data, which led to some efficiency in identifying and locating specific issues. A process of developing themes followed. Some of the emerging themes include: AIDS

¹⁹⁹ Kalof, *Essentials of social research*, 86.

²⁰⁰ M. T. Blanche, *et al.*, “First steps in qualitative data analysis,” in Blanche, *Research in practice*, 321.

²⁰¹ Blanche, “First steps in qualitative data analysis,” 322.

²⁰² Sarantakos, *Social research*, 300-301.

²⁰³ Blanche, “First steps in qualitative data analysis,” 322-325.

and immorality, Government's policy on the use of condoms and the spread AIDS, AIDS as witchcraft, the churches denied existence of AIDS, the churches stigmatised PLHIV, condom use being unacceptable to Christians married couples, Christians' ignorance of causes of AIDS, churchwomen most affected by AIDS, women provided AIDS-related care, the churches helped orphans, the church had limited resources, Government's failure to help, and AIDS assistance from donors. Inducing themes enabled the researcher to analyse responses to HIV by each of the three churches separately and later producing a comparative analysis. The coding of data was carried out by using marks and symbols to further isolate different sections of the data as being instances of, or relevant to, one or more ...themes."²⁰⁴ Themes were explored closely again to ensure that sections of the text were further streamlined and thus elaborated upon. The researcher did some reflection on the data at this stage to establish any prejudices, instances of emotional distress, as well as how the researcher's personal involvement in data collection might lead to creating the interpretation."²⁰⁵

1.9. The Structure of the Study

The study is structured according to a chronological order with three parts respectively focusing on the early years (1985-1994), the middle years (1995-1999) and the later years (2000-2007). Between 1985 and 1994 generally this phase was marked by denial, stigma, and discrimination of people infected by the pandemic. At the institutional level, the ZCBC was the first to come out openly to issue a statement on AIDS in 1987. In 1989 a collective statement issued by some church leaders followed this. In 1990 and 1991 the annual conference session of the United Methodist Church in Zimbabwe adopted a resolution allowing for the use of condoms to prevent HIV in the context of marriage. The Roman Catholic Diocese of Mutare launched an AIDS-related home-based and OVC care organisation. The churches' healthcare centres complemented the State public health system through the provision of ordinary treatment to people who showed signs of having contracted HIV. Between 1995 and 1999 the State's introduction of economic reforms made access to public

²⁰⁴ Blanche, "First steps in qualitative data analysis," 324.

²⁰⁵ Blanche, "First steps in qualitative data analysis," 326.

health unaffordable to most citizens. Many sick people were forced to seek services provided by church healthcare institutions. While in 2000 the state invited the churches to partner with the government in responding to HIV and AIDS, further socio-economic decline was exacerbated by political turmoil. Between 2000 and 2007 the withdrawal of state donors meant that the churches had to carry the burden of responding to the HIV pandemic.

Chapter 1: This chapter will introduce study. The key issues of focus will include an outline of the research study, a statement of the research question and hypothesis, the rationale for the study, and the research problem and objectives. The conceptual and theoretical frameworks will also be discussed. A survey of existing literature on HIV and AIDS in Africa, Zimbabwe and Manicaland will be analysed. Limitations and delimitation of the study will also be outlined and finally, a section on methodology will be included.

Chapter 2: This chapter will focus on important background issues. These include a discussion of AIDS in the context of other earlier epidemics, the African AIDS pandemic and the Zimbabwean context, an overview of the Zimbabwean State policy framework on HIV and AIDS, the State's funding of HIV interventions, and the State's delayed involvement in home-based care. A periodisation of HIV responses in Zimbabwe will also be provided in order to indicate and locate where church interventions fit in. A summary of the chapter will form the conclusion.

Chapter 3: This chapter will cover the findings of the study in the early years (1985-1994) by discussing the responses of to HIV and AIDS by the Roman Catholic, Anglican United Methodist Church. The work of Ted Rogers and the ZCBC will be highlighted, followed by HIV an overview of the interventions by the Roman Catholic Church's Diocese of Mutare. The section on the Anglican Church will discuss the high levels of denial and stigma at the level of its diocesan leadership as well as among its grassroots church members. The same trend will be observed within the United Methodist Church. Finally, the chapter will conclude by offering a summary and comparative analysis of church responses during the period 1985-1994.

Chapter 4: In this chapter the research will focus on responses to HIV and AIDS by all the three churches in the middle period (1995-1999). The chapter will highlight advocacy statements issued by the ZCBC and the effects of a moralistic stance towards HIV prevention found common among all the three churches. HIV interventions by the three church denominations will be discussed. A brief discussion will be given on the decline of AIDS denial and AIDS-associated stigmatisation when church communities gradually became involved in AIDS care at a time when State funding of healthcare declined due economic reform programmes. The chapter will conclude with a comparative synthesis of the responses to HIV by all the three churches in the period.

Chapter 5: This chapter will discuss the three churches' response to the HIV pandemic in the later period (2000-2007). The discussion will also focus on the work of the churches in responding to HIV and AIDS within a further declining socio-economic environment at the height of the political tensions in Zimbabwe. Details will be given of the HIV interventions under all the three churches, which were expanded, with increased use of tangible and intangible resources held by Christian communities. The chapter will also indicate how church leaders have understood HIV and AIDS in moralistic terms and how some parishes increased their involvement in carrying out HIV interventions. Finally, a comparative synthesis of the responses to HIV by all the three churches will be provided.

Chapter 6: The last chapter forms the summary and conclusion of the study. It will pay attention to the effects of HIV and AIDS on church institutions, HIV and AIDS and the churches' discourse, church-related HIV and AIDS interventions and the conclusion. The ramifications of the study and areas for further research will finally be suggested.

CHAPTER TWO

THE HISTORICAL CONTEXT OF HIV AND AIDS IN ZIMBABWE

2.1. Introduction

The main purpose of this chapter will be to provide some background understanding to the HIV and AIDS pandemic in Zimbabwe. In particular, the chapter will discuss HIV and AIDS in the context of earlier epidemics including cholera and influenza due to there being both similarities and differences between AIDS and earlier epidemics. As the HIV pandemic is also a historical phenomenon, responses to earlier epidemics have a bearing on various church responses to AIDS. This will be followed by an exploration of the African AIDS epidemics as they relate to southern Africa in general and Zimbabwe in particular. The major benchmarks in State responses to the pandemic in Zimbabwe including relevant Government legislative policies and funding models of State HIV interventions will be highlighted. A brief analysis of AIDS-related home-based care will also be included with the purpose of locating the place of church institutions in providing these services.

An important task of the study is to locate church responses to HIV and AIDS within a specific historical period stretching for twenty-two years. A brief overview of the history of all the three churches will also be included. They each have parishes, mission centres, schools and healthcare centres in many parts of Manicaland. Issues of individual church polity will be highlighted in order to inform their responses to HIV and AIDS which will be discussed later.

2.2. AIDS in the Context of Other Earlier Epidemics

Generally speaking, the reaction of the public to HIV and AIDS in Zimbabwe is somewhat similar to the way society has responded to earlier epidemics that affected

African communities. Rosenberg suggests that epidemics such as AIDS are a social phenomenon and have a dramaturgic four-fold form and thus observed: "Epidemics start at moment in time. Proceed on a stage limited in space and duration, following a plot line of increasing and revelatory tension, move to a crisis of individual and collective character, then drift towards closure."²⁰⁶ At the onset of an epidemic, there is the presence of denial and stigma. As the epidemic progresses people accept it and eventually develop solutions. Kenneth Doka has linked AIDS to four great epidemics. He notes that the epidemics have included the diseases of bubonic plague or Black Death (sixth and thirteenth centuries, 1894-1902), the influenza disease (1918-1919), and their intermittent epidemics, as well as outbreaks of such diseases such as yellow fever, typhoid and cholera.²⁰⁷ Black Death or the bubonic plague is an earlier epidemic that has been discussed in detail in the light of HIV and AIDS. A major characteristic of an epidemic is that it kills vast numbers of people. For example, between 25-75% of the population of Western Europe perished as a result of the bubonic plague from 1337 to 1350. The same epidemic claimed the lives of 13 million people in Eastern Europe between 1918 and 1922.²⁰⁸

Georg Scriba discussed the plague in Martin Luther's time and compared Luther's reaction with contemporary responses to HIV and AIDS. Scriba notes that Black Death was an epidemic that ravaged Europe, beginning in the middle of the fourteenth century and continued throughout the late Middle Ages to the middle of the seventeenth century. It is estimated that some twenty million Europeans lost their lives due to this epidemic.²⁰⁹ The way in which society in general and religion in particular has responded to earlier epidemics has a bearing on the responses of Christian communities to HIV and AIDS. There are in fact a number of similarities between the behaviour of those infected by Black Death and PLHIV. As Luther stated:

²⁰⁶ Rosenberg, *Explaining epidemics*, 279.

²⁰⁷ K. J. Doka, *AIDS, fear and society: Challenging the dreaded disease*, (Taylor and Francis: London, 1997), 3.

²⁰⁸ Doka, *Aids, fear and society*, 3.

²⁰⁹ G. Scriba "The 16th century plague and the present AIDS pandemic: A comparison of Martin Luther's reaction to the plague and HIV/AIDS pandemic in southern Africa today," *Journal of Theology for Southern Africa* 126 (November 2006), 67.

Some keep it a secret that they have the disease and go among others in the belief that by contaminating and poisoning others they can rid themselves of the plague and so recover. They enter streets and homes, trying to saddle children or servants with the disease and thus save themselves. So these folks infect a child there, a woman there, and can never be caught.²¹⁰

The initial response of society including Christian communities to the plague in sixteenth-century Western Europe was one of panic and confusion with some people choosing to minister to the needs of the sick while others fled to nearby cities.²¹¹ The public response to a pandemic five centuries ago indicates that such diseases were held in dread because of the massive effects they wielded on families, communities and society in general. Doka noted: “These diseases wiped out families and communities. They profoundly altered social institutions. They were epochal events that altered the very course of history. The bubonic plague provides many examples of this.”²¹²

In Africa, sub-Saharan Africa is one of the regions worst affected by HIV and AIDS in that it wiped out entire families and communities and left behind a trail of orphans. According to *The 2008 report on the global epidemic*, in 2007 sub-Saharan Africa had twenty-two million PLHIV, which was two-thirds of the global total of thirty-three million.²¹³ The origin and nature of the virus primarily determined the character of the African epidemic. In addition, the epidemic in sub-Saharan Africa has also been shaped by multitude of circumstances that took place, often with routes far back in the past.²¹⁴ Among the factors identified are: (a) its demographic reach, referring to the expansion of Africa’s population in the twentieth century due to advance in medicine; (b) advances in transport and human mobility; (c) gender inequalities; (d) the widespread prevalence of sexually transmitted infections, the lack of male circumcision, as well as the lack of economic opportunities for women and the disparity between age of partners; (e) the presence of poverty, and the blame for the pandemic based on class. Poor women were at high risk because they had fewer

²¹⁰ M. Luther, “Whether one may flee from a deadly plague,” (date of publication given as 1528) in G. Wienckle and H. Lehmann (eds), *Luther’s works* 43, Devotional writings (Philadelphia: Fortress Press, 1968), 132-133.

²¹¹ Scriba, “The 16th century plague,” 67.

²¹² Doka, *Aids, fear and society*, 4.

²¹³ UNAIDS, *The 2008 report on the global AIDS epidemic*, (Geneva: 2008), 39.

²¹⁴ Iliffe, *The African AIDS epidemic*, 60.

options to use condoms with elderly men. As a result, poverty was seen as an effective incubator.²¹⁵

The denial of HIV and AIDS by society has been seen to be similar to earlier responses to the Black Death. Doka has observed that society was not ready to accept that pathogenic agents caused Black Death. Instead, there was a perception that the disease was, "...divine punishment for heresy's sin and vice. ...In any case, the plague spurred a populace away from medicine, which seemed so unhelpful, to the church, which would now minister to body and soul."²¹⁶ Similarly, Rosenberg noted that the moralisation of an epidemic is a historical phenomenon:

For most previous centuries that framework was moral and transcendent; the epidemic had to be understood primarily in terms of man's [*Sic*] relationship with God; consolation was grounded in submission to the meaning implicit in that framework.²¹⁷

The present research study will illustrate that church leaders and lay members of the Roman Catholic, Anglican and United Methodist churches in Manicaland tended to understand HIV and AIDS in moralistic terms. Indeed, statements issued by the church leaders during the period under review often pronounced that immorality was the main factor that fuelled the spread of HIV.

The public response to the plague in sixteenth-century Western Europe showed a mixture of reactions. One of the most common reactions was that of blaming Black Death on others. This tendency to blame others is also manifest during the HIV and AIDS era. Similarly, as in the time of Black Death, a pattern of apportioning blame on others became a hallmark of AIDS denial and stigma. As Scriba observed:

Within the church HIV and AIDS was often seen as a punishment from God for the sins of mankind [*sic*], and the clergy called for a moral regeneration of society against immoderate eating and drinking, immoral sexual behaviour, excessive luxury, and congregants were called to repentance.²¹⁸

²¹⁵ Iliffe, *The African AIDS epidemic*, 61, 62, 63.

²¹⁶ Doka, *Aids, fear and society*, 5.

²¹⁷ Rosenberg, *Explaining epidemics*, 282.

²¹⁸ Scriba, "The 16th century plague," 68-69.

Apportioning blame was not only confined to the churches, but was also common among members of the general public. At the time of Black Death, ‘others’ were seen as being responsible for causing or spreading the disease. In line with this assertion, Scriba stated:

There were also those who believed that the spread of the disease was caused by the outcasts of society, the beggars and the poor or the Jews (in the case of Germany), and popular fury would turn against them. They were accused of poisoning the wells and in some areas, were massacred for that.²¹⁹

Doka also traced the links between social conditions and the spread of pandemics and linked the bubonic plague to the massive entry of refugees into Europe during the sixteenth century.²²⁰ In the past fifty or so years, southern Africa, including Zimbabwe, has experienced wars of liberation and various situations of political unrest that have led to the vast movement of refugees. Within Zimbabwe, the large movement of people due to the war of liberation during the 1970s, as well as the most recent socio-economic strife, has fuelled the spread of HIV. The rise of cholera that devastated parts of Europe in the nineteenth century was blamed on poor countries because cholera existed where sanitation was poor. As a result, the poor suffered disproportionately. As in AIDS, the victims were blamed for their own fate.²²¹

Whatever the situation, apportioning blame for the disease has had an adverse effect on those interventions aimed at the eradication of the epidemic. During the bubonic plague, the resentment and hatred by those who succumbed to the epidemic towards the authorities was rife. Authorities were suspected of either developing the disease or facilitating its spread. The denial of the epidemic among certain classes of people during the time of the bubonic plague might have certain parallels with that of AIDS in Zimbabwe. In Poland for example, at the national level there was often talk of death from a short illness and blame was placed on the doorstep of strangers. Physicians were accused of seeking to kill the poor including in the US and the rest of

²¹⁹ Scriba, “The 16th century plague,” 69.

²²⁰ Doka, *Aids, fear and society*, 6.

²²¹ Doka, *Aids, fear and society*, 9.

Eastern Europe.²²² The responses to HIV and AIDS by the Roman Catholic, Anglican, and United Methodist Church could also have been affected by blame.

Apart from drastically reducing the population of Europe, in the time of the Black Death epidemic –some villages became depopulated and eventually disappeared, and several towns declined substantially.”²²³ Similarly, the devastating effect of HIV made the Shona speaking people of Zimbabwe to give different labels to AIDS. Consistent with this assertion, Aquilina Mawadza observed: –One of the words used to refer to HIV/AIDS in Shona is *mukondombera* which means ‘plague.’ ...AIDS in Shona is *shuramatongo*, which means an ‘abandoned homestead, a cursed place, or a scene of catastrophe.’”²²⁴ Earlier epidemics including Black Death devastated individuals and families and in a similar fashion AIDS claims the lives of spouses and parents, sexual partners and HIV-positive children. While however Black Death was a disaster for some, to survivors it brought benefits, including a rise in wages, a drop in house rental prices and in the cost of food.²²⁵ Similarly, it could be stated that HIV and AIDS interventions by the churches in Manicaland have attracted huge amounts of foreign funding. As a result, the AIDS ‘industry’ has become a large employer of people who work in AIDS-related service organisation including NGOs, churches and FBOs.

While epidemics throughout history were often eradicated through collective interdicts, differences in the understanding of HIV and AIDS, especially among the religious and medical fraternity has undermined progress in responding to epidemics. Consistent with this observation and in relation to the cholera epidemic of 1832, Rosenberg showed that, –...the picture of a consistent if occasionally awkward coexistence between religious and rationalistic or mechanistic styles of thought was characteristic of mid mid-nineteenth-century Anglo-American society.”²²⁶ Measures taken to deal with the cholera epidemic were similar to responses to HIV and AIDS. The experience of the city of Florence was typical of many others in the control measures that were introduced and widely used across the rest of Europe. These

²²² Doka, *Aids, fear and society*, 9.

²²³ Scriba, –The 16th century plague,” 69.

²²⁴ A. Mawadza, –Stigma and HIV/AIDS discourse in Zimbabwe,” *Alternation* 11/2 (2004), 423-424.

²²⁵ Scriba, –The 16th century plague,” 69.

²²⁶ Rosenberg, *Explaining epidemics*, 286.

included: (1) the rigorous policing of human movement from plague-infested regions; (2) the compulsory burial in special pits of those who had died from the plague and the destruction of their personal belongings; (3) isolating the sick in pest houses and the quarantining their families; (4) introducing special taxes to provide free medical services and food for people in isolation; (5) providing subsistence to those whose livelihoods had been wrecked.²²⁷ Lessons from Luther's time indicate that some members of the Christian community, as well as those of general public cared for people who were attacked by diseases. In a similar way, the present study sought to investigate the way the Roman Catholic, Anglican and United Methodist churches in Manicaland responded to HIV and AIDS.

Responses to epidemics also possess a history of different degrees of collaboration or the lack thereof between the various churches and the State. The present study reveals that the open use of condoms as prophylactics became one of the contentious issues upon which religious leaders disagreed with the State. The churches blamed the Government of Zimbabwe for encouraging sexual promiscuity. Rosenberg notes that such disagreements were historical and were consistent with those of responses to earlier epidemics:

During the first decades of this century, for example, public health workers who urged the use of condoms and prophylactic kits to prevent syphilis met some of the same kind of opposition their successors in the 1980 faced when they advocated distributing sterile needles to intravenous drug user.²²⁸

Similarly, it should also be stated that some church leaders from the Roman Catholic, Anglican and United Methodist churches in Manicaland could be viewed as 'heroes' for promoting abstinence and faithfulness as the only means of reducing HIV transmission. Generally, either not having sex at all or practising safe sex can reduce the spread of sexually contracted HIV. The present research study will indicate that Christians did not speak with one voice on the matters of HIV prevention including the prophylactic use of condoms. While the State and some FBOs including the

²²⁷ S. Watts, *Epidemics and history: Disease, power and imperialism*, (London: Yale University Press, 1997), 16-17.

²²⁸ Rosenberg, *Explaining epidemics*, 289.

churches in Manicaland carried out HIV interventions, there were always a number of limitations. Hence, according to Rosenberg this trend is historical:

AIDS has, in particular, forcefully reminded us of the difficulty of providing adequate care for the chronically ill in a system oriented disproportionately towards acute intervention—and of the complex linkages between disease categories, hospital policies, and reimbursement formulas.²²⁹

Consequently, the present study is a historical analysis of church responses to HIV within the socio-economic context of Zimbabwe. In the section that follows attention will now be drawn to the AIDS epidemic in sub-Saharan Africa

2.3. The AIDS Epidemics in sub-Saharan Africa

In 2001, twenty years after the first AIDS-related case in the US, the majority of countries in sub-Saharan Africa had generalised HIV epidemics. UNAIDS states that, “a generalised HIV epidemic is an epidemic that is self-sustaining through heterosexual transmission. In a generalised epidemic, HIV prevalence usually exceeds 1% among pregnant women attending antenatal clinics.”²³⁰ The spread of HIV in Africa has mainly been through heterosexual transmission, unlike the situation in the US and Western Europe where homosexual transmission has the most prevalent means. Consistent with this observation, in their 2004 publication Sonja Weinreich and Christoph Benn provide the following data on HIV transmission in Africa: 87% heterosexual, 10% mother to child, 2% blood transfusion, 1% intravenous drug use and almost 0% homosexual.²³¹ Anne Buvé has shown that in four countries of Africa including Madagascar, Mauritius, Somalia and Senegal “the HIV prevalence rate in pregnant women was 1% or less. ...In the countries with generalise epidemics the HIV prevalence in the adult population ranged between 1.6% in the Gambia and 38.8% in Botswana.”²³² In sub-Saharan Africa, Zimbabwe appeared to be one of the

²²⁹ Rosenberg, *Explaining epidemics*, 291.

²³⁰ UNAIDS, *UNAIDS terminology guidelines*, Revised edition, (October 2011), 12.

²³¹ S. Weinreich and C. Benn, *AIDS: Meeting the challenge: Data, facts, background*, (Geneva, WCC Publications, 2004), 4.

²³² A. Buvé, “The HIV epidemics in sub-Saharan Africa: Why so severe? Why so heterogeneous? An epidemiological perspective,” in Denis, P and Becker, C (eds), *The HIV/AIDS epidemic in sub-Saharan*

countries in southern Africa where the estimated percentage of adults (15-49) living with HIV rapidly escalated from 5-10% in 1984, reaching 20-36% between 1989 and 1999.²³³

In an overview of the HIV epidemics in sub-Saharan Africa, in 2002 UNAIDS reported that in 2001 approximately 3.5 million new infections occurred, 28.5 million people were living with HIV in sub-Saharan Africa, fewer than 30, 000 people having benefited from antiretroviral drugs, and the number of children orphaned by AIDS in the region was at 11 million.²³⁴ The Arab North has been spared of high level of severity of the African HIV epidemics. At the end of 2001, the estimated number of PLHIV in North Africa together with the Middle East was only 500,000.²³⁵ Comparatively, southern Africa remained the hardest hit area in Africa and topped the world list of HIV prevalence. Buvé noted: “In seven countries of Africa, including Botswana, Lesotho, Namibia, South Africa, Swaziland, Zambia and Zimbabwe, at least one in five adults is infected with HIV and all of these countries are in southern Africa.”²³⁶

This has been further confirmed by statistics of HIV prevalence among pregnant women from southern Africa who attended antenatal clinics during the period 1997-2007. The statistics cited here are not current but serve to give a picture of the situation in different countries as recorded then. Swaziland and Botswana had a HIV prevalence rate of 30%, followed by Lesotho and South Africa at slightly below 30%, Namibia on 20% and Mozambique and Zimbabwe at 15%. On the contrary, in Ethiopia, the rate dropped from 14% in 1997 and to 9% in 2005, whereas in Kenya the rate dropped from 14% to 5% in the same period.²³⁷ This was in further contrast to the situation in West Africa. HIV prevalence in Côte d’Ivoire dropped from 10% in 2001 to 5% in 2005, Burkina Faso experienced a HIV prevalence decline from 6% in 1997 to 2.5% in 2006. In the same period, Ghana had been fluctuating between 2.5%

Africa in a historical perspective, Online edition, (October 2006), 41. See www.sorat.ukzn.ac.za/sinomlando/publications.

²³³ S. Craddock, “Beyond epidemiology: Locating AIDS in Africa,” in E. Kalipeni *et al.* (eds), *HIV and AIDS in Africa: Beyond epidemiology*, (Oxford: Blackwell Publishing, 2004), 2.

²³⁴ UNAIDS, *Report on the global HIV/AIDS epidemic*, (July 2002), 22-23.

²³⁵ UNAIDS, *Report on the global HIV/AIDS epidemic*, 8.

²³⁶ Buvé, “The HIV epidemics in sub-Saharan Africa,” 41.

²³⁷ UNAIDS, *The 2008 report on the global AIDS epidemic*, 41.

and 4%, and in Senegal it has been stable at an average of 1.5% in 1997 to 1% in 2004.²³⁸ It should be noted that these figures only serve to illustrate certain trends and thus have not been given detailed scrutiny.

Iiffe is one of a few authors who provide crucial insights on the African AIDS epidemic. While the origin of HIV is beyond the scope of the present research study, Iiffe used the work of scholars including Luc Montagnier, Elizabeth Bailes *et al.*, Nathan D. Wolfe, William M. Switzer *et al.*, Daniel Candotti and Claire Tareau *et al.* to trace the origins of AIDS to the African soil. This is linked to the collapse of European rule in Africa especially Leopoldville, present day Kinshasa in Belgian Congo, as far back as 1959.²³⁹ For example, Montagnier, whose laboratory first identified HIV, connected it to the death of an American man in 1952, a Japanese Canadian who died in 1958, an African woman who died in 1958, a Haitian American who died in 1959, a sexually active American youth who died in 1969.²⁴⁰ Therefore, AIDS could have existed invisibly on the African continent since 1959. In line with this observation, Caraël also stated:

Tests, which were later carried out on stored blood, confirmed the presence of the virus in central Africa from the end of the 1950s, both in rural and urban areas. But it is likely that the epidemic of the infectious AIDS virus, the human immuno-deficient virus HIV, began towards the end or ends of the 1970s and then slowly spread through several continents amongst the most vulnerable populations.²⁴¹

Within sub-Saharan Africa, the AIDS epidemic could have existed without being noticed and has therefore been described as a silent killer. It is for that reason that Iiffe stated that the African AIDS epidemic is –especially dangerous to human life, makes it difficult to check, ensures that it does not burn itself out...has given the AIDS epidemic its unique character.”²⁴²

An overview of the African AIDS epidemic by Iiffe indicates that –HIV-1 first became an epidemic during the 1970s in western equatorial Africa, its place of

²³⁸ UNAIDS, *The 2008 report on the global AIDS epidemic*, 41.

²³⁹ Iiffe, *The African AIDS epidemic*, 3.

²⁴⁰ Iiffe, *The African AIDS epidemic*, 3, 4.

²⁴¹ Caraël, –Twenty years of intervention and controversy,” 30.

²⁴² *Ibid.*, 8

origin.”²⁴³ Countries in that region include the Democratic Republic of Congo, Central African Republic, Congo, Gabon, Equatorial Guinea and Cameroun. The epidemic spread eastwards to Uganda, Rwanda, Burundi, Tanzania and Kenya,²⁴⁴ before taking a southward move towards Zambia, Malawi, Zimbabwe, Mozambique, South Africa, Botswana and Namibia.²⁴⁵ Later HIV and AIDS penetrated the western part of Africa.²⁴⁶ Epstein has concurred with Iliffe and Caraël’s observations but further argues that AIDS reached the Bukoba-Kagera region of Tanzania from West Africa in the late 1970s and quickly spread to Rwanda, Kenya, Burundi, Uganda, Zambia, Tanzania, Malawi and Zimbabwe.²⁴⁷ In Africa, AIDS was first identified in Zaire (present day Democratic Republic of the Congo) in the early 1980s as Brooke Schoepf noted: –AIDS was diagnosed among Zairians in Europe in 1983.”²⁴⁸ In 1984 the epidemic had spread to other African countries including Uganda, Rwanda, Burundi, Tanzania, Ivory Coast, Burkina Faso, Togo, Zambia, Cameroon, Congo Brazzaville and Zimbabwe.²⁴⁹ Kocheleff, writing on personal day-to-day experience with the epidemic states that in 1983 clinicians in Burundi discovered strange occurrences of what appeared to be AIDS as had been recently described in the United States.²⁵⁰ Malawi appears to be a unique case because AIDS-related sickness was discovered in the Karonga region of the country in 1982.²⁵¹

In Zimbabwe’s southern neighbour, South Africa, HIV was detected in 1982 reportedly –in a white homosexual air steward who had probably contracted the disease in New York. ...Blood specimens from 200 homosexual men in Johannesburg in 1983 later showed that 32 were already infected.”²⁵² Though first identified in a male foreigner from the Democratic Republic of Congo, HIV could have been in existence within South Africa among heterosexuals in 1985. Consistent with this assertion, Iliffe observed: –The first African in South Africa definitely known to have suffered from HIV was a man from DR Congo who apparently sought treatment early

²⁴³ Iliffe, *The African AIDS epidemic*, 10.

²⁴⁴ Iliffe, *The African AIDS epidemic*, 19-22.

²⁴⁵ Iliffe, *The African AIDS epidemic*, 33-47.

²⁴⁶ Iliffe, *The African AIDS epidemic*, 48-57.

²⁴⁷ Epstein, *The invisible cure*, 155-156.

²⁴⁸ B. G. Schoepf, –AIDS, history, and struggles over meaning,” in Kalipeni, *HIV and AIDS in Africa*, 20. See also Caraël, –Twenty years of intervention and controversy,” 30.

²⁴⁹ Buvé, –The HIV epidemics in sub-Saharan Africa,” 44.

²⁵⁰ Kocheleff, –AIDS in Burundi and South Africa,” 143.

²⁵¹ Iliffe, *The African AIDS epidemic*, 33.

²⁵² Iliffe, *The African AIDS epidemic*, 43.

in 1985.”²⁵³ Within the Southern African Development Community (SADC), social-political and economic interdependence has a long history. Economic factors account for high levels of migration in which adult males from Lesotho, Malawi, Mozambique, Namibia (as well as Swaziland and Zimbabwe) migrate to South Africa and Botswana in search of work opportunities. While this has the unintended effect of fuelling the spread of HIV, “This risk is not new and it was recognised before the emergence of HIV.”²⁵⁴ Other than regional factors, a unique set of conditions within a given space seems to fuel the spread of HIV in a particular country or locality. Denis further elucidated upon this by stating:

AIDS develops in a territory which, for generations, has been marked by gender questions, political relations, class conflicts and racial tensions which determine or, or at the very least, explain the particular paths which the epidemic follows.²⁵⁵

The transition from an agrarian and rural based economy to a modern urbanised economic system could have led to increased HIV prevalence in sub-Saharan Africa. In many of the cases, married males live separately from their spouses. Some husbands who move to urban areas in search of jobs usually leave wives in rural areas and this gives way to concurrent sexual relationships especially among male spouses. Epstein has observed that the AIDS epidemic in Africa has been triggered by rapid social and economic transmission “from an agrarian past to a semi-urbanised present. ...The resulting upheavals in social life have generated an earthquake in gender relations that has opened wide channels for the spread of HIV.”²⁵⁶ Similarly, Iliffe focused on Zimbabwe as a specific case and observed: “In Zimbabwe a similar oscillating pattern had grown up in the colonial period as men maintained land rights and families in the communal reserves while working in mines and cities.”²⁵⁷

African HIV epidemics could also have been fanned by transactional sex. In support of this assertion, Epstein has argued that transactional sexual relationships were encouraged by income inequalities among males and females and “the exchange of

²⁵³ Iliffe, *The African AIDS epidemic*, 44.

²⁵⁴ Zungu-Dirwayi, *An audit of HIV/AIDS policies*, 12.

²⁵⁵ Denis, “Towards a social history of HIV/AIDS in sub-Saharan Africa,” 16.

²⁵⁶ Epstein, *The invisible cure*, 67.

²⁵⁷ Iliffe, *The African AIDS epidemic*, 41.

money and gifts gives men a sense of ownership over a girlfriend's sexuality."²⁵⁸ Therefore, generally in Africa the low status of women in society exposed them to risks of contracting HIV and this had negative influence on HIV prevention.

According to *The 2008 Report on the Global AIDS Epidemic*, in Burkina Faso, Cameroon, Ghana, Kenya and the United Republic of Tanzania, two thirds HIV-infected couples were serodiscordant, that is only one partner was infected. Condom use was found to be rare."²⁵⁹ While sex work has also been identified as one of the modes of HIV transmission in the epidemics of sub-Saharan Africa, this has less influence on HIV prevalence in southern Africa. The HIV and AIDS pandemic in Zimbabwe has not mainly been driven by sex work but by other forms of sexual intercourse that include marriage. The same report indicates that Zimbabwe experienced substantial HIV transmission during sexual intercourse unrelated to sex work."²⁶⁰ Within African epidemics, generally the HIV prevalence among females is higher than in males. A survey of HIV prevalence in 15-24 year olds for the period 2005-2007 revealed that Zimbabwe was in third position for both, with females at 11% and males at 4%. Swaziland was at the top of the list with 23% for females and 6% for males, followed by South Africa with 17% for females and 4% for males. The least was Senegal, where the figures were below 1% for females and less than 0.5% for males.²⁶¹ Globally, the HIV epidemics in Zimbabwe, South Africa, Botswana, Lesotho, Namibia, Zambia and Kenya, all from Africa, indicate a bleak future as Denis stated:

In the seven countries where the average rate of HIV prevalence in adults who are sexually active exceeds 20%, the projections for the 2010-2015 period are terrifying: the number of deaths multiplied by three, life expectancy reduced to the age of thirty, and level of infant mortality almost doubled.²⁶²

The trend in Zimbabwe indicated that in February 1986 patients suspected to be suffering from AIDS-related illness were already dying of the pandemic in Livingstone, a town south of Zambia just across the Victoria Falls town in Zimbabwe.

²⁵⁸ See Epstein, *The invisible cure*, 79.

²⁵⁹ UNAIDS, *The 2008 report on the global AIDS epidemic*, 43.

²⁶⁰ UNAIDS, *The 2008 report on the global AIDS epidemic*, 43.

²⁶¹ For this see figure 2.10, UNAIDS, *The 2008 report on the global AIDS epidemic*, 42.

²⁶² Denis, "Towards a social history of HIV/AIDS in sub-Saharan Africa," 18.

It is therefore possible that the ~~–~~silent epidemic had penetrated Zimbabwe some time before, although perhaps three or four years later than Zambia and Malawi as the virus was carried southwards.”²⁶³ Surveys carried out to establish the earliest possible data on HIV and AIDS in Zimbabwe show that ~~–~~the first cases of AIDS and aggressive Kaposi’s sarcoma were diagnosed in 1983.”²⁶⁴ It appears that not much was said and done by the State until two years later in 1985 when blood was screened for the first time. Meanwhile, a young HIV epidemic in Zimbabwe indicated a general north to south pattern of movement. Consistent with this assertion, Bassett and Mhloyi observed: ~~–~~Within Zimbabwe, data support a north-to-south spread. In 1985, for example, 3% of blood donors in the northern city of Harare were seropositive, compared with 0.05% in the city of Bulawayo, to the south.”²⁶⁵ Iliffe also supports the same view and used HIV tests done at the district hospital at Hurungwe in Mashonaland West province which showed that the number of those who tested HIV positive between 1986 and 1988 increased from 16 to 292 people. The HIV prevalence for Harare escalated from 10% in 1989 to 18% in 1991 and reached 32% in 1995. Manicaland, in particular the city of Mutare, located on the border with Mozambique and along the Harare-Beira corridor, experienced a similar phenomenal increase in HIV prevalence reaching 37% by 1997.²⁶⁶

Zimbabwe is one of the countries in southern Africa whereby the AIDS epidemic rapidly escalated from an estimated 5-10% in 1984 to 20-36% in 1994 the number of adults in the 15-49 years range living with HIV.²⁶⁷ Another source indicates estimates of HIV prevalence of ages 15-49 to be 0% in 1983, 12% in 1991 reaching 25% in 1995.²⁶⁸ The figures illustrate that at least a quarter of the economically active citizens aged 15-49 years were living with HIV. Meanwhile, in Zimbabwe, unemployment rate increased phenomenally from 18% in 1982 to 60% in 1999 nationally.²⁶⁹ A report

²⁶³ Iliffe, *The African AIDS epidemic*, 37.

²⁶⁴ Iliffe, *The African AIDS epidemic*, 38.

²⁶⁵ Bassett and Mhloyi, ~~–~~Women and AIDS in Zimbabwe,” 148.

²⁶⁶ Iliffe, *The African AIDS epidemic*, 39. For this also see Gregson, ~~–~~Recent upturn in mortality in rural Zimbabwe,” 1269-1280.

²⁶⁷ Craddock, ~~–~~Beyond epidemiology,” 2.

²⁶⁸ NAC and MOHCW, *The HIV and AIDS epidemic in Zimbabwe: Where are we now? Where are we going?* Harare, (May 2004), 10.

²⁶⁹ M. van Donk, ~~–~~Development planning and HIV/AIDS in sub-Saharan Africa,” A report prepared for the United Nations Development Programme regional project on HIV and development in sub-Saharan Africa (July 2004), 133, <http://web.undp.org/hiv/docs/dev_plan_report_fnl.pdf> [Accessed 2 May 2009].

by the USAID, *Zimbabwe HIV and AIDS Health Profile* published in September 2008 stated that Zimbabwe experienced an increase in the adult population of PLHIV from 10% in the early 1990s to 36% by 1997.²⁷⁰ The cumulative AIDS cases for the period between 1988 and 1997 indicated that Manicaland had 7,050 PLHIV; Harare had 11,776 cases, Bulawayo, 7,751 cases, Mashonaland West, 7,447 cases and in Masvingo, 7,335 cases. The breakdown according to gender for Manicaland showed that 3,890 PLHIV were male, 3,125 were female and 35 were unspecified.²⁷¹ Nationally, the overall picture of HIV prevalence rate was about 29% by 1997.²⁷² HIV prevalence in pregnant women indicated that Manicaland had the highest rate of 53% of women infected in 1997.²⁷³ The HIV prevalence rate stabilised and gradually took a downturn from 1999 and made Zimbabwe one of the first African nations to witness such a trend.²⁷⁴

The USAIDS statistics are higher than those of WHO and Mirjam van Donk. These discrepancies could be due to underreporting and over-reporting of incidence of HIV by both the State and private laboratories in Zimbabwe. According to the NACP, under-reporting was caused by laboratories which carried out HIV tests and did not report the figures to the MOHCW. Furthermore, –some doctors feel that it is no longer necessary to send patients for HIV tests as the symptoms themselves are enough to indicate that a patient is HIV positive.”²⁷⁵ The statistics from antenatal surveillance in Manicaland could be a reliable indicator of HIV prevalence bearing in mind the fact that generally; in Zimbabwe antenatal visits facilitate regular contact between pregnant women and healthcare centres. However, because testing for HIV was voluntary, there could have been cases of under-reporting. The 1997 estimates of HIV prevalence in Zimbabwe by the WHO, UNAIDS and UNICEF, having been shared with the national AIDS programmes for review and comments, indicate a low limit of 28%, a high estimate of 31% and an adult HIV prevalence of 29%.²⁷⁶

²⁷⁰ USAID, *Zimbabwe: HIV and AIDS health profile* (September 2008).

²⁷¹ Edward Rogers' private archives, Harare (ER), NACP and MOHCW, –HIV, STI and AIDS Surveillance Zimbabwe,” *Quarterly report*, (January to March 1997), 2.

²⁷² WHO, UNAIDS and UNICEF, Epidemiological fact sheet on HIV and AIDS: Zimbabwe 2008 update, (October 2008).

²⁷³ International programmes centre, –HIV/AIDS profile, Zimbabwe,” Population Division, U. S Census Bureau, (June 2000). This article was accessed as a pdf.

²⁷⁴ USAID, *Zimbabwe: HIV and AIDS health profile*.

²⁷⁵ ER, NACP and MOHCW, –HIV, STI and AIDS Surveillance Zimbabwe,” 1.

²⁷⁶ WHO, *Epidemiological fact sheet on HIV and AIDS: Zimbabwe*, 4.

In 2001 Zimbabwe had one of the worst HIV pandemics in the world. With a total population numbering 11,500,000, the number of PLHIV was estimated at 1,500,000 people nationally in 2001. The adult HIV prevalence was at 25.06%, the number of AIDS-related orphans was at 900, 000 and that of AIDS-related deaths was at 160,000. Zimbabwe ranked third position in the sub-region after Botswana and Swaziland with an adult HIV prevalence of 35.8% and 25.25% respectively.²⁷⁷ However, the decline of new HIV cases nationally from 29.3% in 1997 to 15.6% in 2007 occurred.²⁷⁸ Gregson *et al.* observed that in rural Manicaland, HIV prevalence in attendees at antenatal clinics dropped from 21% in the period 1998-2000 to 15% in 2003-2005, and in men, HIV prevalence fell from 19.5% to 16.5% in the same period.²⁷⁹ A number of factors accounted for the decline in HIV prevalence that included:

...substantial reductions in the proportion of individuals particularly men reporting non-regular partners...low proportion of men having sex without condoms with regular partners...earlier increase in condom use contributed to a fall in the HIV incidence.²⁸⁰

Economic meltdown led to a reduction in opportunities of travel and entertainment in a context whereby –HIV incidence was associated with poverty in men—especially young men—from 1998 to 2003 in Manicaland, Zimbabwe.”²⁸¹ However, the findings from the study by Gregson *et al.* were quite unclear on how churches contributed towards the subsequent reduction in the spread of HIV.

The Government of Zimbabwe embraced the –Millennium Development Goals,” an initiative of the United Nations launched in 2001. Goal six is critical for the present study as it spells out the commitment by the global family of nations to halt the spread of AIDS, malaria and tuberculosis by 2015.²⁸² Furthermore, in 2001 member states of the United Nations signed the –Declaration of Commitment on HIV and AIDS,” and

²⁷⁷ D. Mullins, —and reform, poverty reduction and HIV/AIDS,” Unpublished paper presented at the Southern Africa regional poverty network (SARPN), Pretoria, (4-5 June 2001).

²⁷⁸ S. Gregson *et al.*, —HIV decline in Zimbabwe due to reductions in risky sex? Evidence from a comprehensive epidemiological review,” *International Journal of Epidemiology* 39 (2010), 1311. See also Halperin, —Surprising prevention success,” 2.

²⁷⁹ Gregson, —HIV decline in Zimbabwe,” 1317.

²⁸⁰ Gregson, —HIV decline in Zimbabwe,” 1321.

²⁸¹ Lopman, —HIV incidence and poverty in Manicaland.”

²⁸² UNAIDS, *The 2008 report on the global AIDS epidemic*, 13.

in 2006 the member states, including Zimbabwe, signed the “Political Declaration on HIV and AIDS,” as a pledge towards “taking extraordinary action to move towards universal access to HIV prevention, treatment, care and support in 2010.”²⁸³

2.4. Overview of the State’s Responses to HIV and AIDS in Zimbabwe

This section will mainly focus on State key policy issues in response to HIV and AIDS in Zimbabwe between 1985 and 2007. It will also explore models of funding of HIV interventions used by the Government of Zimbabwe and indicate why churches became a critical player in public AIDS-related care.

2.4.1. Brief Survey of State Policies and HIV Interventions

The NAC and MOHCW noted that HIV transmission showed that 84% of HIV cases were contracted through sexual transmission, mainly heterosexually, 15% was through mother to child transmission and 1% through other means including blood contact.²⁸⁴ This appears to have concurred with findings by Weinreich and Benn as stated earlier above. In 1985 the State in Zimbabwe declared that all blood be screened before transfusion as a way of stopping the spread of HIV. The National Blood Transfusion Service launched a new programme of screening all blood donated by sources across the country before it was availed to those in need.²⁸⁵ While the move was positive, there were some limitations. One of the major setbacks is that results of blood tests were not released immediately to blood donors. There was a long period of waiting before blood donors were informed of their HIV status.²⁸⁶ This move was misleading to the public because it created the impression that receiving contaminated or HIV positive blood is the only way of contracting HIV, which did not prove to be the case. Potential blood donors also became scared of donating blood in fear of being informed of their HIV status.²⁸⁷

²⁸³ UNAIDS, *The 2008 report on the global AIDS epidemic*.

²⁸⁴ NAC and MOHCW, *The HIV and AIDS epidemic in Zimbabwe*, 5.

²⁸⁵ MOHCW, *National HIV/AIDS policy*, 1.

²⁸⁶ G. Mukaratirwa, interview conducted by M. Mbona, St. David Bonda, Mutasa, 22 September 2010.

²⁸⁷ E. Mbutsa, interview conducted by M. Mbona, Holy Name pasish, Sakubva, 25 August 2010.

The governments of some African countries including Zimbabwe were also quite secretive about AIDS-related deaths. Marta Zaccagnini mentioned that African governments such as in the Democratic Republic of Congo in 1983 and in Zimbabwe in 1987 instructed doctors not to mention AIDS on death certificates.²⁸⁸ In Burundi, in 1985, the Ministry of Health prohibited a research team from presenting results of the investigation on HIV and AIDS at a conference in Brussels, and blocked publication of the findings in a medical journal.²⁸⁹ Apparently, the State in Zimbabwe was secretive about HIV and AIDS since the new ‘disease’ threatened the viability of the tourism industry. A respondent, Dunmore Kusano, a medical doctor who trained in Zimbabwe in the late 1980s stated that “the government’s fear of losing potential tourists was a case of complicity in denying HIV and AIDS. In fact many of the people who died from AIDS-related diseases had pneumonia, TB2, or resistant malaria stated as the cause of fatality.”²⁹⁰

Public policy statements on HIV issued by the State in Zimbabwe were important in locating and dating the responses of the Roman Catholic, Anglican and United Methodist churches in Manicaland to HIV and AIDS (1985-2007). For example, in 1987 the State established the National AIDS Co-ordination Programme (NACP) whose mandate was to spearhead national responses to the HIV and AIDS. The programme initiated a short-term plan (1987-1988) and the main objectives being “public awareness of HIV/AIDS, and training of health personnel in different aspects of HIV/HIV prevention and control.”²⁹¹ The State acknowledged that the problem of HIV and AIDS continued to grow at an alarming rate with 1,5 million people having contracted HIV and more than 400,000 people having developed full blown AIDS at the end of 1998.²⁹² While the figures continued to rise, there is a perception that the Government was in a state of panic and denial. An interviewee, who was at that time training as a medical doctor at the University of Zimbabwe, mentioned that the public medical personnel and the Government of Zimbabwe at large were generally shocked

²⁸⁸ M. Zaccagnini, “History of HIV and AIDS in Africa,” <<http://www.avert.org.history-aids-africa.htm/>> [Accessed 25 May 2009].

²⁸⁹ Kocheleff, “AIDS in Burundi and South Africa,” 146.

²⁹⁰ D. Kusano, interview conducted by M. Mbona, Makuma medical centre, Rusape, 21 September 2010. See also E. Kabungaidze, interview conducted by M. Mbona, Hilltop, Mutare, 13 August 2010.

²⁹¹ MOHCW, *National HIV/AIDS policy*, 1. See also NAC, *Zimbabwe HIV and AIDS national strategic plan monitoring and evaluation framework 2006-2010* (2006), 2. See also *HIV and AIDS in Zimbabwe*, <<http://www.avert.org/aids-zimbabwe.htm/>> [Accessed 10 August 2011].

²⁹² MOHCW, *National HIV/AIDS policy*, 5.

by HIV.²⁹³ Another medical doctor, Tendai Manyeza, stationed at Old Mutare mission hospital, also made a similar observation.²⁹⁴

In Zimbabwe the first years of the pandemic witnessed the quarantining of PLHIV because the members of the general public were afraid of contracting HIV. A study on home-based care in Zimbabwe between 1986 and 1990 observed that: “Anyone suspected of having the disease [AIDS] was isolated into ‘high care’ quarantine units as AIDS was considered a highly contagious disease.”²⁹⁵ A general observation is that between the early 1980s and mid 1990s ordinary Zimbabweans were quite sensitive about exposure to and contact with people suspected of living with HIV. In a study carried out in South Africa, Niehaus also encountered elements of exaggeration among his subjects and noted:

In addition to sexual intercourse, they believe, HIV could be spread by touching others; sharing eating utensils, cutlery and toilets; breathing the same air; nursing a sick person without using latex gloves; or by merely coming into contact with his or her germs, saliva and blood, especially if one had a wound.²⁹⁶

The nature of AIDS as a slow killer made PLHIV to be seen by family members and other carers as being a burden and also dangerous. HIV has a long incubation period lasting between five and twenty years,²⁹⁷ and has the effect of draining resources including money and food among others. Being HIV positive and having full-blown AIDS were also considered as ‘shameful’ conditions and stigma led to isolation or separatism. The incubation period of HIV varies since others take a long time as carriers of the virus before they develop full-blown AIDS.

It is important to understand the nature of HIV transmission in Zimbabwe as it had an influence on the methods of prevention of HIV transmission that were adopted by the State as well as churches. A study conducted by Lisa Garbus and Getrude Khumalo-

²⁹³ D. Kusano, same interview.

²⁹⁴ Tendai Manyeza, interview conducted by M. Mbona, Old Mutare hospital, 24 August 2010. See also, E. Kabungaidze, same interview.

²⁹⁵ Irish Aid *et al.*, *Looking back, mapping forwards: Research findings on home-based care in Zimbabwe*, (November 2007), 29.

²⁹⁶ Niehaus, “Leprosy of a deadlier kind,” 325.

²⁹⁷ Doka, *Aids, fear and society*, 27.

Sakutukwa based at the University of California San Francisco, ranked all three known modes of HIV transmission in Zimbabwe thus:

The epidemic is driven largely by heterosexual transmission, which accounts for 92% of infections; mother to child is also an important factor, accounting to 7% of infections. Transmission via blood transfusion is rare: Zimbabwe was one of the first countries in the world to implement universal screening of blood and the selection of all voluntary, low-risk donors. Transmission via men who have sex with men is probably underestimated, given the Government's fervent antihomosexual stance.²⁹⁸

The findings appear to differ slightly but generally concur with those already cited above. The Government of Zimbabwe took the position that: "Condoms are effective barriers to viruses, including HIV. However, condoms are not 100% effective. To maximise effectiveness, condoms must be used correctly and consistently with all sexual partners."²⁹⁹ In 1993 the National AIDS Co-ordination Programme's publication, *AIDS questions and answers*, identified three major ways by which HIV was spread namely: sexual transmission, mother-to-child transmission (PMTCT), and blood transmission. The Government's approach to the prevention of HIV appeared pragmatic by recommending one sexual partner, consistency in condom use, and avoidance of contact with contaminated blood.³⁰⁰

Zimbabwe launched its first medium term plan (MTP1) on HIV and AIDS covering the period 1988-1993. The new plan aimed at increasing HIV prevention activities through "motivating appropriate behaviour change among specific population groups, counselling and caring for people with HIV [PLHIV] and monitoring the epidemic through epidemiological surveillance."³⁰¹ In 1994 National AIDS Co-ordination Programme repeated the same message as spelt out in its earlier booklet but further emphasised that contracting sexually transmitted HIV could be prevented by taking the following steps:

²⁹⁸ L. Garbus and G. Khumalo-Sakutukwa, "HIV and AIDS in Zimbabwe: Country AIDS policy analysis project," AIDS Policy Research Centre, University of California San Francisco (October 2003), 5.

²⁹⁹ NACP, *AIDS questions and answers*, 22.

³⁰⁰ NACP, *AIDS questions and answers*, 14-19.

³⁰¹ MOHCW, *National HIV/AIDS policy*, 1. See also NAC, *Zimbabwe HIV and AIDS national strategic plan*, 2.

By not having sex at all. This is the surest way to avoid HIV infection...by having sex with one faithful, lifelong, uninfected partner. This will ensure that neither partner is infected. By using a condom every time you have sex. Condoms, if used properly protect you from HIV and other sexually transmitted diseases.³⁰²

While some church leaders did not disagree with the State on the importance of preventing the spread of HIV, the present study will demonstrate that church leaders appeared uncomfortable with the State's policy to openly encourage condom use. For example, some church leaders attacked the State's policy of exposing young people to information about sex and condoms as well as making condoms appear to be the only way of reducing the spread of HIV.³⁰³

The second medium term plan (1994-1998) had three objectives laid down as the reduction of: (1) transmission of HIV and other sexually transmitted infections (STI), (2) personal and social impact of HIV/AIDS/STI, and (3) socio-economic consequences of the epidemic.³⁰⁴ A special arm was established to specifically work on a national HIV and AIDS policy under the leadership of a national interdisciplinary and intersectoral task force together with seven expert groups. This initiative culminated in the first national HIV and AIDS policy for Zimbabwe that was launched at the end of 1999.³⁰⁵ Little was achieved by the State in reducing HIV prevalence and AIDS mitigation. Escalation in AIDS-related deaths appears to have pressurised the Government of Zimbabwe to incorporate other players including churches, civic organisations, and the business community in forming a multisectoral approach to HIV interventions. Up to this point, any HIV interventions carried out by churches or FBOs were done without statutory instruments. The churches and FBOs launched home-based care and AIDS-related orphan care interventions without proper guidelines from a legislative policy framework.

Some of the key tenets that the national policy sought to address were as follows: (a) that HIV and AIDS is a serious public health, social and economic problem affecting the whole country and requiring to be addressed as a major priority through

³⁰² NACP, *Living with HIV and AIDS*, 15.

³⁰³ For this see HOCD, *AIDS: The Christian response*, 7.

³⁰⁴ MOHCW, *National HIV/AIDS policy*, 1.

³⁰⁵ MOHCW, *National HIV/AIDS policy*, 2.

appropriate individual and collective actions; (b) that access to information and behaviour change are cornerstones for the prevention and control of HIV and sexually transmitted infections; (c) that human rights and dignity of all people irrespective of their HIV status should be respected and that avoidance of discrimination against HIV positive people should be promoted. Special consideration needs to be attached to HIV and AIDS and the responsibility to protect oneself and others from infection should be upheld by all people including PLHIV; (d) that providing care and counselling is essential in order to minimise the personal and social impact of HIV and AIDS; (e) that sensitivity to gender and commitment to promoting equality should be integrated into the different policies; (f) that research should be an integral part of the effort to combat HIV; (g) that a supportive environment at every level of society will enhance the response to HIV and AIDS by individuals, families and communities, and (h) that an appropriated national AIDS coordination and advocacy framework was essential to oversee further policy development, implementation and coordination.³⁰⁶

The present study might not provide further intricate details regarding the policy but it is important to highlight that the Government gave the impression that responses to HIV and AIDS by churches were significant. At the launch of the national HIV and AIDS policy in December 1999, President Robert Mugabe stated that a coherent and sustained multi-sectoral approach supported by State and civic leadership at all levels of society became critical in containing the pandemic.³⁰⁷ Apparently, all sectors were called upon to consider HIV and AIDS as a priority and integrate it into their planning and programming. This became a positive move in confronting the pandemic. The churches were identified as part of the contingent of actors expected to lead the way in preventing the spread of HIV and AIDS mitigation. The National HIV and AIDS policy document stated:

The national strategy against AIDS calls for a broad-based multi-sectoral response, through the proposed National AIDS Council [NAC] by Government ministries/departments, the private sector, non-governmental organisations, the churches, communities, community

³⁰⁶ MOHCW, *National HIV/AIDS policy*.

³⁰⁷ R. Mugabe, "Foreword," in MOHCW, *National HIV/AIDS policy*, v.

based organisations including support groups for people living with HIV/AIDS, the media and international collaborating partners.³⁰⁸

From then henceforth the State in Zimbabwe expected church responses to HIV to be streamlined by being an integral part of a multi-sectoral approach.

The inclusion of churches and other players in a multi-sectoral collaboration could have meant that the State valued HIV and AIDS interventions carried out by some of the churches and would thus support such work. However, the present study indicated that churches encountered multiple challenges arising from the State being suspicious of the churches' agenda in carrying out HIV interventions. It has to be noted that not all churches were represented in the multi-sectoral collaboration with the Government. A fraction of leaders of church denominations that own healthcare centres and churches involved in HIV and AIDS-related programmes were drawn into the multi-sectoral collaboration. At national level a few church leaders were nominated into the new structure and clergy and medical personnel from church-led healthcare centres also incorporated at both the provincial and district levels.³⁰⁹ Representatives were drawn from the Zimbabwe Council of Churches of which the Anglican and United Methodist churches were part.³¹⁰ The Roman Catholic Church through the ZCBC together with the Evangelical Fellowship of Zimbabwe was also included in the multi-sectoral collaboration at different levels.³¹¹

The Zimbabwe Government took fifteen years before formally integrating church-based HIV and AIDS interventions into a multi-sectoral collaborative strategy. From 1985 onwards responses to HIV and AIDS by churches were not officially recognised by the State. While this appeared to be the case, a number of FBOs including churches were already involved in the response to HIV and AIDS. For instance, in Manicaland FACT in Mutare established AIDS-related care interventions in 1987,³¹² and the Roman Catholic Church project was launched in 1992.³¹³ The State's new drive was underpinned by a need to ensure that HIV and AIDS interventions by

³⁰⁸ MOHCW, *National HIV/AIDS policy*, 3.

³⁰⁹ P. Jani, interview conducted by M. Mbona, NAC office, Sakubva Hospital, Mutare, 4 January 2011.

³¹⁰ E. Kabungaidze, same interview. See also S. Bakare, same interview.

³¹¹ P. Mutume, interview conducted by M. Mbona, Mutare, 2 September 2010. See also L. Kupara, interview conducted by M. Mbona, NAC Manicaland provincial office, Mutare, 12 January 2011.

³¹² G. Foster, interview conducted by M. Mbona, FACT office, Mutare, 17 September 2010.

³¹³ P. Mutume, same interview.

different players were planned, monitored and evaluated systematically. To accomplish this goal, the National AIDS Council (NAC) was created by an act of parliament in 1999 and it started functioning in 2000.³¹⁴ The responsibility of this council entailed the development of a national strategy, coordinating, monitoring and evaluation of HIV interventions under the supervision of a national board.

The NAC has a thirteen member national board drawn from various sectors including PLHIV. The President of the Republic of Zimbabwe in terms of the National AIDS Council Act Chapter 15.14 of 1999 appoints members of the board for a three-year term.³¹⁵ Ten provincial AIDS committees each representing Manicaland, Mashonaland East, Mashonaland Central, Mashonaland West, Midlands, Masvingo, Matabeleland North, Matabeleland South, and the cities of Harare and Bulawayo have been established. A total of 120 district AIDS action committees have been created from sixty-six administrative districts. This was followed by the launch of 1,839 ward AIDS action committees and each village has a village AIDS action committee.³¹⁶ These structures were set to assist with the coordination of HIV and AIDS interventions at different levels and the council plays an overall managerial and coordinating role. Thus, the council is meant to work with government, development agencies, local authorities, NGOs, civic society, community based organisations (CBOs), faith-based organisations (FBOs), donor agencies, and communities to implement the national response.³¹⁷

The national HIV and AIDS policy for Zimbabwe also upholds the rights and dignity of all PLHIV including their right to confidentiality.³¹⁸ However, within that policy, space has been provided to allow medical personnel to disclose a patient's HIV status to a third party such as a spouse/partner and care giver if there were critical reasons.³¹⁹ The policy also declares that HIV and AIDS is a public health issue and calls upon society to value marital integrity and sustainability stable family unions. In that

³¹⁴ NAC, *Zimbabwe HIV and AIDS national strategic plan*, 2, 3.

³¹⁵ See also NAC, *Zimbabwe national HIV and AIDS strategic plan 2006-2010* (July 2006), 7. See also —Appointment of the National AIDS Council board members,” <<http://www.nac.org.zw/about/board-members/>> [Accessed on 20 June 2011].

³¹⁶ NAC, *Zimbabwe HIV and AIDS national strategic plan*, 3-4. See NAC, “Know about NAC: Coordinating the multi-sectoral response to HIV and AIDS,” Information brochure, nd.

³¹⁷ NAC, *Zimbabwe HIV and AIDS national strategic plan*, 4.

³¹⁸ MOHCW, *National HIV/AIDS policy*, 4.

³¹⁹ MOHCW, *National HIV/AIDS policy*, 6, 19-28.

regard, the policy tasks churches and civic society to assist the Zimbabwean society to respect and uphold the institution of marriage. The policy also addresses barriers faced by women and young people in seeking treatment for sexually transmitted infections (STIs), advocacy in the proper use of male and female condoms, as well as PMTCT.³²⁰ The State became involved in PMTCT programming on experimental basis in 2001.³²¹ According to the UNAIDS, in 1998 PMTCT was initially found to be effective in resource-poor settings and was thus recommended for implementation globally.³²² Consequently, the World Health Organisation (WHO) issued recommendations for the use of ARV drugs for PMTCT in 2000 and the United Nations (UN) promoted a comprehensive approach to PMTCT in 2002.³²³ The launch of PMTCT in Zimbabwe soon followed the recommendations by the WHO and the UN. However, low access to ARVs locally remained a hindrance.

Another aspect discussed by the policy is that comprehensive, cost-effective and affordable care should be made accessible to PLHIV. The churches were identified as providers of care together with other role players including the community, and traditional health practitioners.³²⁴ AIDS-related care for PLHIV became critical at a time when the poor could hardly afford to purchase AIDS drugs. The churches were expected to provide counselling services as well as psychosocial support, encourage people in general to go for voluntary testing and counselling (VCT), and informed consent to HIV testing. The churches were also seen to be in a strategic position in encouraging couples envisaging marriage or already in matrimony to routinely go for VCT. Spouses were also encouraged to share results with each other.³²⁵ The policy also took a gendered approach by according equal status to males and females, called them to respect each other's sexuality, and spelt out that all HIV and AIDS programmes should be gender sensitive.³²⁶ Finally, the policy provided for public

³²⁰ MOHCW, *National HIV/AIDS policy*, 7-11.

³²¹ MOHCW, *Zimbabwe prevention of mother-to-child transmission of HIV programme*, (April 2003), 3.

³²² UNAIDS, *The 2008 report on the global AIDS epidemic*, 96.

³²³ WHO, *Prevention of Mother-To-Child Transmission (PMTCT)*, Briefing Note, Department of HIV/AIDS, (October 2007), 6-7, <<http://www.who.int/hiv/pub/toolkits/PMTCT%20HIV%20Dept%20brief%20Oct%2007.pdf>> [Accessed 15 May 2009].

³²⁴ MOHCW, *National HIV/AIDS policy*, 15.

³²⁵ MOHCW, *National HIV/AIDS policy*, 15-16.

³²⁶ MOHCW, *National HIV/AIDS policy*, 29-31.

access to accurate information and education about HIV/AIDS/STI.³²⁷ In 2006, the National AIDS Council launched the –Zimbabwe National Behavioural Change Strategy for Prevention of Sexual Transmission of HIV, 2006-2010.”³²⁸ Churches and FBOs were integrated into the strategy in which they were to make input.³²⁹

The national behaviour change strategy is underpinned by the principle that in Zimbabwe, HIV is predominantly transmitted heterosexually. The framework assumes that between 80% and 90% of infections were due to sexual transmission; hence the emphasis on safe sexual behaviours becoming the key strategy to HIV prevention.³³⁰ The new blueprint acknowledged the critical role that churches could play in influencing sexual behaviour change and has thus stated: –An enabling environment for behavioural change will be created through involvement of religious, traditional and administrative leaders as advocates and role models in responsible behaviours such as faithfulness in marriage and openness about one’s HIV status.”³³¹ Apparently, the present study will seek to indicate the extent to which the churches in Manicaland either embraced or refuted the prophylactic use of condoms in addition to the abstinence and be faithful messages. The National AIDS Council also acknowledged the role of churches in denouncing cultural practices that increased people’s vulnerability to HIV and AIDS:

Umbrella bodies of faith-based organisations made concerted declarations of the church’s disapproval of risky traditional practices. This is a major development in the fight against this source of risk. The church is uniquely positioned to create new norms in this area in support of behavioural prevention.³³²

Gradually, the churches had a role in addressing cultural practices that exposed people to the risks of contracting HIV including multiple sexual partners, polygamy, dry sex,

³²⁷ MOHCW, *National HIV/AIDS policy*, 32-34.

³²⁸ NAC, *Zimbabwe national behavioural change strategy for prevention of sexual transmission of HIV, 2006-2010* (2006).

³²⁹ M. Mbona is grateful to G. Shumba for sharing with me this information, FACT, Mutare, 29 July 2010 and to C. Chindomu on behalf of FACT behaviour change programme, Makoni, Rusape, 1 September 2010.

³³⁰ D. Parirenyatwa, Minister of health and child welfare, –Foreword,” NAC, *Zimbabwe national behavioural change strategy*, 1.

³³¹ NAC, *Zimbabwe national behavioural change strategy*, 5.

³³² NAC, *Zimbabwe national behavioural change strategy*, 9.

girl pledging, widow inheritance, and sexual abuse of sister-in-law by males known locally in Shona as *chiramu*.³³³

2.4.2. The State's Funding of HIV and AIDS Interventions

The capacity of the Government of Zimbabwe to make resources available for HIV prevention and AIDS mitigation programmes was affected by economic downturn that hit the nation from the mid-1980s through to the 1990s and peaked in the years 2000-2007. For example, the gross national income per capita in Zimbabwe dropped from US\$10, 523 in 1985 to US\$395 in 2000.³³⁴ Poverty among ordinary citizens escalated and was exacerbated by rapid unemployment. Van Donk observed: "By the end of 2002, an estimated three out of four (74%) people were expected to live on less than US\$2 a day. Unemployment has also increased phenomenally over the years from 18% in 1982 to 60% by 1999."³³⁵ Meanwhile, the Government of Zimbabwe's foreign bred economic reforms launched in 1991 had negative effects on the State's funding of the public sector and led to cuts in healthcare service provision. A report issued by Irish Aid made the observation that the new economic policy led to:

...the introduction of cost recovery measures, which meant that hospitals were expected to charge market related tariffs for their services to all people. The cumulative impact of the resulting neglect of non-productive sectors such as health, was a serious decline in the quality of health services and shortages of essential drugs.³³⁶

The poor, including PLHIV were left with limited options and thus resorted to using church healthcare centres whose rates were generally affordable.³³⁷ The churches could also access essential drugs through external funding and contacts.

After the controversial economic reform policies of the 1990s, worse was yet to come. The Government's land invasions from 1999 and the rise in political intolerance gave

³³³ NAC, *Zimbabwe national behavioural change strategy*, 9, 13.

³³⁴ Van Donk, "Development planning and HIV/AIDS in sub-Saharan Africa," 132-133.

³³⁵ Van Donk, "Development planning and HIV/AIDS in sub-Saharan Africa," 133.

³³⁶ Irish Aid, *Looking back, mapping forwards*, 30. See also Van Donk, "Development planning and HIV/AIDS in sub-Saharan Africa," 138.

³³⁷ V. Chitimbire, same interview.

way to –economic contraction, disintegrating public services, runaway inflation, and widespread public discontent.”³³⁸ Furthermore, the redistribution of land by the State might have been of benefit to some local emerging black farmers but the initiative appears to have yielded more economic challenges than benefits.³³⁹ The withdrawal of international donors from the provision of financial support towards public infrastructure including healthcare services exposed PLHIV to untold hardships and misery. As Stephen O’Brien observed:

As the post 1999 political and economic crisis progressively unravelled, the international donors withdrew funding or channelled development assistance through means other than the State. ...Certainly, overall AIDS funding to Zimbabwe decreased.³⁴⁰

Without foreign donor support, HIV and AIDS interventions under the State in Zimbabwe became quite minimal. As O’Brien has shown, external support including the Global Fund remained the largest funding source for AIDS-related programmes. In 2005, AIDS funding indicated that US\$103,052,437 was obtained from external sources in comparison to US\$10 million raised from the local AIDS levy.³⁴¹

While the Government committed itself to play a leading role in mobilisation of resources,³⁴² the socio-political climate in Zimbabwe in the period 2000-2007 had negative consequences for HIV and AIDS interventions. The State had very limited options and therefore was forced to establish a local fund known as the National AIDS Trust Fund (NATF) in 1999. This AIDS levy was to be:

...the first of its kind in the region, a unique strategy under which all employed persons in Zimbabwe are levied an additional 3% tax on their taxable income. The fund was meant to finance the operations of the National AIDS Council and key HIV and AIDS interventions.³⁴³

³³⁸ M. Bratton and E. Masunungure, “The anatomy of political predation: Leaders, elites and coalitions in Zimbabwe, 1980-2010,” iv. Research paper number 9 for the Developmental Leadership Programme (January 2011).

³³⁹ Rodriguez, “AIDS in Zimbabwe,” 10.

³⁴⁰ O’Brien, “The prevalence and politics of HIV/AIDS in Zimbabwe,” 8.

³⁴¹ O’Brien, “The prevalence and politics of HIV/AIDS in Zimbabwe,” 8.

³⁴² O’Brien, “The prevalence and politics of HIV/AIDS in Zimbabwe,” 8.

³⁴³ N. Madzingira, “The Zimbabwe National AIDS Levy Trust (The AIDS levy),” SADC HIV and AIDS best practice series (March 2008), 11, <http://www.saf aids.net/filesSADC_BestPracticeZimbabwe/> [Accessed 7 May 2012].

Funds from the AIDS levy were prioritised for: (a) Purchase of ARVs by the National AIDS Council's and financially support the HIV and AIDS activities carried out by Zimbabwe National Family Planning and the MOHCW, (b) direct funding of the Basic Education Assistance Module (BEAM) for payment of school fees, (c) funding of projects proposals submitted by army, prison services, the churches, and (d) procurement and distribution of AIDS-related care materials.³⁴⁴ In sum, the AIDS levy in Zimbabwe aimed at providing holistic funding for HIV and AIDS interventions at national, provincial, district and ward levels in areas that included prevention, mitigation, care, treatment, capacity building, co-ordination and research.³⁴⁵

Revenue from the AIDS levy could not sustain national HIV and AIDS interventions because of mismanagement and this affected its capacity to assist people infected and affected by HIV. Consistent with this observation, van Donk stated that there were general complaints that the AIDS levy in Zimbabwe encountered administrative challenges. The fund's problems could have been exacerbated by the public's limited knowledge of the existence of such funds to the extent that most vulnerable groups remained unassisted.³⁴⁶ While the intention of the fund appeared to be quite noble, the failure by National AIDS Council to cope with overwhelming demands amid economic decline became apparent. The State was aware of this and thus had to admit:

Nonetheless, the ultimate sustainability of the levy is determined by the overall state of the economic environment. Hyperinflation and a significant increase in unemployment levels inevitably reduce the income obtained from such a levy.³⁴⁷

Given this situation, in which the AIDS levy could only assist limited numbers of people in need, churches were faced with the reality of responding to the needs of PLHIV and OVC. The failure by the State to adequately meet its obligations to the

³⁴⁴ Prisma, ICCO and Woord Daad, *A survey on HIV/AIDS in Zimbabwe*, (September 2007), 12.

³⁴⁵ Madzingira, "The Zimbabwe National AIDS Levy Trust," 17.

³⁴⁶ Van Donk, "Development planning and HIV/AIDS in sub-Saharan Africa," 141. See also, Kaseke and Dhembu, "Zimbabwe country report," 12.

³⁴⁷ Madzingira, "The Zimbabwe National AIDS Levy Trust," 31.

Zimbabwean citizenry left the churches with few options and that included outsourcing of resources to fend for HIV interventions.

Between 2000 and 2007, the socio-economic and political history of Zimbabwe had an effect on people infected and affected by HIV and AIDS. The attention of the Government shifted from social responsibility for the majority of the poor citizens to other non-essential priority areas. For example, Tabona Shoko of the University of Zimbabwe observes that from 1999 onwards the politics of land in Zimbabwe ignored the plight of those infected by HIV and AIDS and therefore exacerbated the problem.³⁴⁸ The trend was common with historical responses to infectious diseases as noted by Myron Echenberg who stated: “Historical responses to infectious diseases have followed a general pattern characterised by denial, blaming the victim, arbitrary use of State power, and criticism of allegedly negligent official authorities.”³⁴⁹ Generally speaking, in Zimbabwe the State’s funding of the public health sector including HIV and AIDS interventions was far from being adequate. The study will observe that non-governmental players including the churches carried out HIV and AIDS interventions in communities reeling under poverty and therefore the churches filled in an important gap.

In 1996 the Government of Zimbabwe required all NGOs to register under the Private Voluntary Organisations Act.³⁵⁰ This was repealed by the NGO Act passed into law in December 2004.³⁵¹ The NGO Act stipulated that all organisations involved in community development, charity, relief, human rights, gender awareness and environmental protection register with the NGO board. At least one representative from NGOs working in the field of HIV and AIDS was appointed to the twenty-six-member board largely dominated by the State.³⁵² Following the passing of the NGO Act into law, the number of home-based care programmes operated by NGOs

³⁴⁸ T. Shoko, “Religion, land and HIV/AIDS,” Unpublished paper, University of Zimbabwe, (2007), 10.

³⁴⁹ M. Echenberg, “Historical perspectives on lessons from South Africa and Senegal,” in Denis and Becker, *The HIV/AIDS epidemic in sub-Saharan Africa*, 90.

³⁵⁰ Kaseke and Dhemba, “Zimbabwe country report,” 30.

³⁵¹ Zimbabwe Government, *The Non-Governmental Organisation Act of Zimbabwe*, (December 2004). The document was downloaded as pdf. See also Amnesty International, *Zimbabwe: NGO Act is an outrageous attack on human rights*, (December 2004), downloaded as pdf.

³⁵² Zimbabwe Government, *The Non-Governmental Organisation Act*, 4, 5.

including churches dropped drastically from 500 in 2001 to only 120 in 2007.³⁵³ The underlying motivation of the NGO Act was understood as being to curtail the influence of NGOs on Zimbabwean politics:

The Act also gives the Government sweeping powers to interfere with the operations of any NGO in Zimbabwe. ...Under the Act, the Zimbabwean NGOs were prohibited from receiving any foreign funding to engage in human rights work.³⁵⁴

The NGO Act made it compulsory for churches to declare having received foreign donor funding and later this was actually done through the State's central bank. The State also closely monitored HIV and AIDS interventions under NGOs including those that were operated by churches. While the State did not appear to have adequate financial resources, the churches used external links to outsource resources. With this, the churches had to complement and almost replace the State's healthcare system. The case of the Government's inability to launch and sustain home-based care interventions early as discussed in section 2.5 that follows immediately below is a relevant illustration. While this was the case, the churches appeared to be willing to assist communities infected and affected by HIV and AIDS.

2.5. Brief Overview of AIDS-Related Home-Based Care in Zimbabwe

Home-based care in Zimbabwe existed prior to the AIDS era and has been used in other situations where patients need such support. According to the WHO, home-based or long term care can be defined as: "Activities undertaken for people requiring care by informal caregivers (family, friends and neighbours) by formal caregivers, including professional and auxiliaries (health, social and other workers), and by traditional caregivers and volunteers."³⁵⁵ The present research study uses this definition of home-based care. Prior to and soon after independence from British rule in 1980, home-based care in Zimbabwe focused on people who were physically or

³⁵³ Irish Aid, *Looking back, mapping forwards*, 31.

³⁵⁴ Amnesty International, *Zimbabwe: NGO Act is an outrageous attack on human rights*.

³⁵⁵ WHO study group, "Home-based and long term care," WHO technical report series 898, (Geneva: WHO, 2000), <http://whqlibdoc.who.int/trs/WHO_TRS_898.pdf> [Accessed 10 May 2012].

mentally challenged and the terminally ill.³⁵⁶ In this regard home-based care appeared not as a new practice and therefore preceded HIV and AIDS specific situations. A study by Irish Aid indicates that within Zimbabwe, the caring for HIV positive people at home is connected with six evolutionary stages that the epidemic went through as thus: (1) the silent epidemic (1980-1985), (2) the medicalisation, sensationalisation and moralisation of HIV (1986-1990), (3) the rise of advocacy, care and support groups (1991-1995), (4) the expansion of care and support (1996-2000), (5) the storm of home-based care (2001-2005) and (6) the period of hope for HIV positive people due to increased accessibility of antiretroviral treatment (2006-2007).³⁵⁷ The present research study follows this categorisation and uses it to analyse AIDS-related home-based care interventions by the Roman Catholic, Anglican and United Methodist churches in Manicaland (1985-2007).

The emergence of home-based care within the context of the AIDS pandemic in Zimbabwe is a new phenomenon that has been associated with the ever-increasing number of people in need of care. Therefore, AIDS-related home-based care was born out of necessity. At the national level, Batsirai group, an NGO formed by former health workers of Chinhoyi general hospital in Mashonaland West province in 1988, started the first publicly known AIDS-related home-based care initiative.³⁵⁸ The presence of migrant labour working on farms and mines in Mashonaland West could have given rise to high rate of HIV infection in that region. This was similar to findings from Catherine Campbell's study on HIV and migrant miners in South Africa.³⁵⁹ A similar programme launched by the FACT in Manicaland in 1990 followed after the home-based care initiative under Batsirai.³⁶⁰ Within the Roman Catholic Church, the Catholic Diocese of Chinhoyi set up an FBO, Catholic Health Care Commission in 1991.³⁶¹ In the same year, the civic community in Gweru formed

³⁵⁶ HDN and SAfAIDS, *Caring from within: Key findings and policy recommendations on home-based care in Zimbabwe*, Harare (2008), 16.

³⁵⁷ Irish Aid, *Looking back, mapping forwards*, 29-33. See also HDN and SAfAIDS, *Caring from within*, 16-23.

³⁵⁸ Irish Aid, *Looking back, mapping forwards*, 1. See also T. Mukandi, "Batsirai: An integrated approach to home-based care," in HDN, SAfAIDS and Irish Aid, *Inside stories: Local experiences of home-based care in Zimbabwe* (2008), 55.

³⁵⁹ For this see C. Campbell, "Going underground and going after women: Masculinity and HIV transmission amongst black workers on the gold mines," in R. Morrell (ed), *Changing men in southern Africa* (Pietermaritzburg: UKZN Press, 2001), 275-286.

³⁶⁰ T. Madava (compiler), *The FACT story, Annual report 2004*, (2005), 8-9.

³⁶¹ Irish Aid, *Looking back, mapping forwards*, 14.

the Midlands AIDS Service Organisation whose HIV interventions included home-based care.³⁶² The Roman Catholic Diocese of Mutare launched an AIDS-related home-based care project in Manicaland in 1992.³⁶³ In the same year the Roman Catholic Archdiocese of Harare founded Dananai Home-Based Care at Murambinda mission hospital, Buhera district, also in Manicaland.³⁶⁴

The State identified AIDS-related home-based care to be a crucial intervention as espoused in the National HIV/AIDS policy for the Republic of Zimbabwe (December 1999).³⁶⁵ The general outlook indicates that some individuals, communities, churches, FBOs and NGOs entered the fray ahead of the State. Apparently, the Government of Zimbabwe's national HIV and AIDS strategic plan identified AIDS-related community home-based care as a crucial intervention much later.³⁶⁶ Auxilla Chimusoro of Masvingo province, Zimbabwe, became one of the few individual who pioneered support for PLHIV through home-based care. Chimusoro is reported to have openly declared her HIV-positive status in 1989 and subsequently formed up to fifty AIDS care and support groups in Masvingo and other parts of Zimbabwe before her death in 1998.³⁶⁷ Whereas the State could not fund AIDS-care in consistent and sustainable ways, Chimusoro mobilised community members to form support groups for the care of PLHIV and used non-governmental resources. AIDS-related home-based care became a critical intervention at a time when PLHIV were discharged from State hospitals where tariffs were charged at market rates.³⁶⁸

The delay by the Government of Zimbabwe to recognise and financially support home-based care interventions made some churches fill in an important gap in public health for which the Government was responsible. Many rural mission hospitals took over the burden of AIDS-related care in Zimbabwe and this became the case in some countries of southern Africa. Consistent with this assertion, Sue Parry has observed that: ~~r~~rural mission hospitals record an increasing burden as patients are discharged

³⁶² Midlands AIDS Service Organisation, <<http://www.maso.org.zw/>> [Accessed 24 June 2011].

³⁶³ See Diocese of Mutare Community Home Care project, St. Joseph's Rusape (DOMCCPR), archives, E. Benyera, T. Kureya and G. Mutsoka, *Evaluation of CRS Zimbabwe's home-based care programme*, (January 2008), 18.

³⁶⁴ Irish Aid, *Looking lack, mapping forwards*, 16.

³⁶⁵ MOHCW, *National HIV/AIDS policy*, 14.

³⁶⁶ HDN and SAfAIDS, *Home-based care in Zimbabwe: Dialogue and opinion on home-based care in Zimbabwe: Summary of online discussion*, (2008), 7.

³⁶⁷ HDN and SAfAIDS, *Caring from within*, 17.

³⁶⁸ Irish Aid, *Looking back, mapping forwards*, 30.

from urban health facilities to return to their homes in rural areas.”³⁶⁹ Similarly, Chitimbire stated: “The patients who were discharged from public hospitals in towns and cities sought healthcare services from mission hospitals and clinics mainly located in rural areas.”³⁷⁰ Chitimbire’s sentiments were not in isolation of opinions expressed by other informants on this subject.³⁷¹ The drop in state funding of public health in general also adversely affected healthcare centres belonging to churches in Manicaland. However, “besides receiving state grants under the mission section of the MOHCW, church healthcare centres still had the advantage of obtaining medical supplies through foreign donations directly and through ZACH.”³⁷² This was different from the situation at the healthcare centres under the State and local government authorities countrywide.

The location of churches within communities placed them in a precarious position whereby “members of the community lived with expectations of some support towards PLHIV including home-based care.”³⁷³ A decrease in the number of organisations involved in home-based care noted in the period 2000-2007 could have made it extremely difficult for role players providing home-based care services. According to Irish Aid, the effects were disastrous:

The health sector as a whole was not spared from the economic challenges, resulting in substantial brain drain and the disintegration of the hospital-linked models of home-based care. Home-based care programmes were now dependent on churches, NGOs and communities, with minimal support from the Government through the AIDS levy.³⁷⁴

³⁶⁹ S. Parry, “Responses of the faith-based organisation to HIV/AIDS in sub-Saharan Africa,” (2003), 8. The paper was downloaded as pdf. See also V. Chitimbire, same interview

³⁷⁰ V. Chitimbire, same interview. See also Health Development Network, Zimbabwe, “Christ for care: The church’s role in home-based care,” <<http://healthdev.net/site/post.php?s=1069/>> [Accessed 3 May 2009].

³⁷¹ See T. Manyeza, interview conducted by M. Mbona, Old Mutare hospital, 24 August 2010. See also D. Kusano, same interview. See also M. Chikukwa, interview conducted by M. Mbona, St David’s Bonda mission hospital, 22 September 2010.

³⁷² V. Chitimbire, same interview. See also T. Manyeza, same interview. See also M. Chikukwa, same interview. See also C. Mukazi, interview conducted by M. Mbona, St Joseph’s mission hospital, Mutare, 19 August 2010.

³⁷³ P. Mutume, same interview. See also V. Chitimbire, same interview.

³⁷⁴ Irish Aid, *Looking back, mapping forwards*, 31.

2.4. Periodisation of the Study

The responses to HIV and AIDS by the churches in Manicaland were also affected by developments on the African continent as well as globally. Several attempts have been made by some scholars to periodise the HIV pandemic with each stage demarcated by specific trends. Caraël identified and discussed three distinct periods of the epidemic in Africa. The first period (1984-1988) was characterised by denial in which:

The African elites denounced AIDS as a foreign disease spread on the continent by white homosexuals, as an attempt to bring down the birth rate by imposing condoms, as an attack associated with the Puritanism of Christian sects in the face of African traditions such as polygamy.³⁷⁵

Caraël further stated that the second period (1989-1994) witnessed a belated and vertical response to the epidemic in Africa and finally the third stage (1995 onwards) was characterised by a broader response to the HIV epidemic at the global level.³⁷⁶ However, this does not fit well with the situation in Zimbabwe where the third stage illustrated by the intensity of global HIV interventions that became a reality from 2000 onwards.

A different pattern emerges in the work of van Houten, based on input from the experiences of healthcare workers as they interfaced with the HIV epidemic in the Western Cape, South Africa. Van Houten's analysis identified four stages: (1) the early days (1990-1994); (2) the growing epidemic (1995-1998); (3) the questioning of orthodoxy (1998 onwards), and finally, (4) the generalised epidemic (1999-2003).³⁷⁷ While van Houten looked at a broad periodisation and used the South African context, the Zimbabwean situation and that of other African countries could be unique. Local contexts of the HIV epidemic dictate the different stages in any given country and therefore could establish local periodisation. In line with this assertion, Denis argued:

Such periodisation can be multiplied. Each context calls for its own special one. ...The history of AIDS in Africa demands a fine

³⁷⁵ Caraël, "Twenty years of intervention and controversy," 31.

³⁷⁶ Caraël, "Twenty years of intervention and controversy," 32-39.

³⁷⁷ Van Houten, "Historical trends in the HIV/AIDS training," 157-159.

chronology which is based not only on the official levels of HIV prevalence but also on the experience of those involved whilst account must be taken of local and regional differences.³⁷⁸

Globally, the first publicly known case of AIDS-related illness appeared among gay men in the US in 1981.³⁷⁹ Two years later in 1983 medical experts in the US identified HIV as being the cause of AIDS.³⁸⁰ Generally, in Africa the first publicly identified AIDS-related case appeared in the early 1980s.³⁸¹ During the period of post-independence euphoria, between 1980 and 1985, Zimbabwe must have experienced a silent epidemic. Within medical circles in the period 1983-1985, cases of people suffering from strange unknown diseases were later identified as having contracted AIDS.³⁸²

While the first public case of HIV was identified in Zimbabwe in 1985,³⁸³ it is entirely possible that the HIV epidemic had existed in the country prior to that date. A problem of dating the epidemic emanates from a lack of competence in testing for HIV prior to 1985. As Buvé has observed, in sub-Saharan Africa:

No reliable diagnostic test existed until 1985 when the first antibody test for the detection of HIV (infection) was approved by the United States Food and Drug Administration. Up until the 1980s we have to rely on clinical reports and (few) stored serum samples.³⁸⁴

Hence, for Zimbabwe, 1985 provided a starting point to examine the progression of the HIV epidemic as well as responses to it by the public and private sectors. Deborah Dortzbach and Meredith Long provide the following global trends: in 1985 each region of the world reported at least one case of AIDS, the first International Conference on HIV and AIDS was held in Atlanta and the US Public Health Service recommended the first guidelines on the prevention of HIV transmission from

³⁷⁸ Denis, "Towards a social history of HIV/AIDS in sub-Saharan Africa," 21.

³⁷⁹ R. Bayer and G. M. Oppenheimer, *AIDS doctors: Voices from the epidemic*, (New York: Oxford University Press, 2000), 4.

³⁸⁰ Epstein, *The invisible cure*, 15.

³⁸¹ See section 2.3 above. See also Iliffe, *The African AIDS epidemic*, 33, 155. See also Schoepf, "AIDS, history, and struggles over meaning," 20. See also Caraël, "Twenty years of intervention and controversy," 30. See also Buvé, "The HIV epidemics in sub-Saharan Africa," 44. See also Kocheleff, "AIDS in Burundi and South Africa," 143.

³⁸² T. Manyeza, same interview.

³⁸³ See chapter one of the present thesis. See also Zungu-Dirwayi, *An audit of HIV/AIDS policies*, 10. See also MOHCW, *National HIV/AIDS policy*, 1.

³⁸⁴ Buvé, "The HIV epidemics in sub-Saharan Africa," 44.

mother-to-child.³⁸⁵ In 1985, Zimbabwe launched a programme whose purpose was the universal screening of all blood before transfusion as a measure against transmission of HIV.³⁸⁶ Ecumenically, the World Council of Churches (WCC) became involved in advocacy calling the Christian church to be a healing community. The executive committee of the WCC endorsed a statement emerging from a consultation in June 1986, part of which read:

The AIDS crisis challenges us profoundly to be the church in deed and in truth: to be the church as a healing community. AIDS is heartbreaking and challenges the churches to break their own hearts, to repent of inactivity and of rigid morals.³⁸⁷

The year 1987 witnessed the launch of the Global Programme on AIDS by the World Health Organisation and the approval of the first antiretroviral drug by the US Centre for Disease Control. In 1994, Azidothymidine (AZT) was recommended for the reduction of mother-to-child transmission of HIV.³⁸⁸ In the late 1980s, some religious organisations in Africa and especially in sub-Saharan Africa pioneered HIV interventions in their respective countries. For example, Denis has noted that in the late 1980s church-based groups from Zambia and Uganda pioneered hospital-based and community-based home care and gave examples of the Salvation Army Hospital of Chikantanka in Zambia and community-based home care programmes in Uganda, Zambia and Zimbabwe. As Denis has further stated: “Many of these had strong church links, like the Family AIDS Caring Trust [FACT] in Zimbabwe, or the programme set up by the Catholic Diocese of Ndola in Zambia.”³⁸⁹

While this might be the case, religious bodies including the churches in Africa have carried out HIV interventions often without being noticed or documented. As a result, little was known about their activities in the early years of the HIV epidemic including the period 1987-1994. Jill Oliver and Gillian Paterson explained: “This

³⁸⁵ D. Dortzbach and W. M. Long, *The AIDS crisis: What we can do*, (Downers Grove: InterVarsity Press, 2006), 24. See also Kaiser Family Foundation, *The global HIV/AIDS epidemic: A timeline of key milestones*, <<http://www.kff.org/>> [Accessed 10 June 2012].

³⁸⁶ See also NAC, *Zimbabwe HIV and AIDS national strategic plan*, 2.

³⁸⁷ WCC, “AIDS and the churches as a healing community,” WCC Executive Committee Statement, 15-19 September 1986.

³⁸⁸ Kaiser Family Foundation, *The global HIV/AIDS epidemic*. See also Dortzbach and Long, *The AIDS crisis*, 24.

³⁸⁹ Denis, “HIV, AIDS and religion in sub-Saharan Africa,” 69-70.

invisibility was as a result of a series of factors, including the secularisation and religion-blindness of the social sciences in general, and also the sense that religious attitudes were often unhelpful to HIV prevention messages.”³⁹⁰ In 1987 the WCC made another passionate plea to churches to be active in responding to HIV and AIDS and thus –called the churches to address the urgent challenges posed by the spread of HIV/AIDS throughout the world.”³⁹¹ The Anglican and the United Methodist churches in Zimbabwe were known members Zimbabwe Council of Churches that is an affiliate member of WCC. The researcher takes the position that ecumenical publications and statements in 1989 and 1993 in Zimbabwe can be interpreted as direct responses to the recommendations by the WCC. In Zimbabwe, the response to the HIV and AIDS pandemic by religious entities began from the mid-1980s onwards. For example, Rogers of the Roman Catholic Church, Foster of FACT, the ZCBC, the Roman Catholic diocesan project, Zimbabwe Council of Churches and the Heads of Christian Denominations were all engaged with the HIV epidemic in different ways and at different levels between 1986 and 1994. This clearly illustrates that, although being sporadic and weak, the religious sector in Zimbabwe responded to the epidemic within the first decade of its public existence.

At the global level in 1995 the treatment of AIDS-related illness was further enhanced by the use of highly active antiretroviral therapy and nevirapine in the US. This led to a decline in AIDS-related deaths by 40% in the US in 1997. In 1996, Brazil was the first known developing country in the world to launch the national distribution of antiretroviral treatment to its citizens. In 1998, the civil society in South Africa launched the Treatment Action Campaign (TAC) in which grassroots movements including some churches advocated for access to treatment.³⁹² However, increased access to ARVs by members of the general public did not exist in Zimbabwe until after 2004. The failure by the Government of Zimbabwe to launch public access to treatment of AIDS-related illness indicates that the State did not consider this as a top priority. It was also a time marked by much denial of AIDS (1985-1994) as indicate by the present study. As Caraël further elaborated:

³⁹⁰ J. Oliver and G. Paterson, –Religion and medicine in the context of HIV and AIDS: A landscaping review,” in Haddad, *Religion and HIV and AIDS*, 28.

³⁹¹ WCC, –The impact of HIV/AIDS and the churches,” Document number 6.2, A statement adopted by the WCC central committee, September 1996.

³⁹² Kaiser Family Foundation, *The global HIV/AIDS epidemic*. See also Dortzbach and Long, *The AIDS crisis*, 25.

When local studies showed that the level of HIV infection was particularly high amongst blood donors, prostitutes and patients with STDs, the majority of governments denounced the insults made to African culture, to their countries and their economy, which often partially depended on tourism.³⁹³

During the period 1995-1999 there was increased involvement in HIV prevention and AIDS mitigation by some churches. However, this has not been well documented as Oliver and Paterson have observed: “Little of these responses were documented and there was limited awareness among public health planners of religious organisations’ involvement in health and HIV.”³⁹⁴

Van Houten’s fourth phase of a generalised epidemic (1999-2003) in South Africa appears to suit the third period (2000-2007) of the present study. The key reason for this being that:

The last phase is characterised by programme and intervention specific HIV/AIDS input. It was now rare to encounter participants who did not believe in HIV/AIDS and its massive impact on their community and the country at large. Many participants received specialised and advanced training in the areas of treatment and counselling.³⁹⁵

During the period 2000-2007, HIV and AIDS interventions by the churches, FBOs and NGOs in Zimbabwe increased in response to ever-escalating demand. As mentioned before, the country experienced socio-political upheavals, economic decline and a steep drop in public sector funding by the State.³⁹⁶ The launch of a national HIV and AIDS policy for Zimbabwe by the State at the end of 1999,³⁹⁷ the subsequent establishment of multi-sectoral collaborative approaches and the formation of the National AIDS Council in 2000,³⁹⁸ were key developments on the AIDS landscape nationally.

³⁹³ Caraël, “Twenty years of intervention and controversy,” 31.

³⁹⁴ Oliver and Paterson, “Religion and medicine in the context of HIV and AIDS,” 28.

³⁹⁵ Van Houten, “Historical trends in the HIV/AIDS training of health care workers,” 159-160.

³⁹⁶ For this see Bratton and Masunungure, “The anatomy of political predation,” iv. See also Rodriguez, “AIDS in Zimbabwe,” 10. See also S. O’Brien, “The prevalence and politics of HIV/AIDS in Zimbabwe: Examining the ideological, political and historical factors behind the decline in HIV prevalence,” Unpublished paper submitted to APSA conference, Macquarie University (27-30 September 2009), 8.

³⁹⁷ MOHCW, *National HIV/AIDS policy*. See also Zungu-Dirwayi, *An audit of HIV/AIDS policies*, 31.

³⁹⁸ NAC, *Zimbabwe national HIV and AIDS strategic plan*, 7.

Internationally, the HIV epidemic received increased attention from 2000 onwards. This is particularly seen in the following events: (1) the 13th International AIDS Conference, hosted in Durban, South Africa, the first in a developing country (2000); (2) the reversal of the HIV prevalence listed as part of the Millennium Development Goals (2000); (3) the holding of the first United Nations General Assembly on AIDS (UNGASS) (2001); (4) the signing of the Doha Agreement that enabled developing countries to access generic medicines for the treatment of AIDS-related illnesses (2001); (5) the distribution of grants via the Global Fund to Fight AIDS, Tuberculosis and Malaria (2002); (6) the launch of the US President’s Emergency Programme for AIDS Relief (PEPFAR) (2003).³⁹⁹

During this period, Zimbabwe, being a member of the global family of nations, also benefited from the Global Fund. In Zimbabwe, limited public access to ARVs only came after the Doha Agreement, which enabled the State to produce generic HIV treatment drugs locally, as well as through the Global Fund AIDS-related support grants. The same period (2000-2007) also witnessed increased involvement of the WCC in HIV interventions in Africa. In 2001, the WCC held a continental consultation on HIV and AIDS in Nairobi, Kenya. The participants acknowledged that the church had been slow in its response to HIV and thus –called for churches to overcome stigma and discrimination within their own structures so that the rights and dignity of people living with HIV/AIDS can be respected.”⁴⁰⁰

Figure 4. Chronology of State and Church Responses to HIV and AIDS

| YEAR | STATE HIV POLICIES | CHURCH INTERVENTIONS |
|------|---|---|
| 1985 | First public AIDS case in Zimbabwe followed by universal screening of blood | |
| 1986 | | Ted Rogers of the Roman Catholic Church initiated talks on HIV and AIDS in Zimbabwe and southern Africa |
| 1987 | MOHCH established the National AIDS Coordination Programme | ZCBC issued first statement on AIDS in Zimbabwe. UMC |

³⁹⁹ Kaiser Family Foundation, *The global HIV/AIDS epidemic*. See also Dortzbach and Long, *The AIDS crisis*, 25.

⁴⁰⁰ WCC, –World Council of Churches unique consultation on HIV/AIDS in Africa,” Nairobi, Kenya (25-28 November 2001), pdf.

| | | |
|--------|--|---|
| | | mentions AIDS at annual conference session |
| 1987-8 | First short term plan on AIDS awareness | |
| 1988 | First Medium Term Plan First AIDS-related home-based care intervention launched by community members if Chinhoyi | UMC medical personnel from Zimbabwe train in AIDS management in the US |
| 1989 | | First ecumenical statement on AIDS issued by HOCD |
| 1990 | | UMC annual conference first resolution recommending use of condoms in HIV prevention |
| 1991 | State's introduction of ESAP reduces government's financial input in public health care | Church healthcare system carries burden of treatment for the sick in including PLHIV |
| 1992 | | Establishment of the Roman Catholic Church's Mutare Community Home Care project |
| 1993 | | UMC annual conferences in southern Africa hold special consultation on HIV and AIDS in Harare, Zimbabwe First HIV and AIDS Policy issued by HOCD in Kadoma |
| 1994 | State's second Medium Term Plan | |
| 1995 | | St. Augustine's Mission Clinic of the Anglican Church in Manicaland launches AIDS-related care programme |
| 1998 | First VCT centre opened | HOCD and ZCC issue another joint statement on HIV and AIDS |
| 1999 | State launches the first National HIV and AIDS policy for Zimbabwe State introduces the National AIDS levy and launches BEAM Government recognises home-based care | Bishop Bakare of the Anglican Church issues statement on diocesan HIV interventions |
| 2000 | State establishes multi-sectoral body called the NAC and included some church leaders on the board | Anglican diocese passes first resolution on HIV prevention at synod |
| 2002 | Government launches PMTCT | |
| 2004 | NGO Act passed and negatively impact on NGOs. Organisations involved in AIDS-related care drop from 500 to 120 | Anglican diocesan synod passes resolution on AIDS as an emergency Roll-out of public ART at Murambinda Mission, Buhera |

| | | |
|------|--|--|
| 2005 | | HOCD publishes second HIV and AIDS policy for churches |
| 2007 | Expansion of ART within State healthcare system to other State hospitals | ZACH sponsors ART at selected church hospitals in Manicaland |

Having periodised and shown a chronology of major State and church responses to HIV, this illustrates that generally, the two key entities were operating separately and at the official level the churches either worked together or individually. The brief historical overview in the following section will aid one's understanding of how each of the three churches functioned.

2.7. The Roman Catholic, Anglican and United Methodist Churches

This section will familiarise the reader with the Roman Catholic Church, Anglican and United Methodist Church with a special focus on their historical presence in Manicaland. A brief historical overview of each of the three churches will be of importance in understanding their different polity and structures in relation to responses to the HIV pandemic.

2.7.1. The Roman Catholic Church in Manicaland

The presence of the Roman Catholic Church missionaries in Zimbabwe can be traced as far back as the beginning of the seventeenth century. The Jesuits and the Dominicans set up missions in the kingdom of Munhumutapa at Musapa, Ruhanje and Dambarare as well as in the neighbouring kingdom of the Manyika.⁴⁰¹ The area mentioned as Manyika refers to Manicaland located in the eastern part. The predominant tribe is the Manyika people who speak *chimanyika*, a dialect of Shona,

⁴⁰¹ For this see P. Denis, *The Dominican friars in southern Africa: A social history*, (Leiden: Brill, 1998), 12-54. See also P. Denis, —South East Africa,” in P. Denis, (ed), *Dominicans in Africa: A history of the Dominican friars in sub-Saharan Africa*, (Pietermaritzburg: Cluster Publications, 2003), 33, 36. See also J. Weller and J. Linden, *Mainstream Christianity to 1980 in Malawi, Zambia and Zimbabwe*, (Gweru, Mambo Press, 1984), 2.

one of the major indigenous languages of Zimbabwe. Though it fell under British colonial rule, the close proximity of Manicaland to Mozambique exposed it to Portuguese influence especially prior to 1900. Denis has shown that the role of the Portuguese missions in South East Africa gradually diminished due to moral decline and that many of the Jesuits and Dominicans were either withdrawn or sent back by the colonial administrators. By the late nineteenth century, however, the Portuguese liberal government re-established the missions.⁴⁰² A strong relationship between church and colonial authorities was evident in the fact that the Roman Catholic missionaries were chaplains of the Portuguese and the Pioneer Column. The Dominican sisters provided medical services to colonial settlers though they often expressed the need to work independently of the government or its administrators.⁴⁰³ One of the oldest Roman Catholic Church centres established at the turn of the twentieth century circa 1893 was Triashill mission in Mutasa district north of present day city of Mutare. The mission was selected as one of the research sites for the present study.

In 1955, the Roman Catholic Church in Rhodesia (now Zimbabwe) attained the status of an Ecclesiastical Province with five dioceses of which the Catholic Diocese of Umtali (Mutare) formed part.⁴⁰⁴ In line with changes in names after Zimbabwe attained political independence in 1980, it assumed a new name as the Catholic Diocese of Mutare.⁴⁰⁵ The first bishop was Donal R. Lamont who was consecrated on 15 February 1957. After Lamont's resignation on 5 November 1981, Alexio C. Muchabaiwa became his successor. Patrick M. Mutume was installed as auxiliary bishop on 15 March 1972 and with Bishop Muchabaiwa they were the current bishops.⁴⁰⁶ Within the Roman Catholic Church, important decisions and statements on ecclesiastical matters were made by the bishop(s) in a diocese, at the bishops' conference in a particular ecclesiastical province, and the synod led by the Pope. These decisions might be done with 'prior consultation' with the laity (but not mandatory) and were always to be in conformity with the social teaching of the Roman Catholic Church. However, the hierarchical and centralised nature of the

⁴⁰² Denis, *The Dominican friars in Southern Africa*, 60-65. See also Denis, "South East Africa," 41-45.

⁴⁰³ Weller and Linden, *Mainstream Christianity to 1980*, 53.

⁴⁰⁴ Weller and Linden, *Mainstream Christianity to 1980*, 62.

⁴⁰⁵ Catholic Diocese of Mutare hierarchy, <<http://www.catholic-hierarchy.org/dioceses/dmutr.html>> [Accessed 20 January 2010].

⁴⁰⁶ Catholic Diocese of Mutare hierarchy.

church means that decisions on church programmes and activities are usually done from the highest position through to diocesan bishops and finally to the clergy and the laity.

In 1980, the Roman Catholic Diocese of Mutare had eighteen parishes served by thirty-one priests and twenty-four years. In 2004 the number of parishes had increased to thirty-six and was served by fifty-one priests.⁴⁰⁷ Parishes and mission stations include St. Joseph's Sakubva, Triashill, Kriste Mambo, St. Joseph's Rusape, St. Michael's Tanda and Regina Coeli in Nyamaropa, to name some. Some examples of Roman Catholic Church healthcare centres are: St. Joseph's Sakubva, St. Theresa Chiduku, Triashill, Regina Coeli, Mount Mellery and St. Michael's Tanda. Only St. Joseph's hospital, Sakubva is located in Mutare urban and the other ten healthcare centres are located in rural settings throughout Manicaland. Two main religious orders that have served in different diocesan institutions include the Dominican sisters and the Carmelites. The present research study will indicate the extent to which the wide network of mission stations and historical track record of the church's involvement in the provision of social services influenced its response to the HIV and AIDS pandemic in Manicaland.

The establishment of an Episcopal conference under a Roman Decree on 1 October 1969 meant that Catholic bishops in Rhodesia (now Zimbabwe) could exercise ordinary jurisdiction and authority over the welfare of members of their dioceses.⁴⁰⁸ The membership of the ZCBC includes the bishops of Masvingo, Hwange, Gweru, Chinhoyi, Gokwe, Bulawayo, Harare, and Mutare. Africa Synod House in Harare houses the secretariat currently headed by Father Frederick Chiromba.⁴⁰⁹ In 2007 the ZCBC had a total of ten commissions all of which were to assist the bishops in leading the Roman Catholic Church in Zimbabwe. Healthcare is one of such commissions and the HIV and AIDS commission or desk got established in 1988.⁴¹⁰ It is therefore important for the reader to be aware of the fact that while individually, the church's dioceses such as Mutare established HIV and AIDS interventions, the

⁴⁰⁷ Catholic Diocese of Mutare hierarchy.

⁴⁰⁸ ZCBC, <<http://www.zcbc.co.zw/>> [Accessed 22 January 2010].

⁴⁰⁹ ZCBC HIV and AIDS Commission archives, Harare, (ZCBCH), ZCBC, "Responsibility – honesty – solidarity," A joint pastoral statement of the ZCBC, April 1997.

⁴¹⁰ ZCBC, <<http://www.zcbc.co.zw/>> [Accessed 22 January 2010]. See also Information supplied to the present researcher by C. Mtize by email, 26 June 2011.

ZCBC's HIV and AIDS commission also featured at national and diocesan levels. It aimed at promoting values of life meant to prevent the spread of HIV and also carried out AIDS mitigation interventions targeting OVC at the church's schools.⁴¹¹ The primary focus of the present research study is to explore responses to HIV and AIDS by the Roman Catholic Church in Manicaland. However, input by the commission constituted an integral part of the church's response to HIV and AIDS in Manicaland, Zimbabwe (1985-2007). The present study is also aware of the input of other role players from the church in including the Episcopal Conferences of Africa and Madagascar as well as the Vatican.⁴¹²

2.7.2. The Anglican Church in Manicaland

The Anglican Church in Manicaland traces its establishment to the work of George Knight-Bruce of the Diocese of Bloemfontein, South Africa. Knight-Bruce set up the first mission station at St. Augustine's Penhalonga about twenty kilometres outside the present city of Mutare in 1891.⁴¹³ The end of 1891 witnessed the carving of the Diocese of Mashonaland which then covered the whole of present day Zimbabwe including the Zezuru, Manyika, Karanga and Ndebele ethnic groups. Knight-Bruce became the first bishop.⁴¹⁴ This was part of an expansion programme by the Church of the Province of South Africa and this project received financial support from the Church of England's Society for the Propagation of the Gospel, later to be known as the United Society for the Propagation of the Gospel (USPG).⁴¹⁵ It is important to note that the newly carved Anglican dioceses including Manicaland have maintained strong connections with the Church of England and the USPG. The present study is aware that this link has been used to support church initiated HIV and AIDS responses in the Anglican Church in Manicaland.

⁴¹¹ ZCBCH, ZCBC HIV and AIDS desk action document, January 2010.

⁴¹² See for example Symposium of Episcopal Conference of Africa and Madagascar, "The Church in Africa in the face of HIV/AIDS Pandemic," Dakar, Senegal, 7 October 2003, <<http://www.oikoumene.org/en/resources/documents/other-ecumenical-bodies/church-s/>> [Accessed 16 May 2009]. See also The church response to HIV/AIDS: Quotes and statements by the Catholic Church, 1996, <<http://199.72.156.136/resources/documents/html/Church%20respondsto%20%20HIV/>> [Accessed 18 May 2009].

⁴¹³ J. C. Weller, *Anglican centenary in Zimbabwe, 1891-1991*, (Mutare: Manica Post, circa. 1991), 5.

⁴¹⁴ Weller, *Anglican centenary in Zimbabwe*, 6. See also Weller and Linden, *Mainstream Christianity to 1980*, 67.

⁴¹⁵ Weller, *Anglican centenary in Zimbabwe*, 6.

Two dioceses from Southern Rhodesia (now Zimbabwe) namely Mashonaland and Matabeleland (carved in 1952), and the dioceses of Northern Rhodesia (Zambia) and also Nyasaland (Malawi) established the Church of the Province of Central Africa (CPCA) constituted on 8 May 1955.⁴¹⁶ In 1996 the church's province had twelve dioceses as follows: Botswana, Central Zambia, Northern Zambia, Matabeleland, Lake Malawi, Harare, Southern Malawi, Lusaka, Northern Malawi, Eastern Zambia, Central Zimbabwe, and Manicaland.⁴¹⁷ At the end of 2006, the number of dioceses constituting this province had further increased to fifteen with the Diocese of Masvingo in Zimbabwe being the latest. The Anglican Diocese of Manicaland was carved in 1981 and Elijah Masuko became the first bishop.⁴¹⁸ The first diocesan synod for the Anglican Church in Manicaland was held in September 1982.⁴¹⁹ Sebastian Bakare who succeeded Masuko was consecrated in 1999 and retired in 2006 to be succeeded by Elson M. Jakazi who seceded from the CPCA in 2008.

The Anglican Church in Manicaland is part of the Anglican Council of Zimbabwe and the council recently incorporated responses to HIV and AIDS into its relief work.⁴²⁰ At continental level, Anglican Church provinces in Africa constitute the Council of Anglican Provinces of Africa (CAPA) established in 1979. This council of Anglican provinces defined itself as a FBO, established by the Anglican primates of Africa covering twenty-five countries with a goal ~~to~~ coordinate and articulate issues affecting the church [Anglican] and communities across the region."⁴²¹ It must be noted that perhaps the description of this council as a FBO had the intentions of attracting foreign funding to carry out HIV and AIDS, tuberculosis and malaria interventions. In 2001, the council emerged with a strategic plan entitled: ~~P~~Planning Our Response to HIV/AIDS: A step by step guide to HIV/AIDS Planning for the

⁴¹⁶ MM, CPCA, *Order of service, inauguration of the Church of the Province of Central Africa held at the Cathedral parish of St. Mary and All Saints*, Salisbury, 8 May 1955, (Salisbury: The Rhodesian printing and publishing company, 1955), 2.

⁴¹⁷ MM, CPCA, *Constitution and canons of the Church of the Province of Central Africa*, (April 1996), 21, 22.

⁴¹⁸ MM, CPCA, *Constitutions and canons of the CPCA*, 21.

⁴¹⁹ MM, Diocese of Manicaland, *Acts of the Diocese of Manicaland as enacted by the first synod, September 1982, and promulgated by the tenth session*, (May 2002), 1.

⁴²⁰ Information supplied to M. Mbona by D. Magurupira, Mutare, 5 August 2010.

⁴²¹ CAPA, *Integrated HIV/AIDS, tuberculosis and malaria strategic plan, 2007-2011* (CAPA, Nairobi, 2007), 10.

Anglican Communion.”⁴²² Within the Anglican Church in Africa, input from diocesan bishops, CAPA, the Lambeth Conference and primates from the Anglican Communion could have influenced responses to the pandemic directly or indirectly.⁴²³ In the Anglican Church in Manicaland responses to HIV and AIDS could be analysed focusing on the input or lack of thereof by the Episcopal leadership, diocesan synods, healthcare institutions, school and parishes.

It was not always given that HIV interventions proposed by CAPA filtered down to every Anglican diocesan in Zimbabwe and Africa. Within Anglican Church polity, crucial decisions on any church-related matters were usually passed by a synod. A church synod refers to a council or an assembly of church officials or churches and is also known as an ecclesiastical council or an assembly,⁴²⁴ or an important meeting of a church.⁴²⁵ A synod is the highest decision making body of a diocese also called a diocesan synod or provincial synod in the case of a church province. The three organs that constitute a diocesan synod are the: (1) house of bishops, (2) house of clergy, and (3) house of laity. The diocesan bishop presides over a synod within the diocese and therefore yields a lot of power and influence in terms of determining programmes of actions adopted as resolutions.⁴²⁶ Unlike the situation in the Roman Catholic Church, in the Anglican Church in Manicaland, the houses of laity, comprises of representatives from each church division who number between one and four adult male and female communicants. This house or group is numerically larger than the house of clergy that comprises of only all ordained priests and deacons licensed and living in the diocese.⁴²⁷

The emergence of HIV and AIDS in Zimbabwe in the early 1980s coincided with the time when the new Anglican Diocese of Manicaland was carved. Within the first and

⁴²² CAPA, HIV/AIDS, TB and malaria network strategic plan background, <http://hiv aids.anglicancommunion.org/hiv/strategic_plan/background.cfm/> [Accessed 16 May 2009].

⁴²³ See for example WCC, —Report of the meeting of Anglican primates: Statement of Anglican primates on HIV/AIDS,” CANS2961, Canterbury, United Kingdom (17 April 2002), <<http://www.oikoumene.org/en/resources/documents/other-ecumenical-bodies/church-s/>> [Accessed 29 September 2009].

⁴²⁴ See <<http://www.answers.com/topic/synod#ixzz1DHRAUyhQ/>> [Accessed 10 December 2011].

⁴²⁵ D. Summers, *Longman dictionary of contemporary English*, (Essex: Pearson Educational Limited, 2003), 1685.

⁴²⁶ MM, Diocese of Manicaland, —Chapter 1: The diocesan synod,” *Acts of the Diocese of Manicaland, eighth session* (December 1997), 1.

⁴²⁷ MM, Diocese of Manicaland, —Chapter 1: The diocesan Synod,” *Acts of the Diocese of Manicaland, eighth session* (December 1997), 1, 2.

second periods of the present research study, the new diocese and its leadership had other priorities and HIV and AIDS interventions were not an urgent issue. In 1997 the Anglican Church in Manicaland had eight parishes, twelve mission districts, eight chaperies and three divisions under development scattered throughout Manicaland. A parish or mission district comprises of a single congregation or several congregations within the same geographical area. In 1997 the Anglican Church in Manicaland had three healthcare centres all located in remote rural areas. They included St. David's Bonda hospital, and St. Augustine's and St. Peter's Mandeya clinics. Twelve primary and nine secondary schools were registered as diocesan educational institutions.⁴²⁸ In 2004 the figures showed an increase: mission districts were now sixteen, twenty-one primary schools, twelve secondary schools and six healthcare centres.⁴²⁹

The exact membership of Anglicans in Manicaland and in Zimbabwe as a whole cannot be drawn up with much exactitude. Towards 1980 the Anglican Church in Zimbabwe comprised of around 150,000 black Africans and 79,000 Europeans (second to the Roman Catholics).⁴³⁰ Figures for 1991 suggested that the church experienced growth with Manicaland claiming 60% of the national Anglican membership. These statistics were debateable as other dioceses provided varying figures. The Diocese of Matabeleland had 20,000 communicants and the Diocese of Lundi only had 4, 500 communicants.⁴³¹ While the issue of numbers may not be the primary focus of this study, the Anglican parishes and mission stations have a known presence in communities throughout Manicaland from Nyanga to Chipinge and from Makoni to Honde Valley. Within the Anglican Church in Manicaland, the distribution of membership by gender indicates that 30% were male and 70% were female.⁴³² Apparently, women formed the majority of Anglican Church membership in Manicaland and Zimbabwe and this was also confirmed from the various encounters of the researcher as an insider to the diocese being initially a lay member and later one of the clergy.

⁴²⁸ MM, —Appendix B and C, List of ecclesiastical divisions,” *Acts of the Diocese of Manicaland, eighth session* (December 1997), 23, 24, 25.

⁴²⁹ MM, —Appendix B and C, List of ecclesiastical divisions and diocesan institutions,” *Acts of the Diocese of Manicaland, tenth session* (May 2002), 36, 37.

⁴³⁰ Weller and Linden, *Mainstream Christianity to 1980*, 81.

⁴³¹ Weller, *Anglican centenary in Zimbabwe*, 25-30.

⁴³² MM, Diocese of Nova Scotia and Prince Edward Island, —Services of prayer and solidarity with our companion Diocese of Manicaland and with the people of Zimbabwe,” Ash Wednesday, 25 February 2009.

The earliest healthcare centre established by the Anglican Church in the colonial era was set up in Umtali (now Mutare). Early Western missionary-initiated healthcare services in colonial times served white settlers, local people and the missionaries too. Knight-Bruce arranged with the British South Africa Company to provide a similar nursing service in Manicaland:

When the Anglican mission started there in 1891 it did so entirely as a medical station with three nursing sisters and a doctor. The medical man, Dr Granville, did not survive long but the nurses engaged by the Anglicans cared for the Umtali (now Mutare) area until 1898, when the little hospital was taken over by the nurses of the government.⁴³³

More than one hundred years later in 1999, the Anglican Church in Manicaland professed as having been called to be part of God's mission of liberating humankind and the whole of creation. Part of its mission statement read: "The church is, therefore, called in every age and place to participate in the liberating mission of God in Jesus Christ. She is the sign of hope for the poor, the marginalized and thereby enables them to achieve wholeness and freedom."⁴³⁴ One of the five objectives drawn up by the diocese has a bearing on HIV and AIDS interventions as noted: "To run HIV/AIDS home based and orphan care programmes in line with prevailing preventions and interventions of diseases."⁴³⁵ The Anglican Church in Manicaland understands itself as one of the main providers of educational and healthcare services to the nation. Orphanages were also identified as a critical area given the fact that HIV and AIDS claimed the lives of 2,000 people every week in Zimbabwe leaving behind a trail of many orphaned children.⁴³⁶

2.7.3. The United Methodist Church in Manicaland

The Methodist Episcopal Church of America that later became known as the United Methodist Church was governed by an autonomous body known as the annual

⁴³³ Gelfand, "Medicine and the Christian missions in Rhodesia," 113.

⁴³⁴ MM, Diocese of Manicaland, "Mission statement," (1999).

⁴³⁵ MM, Diocese of Manicaland, "Mission statement."

⁴³⁶ MM, Diocese of Manicaland, "Mission statement."

conference.⁴³⁷ The American Methodist Church evangelised the eastern parts of Zimbabwe while the central and western parts of the country fell under the influence of British Wesleyan Methodist missionaries.⁴³⁸ With the first session in November 1901 under the East Central African Annual Conference, this later became the Rhodesia mission conference in 1915, the Rhodesia Annual Conference in 1931, the Methodist Church Conference in 1939, the United Methodist Conference in 1968, and was finally renamed the Zimbabwe Annual Conference in 1980.⁴³⁹ At the end of 2000 the church's single annual conference evolved and gave birth to two annual conferences known as Zimbabwe East Annual Conference (ZEAC) and Zimbabwe West Annual Conference.⁴⁴⁰ The church's districts of Mutasa-Nyanga, Makoni-Buhera, Mutare, Marange and Chimanimani in Manicaland constitute the ZEAC. An elected bishop presides over proceedings of each annual conference session. Lay and ordained delegates at the church's annual conference debate matters crucial to the life of the church. The decisions that are passed are known as resolutions and have a binding effect on all the church's members and activities.

In 1985, Bishop Abel T. Muzorewa (now deceased) was the leader of the United Methodist Church and upon his retirement in 1992, Christopher Jokomo (now deceased) was elected as successor.⁴⁴¹ Eben Nhwatiwa who is serving as the current bishop and president of the Zimbabwe Episcopal Area was elected into office in 2004. In 1984 the church had a total of five ecclesiastical districts throughout Zimbabwe of which two were from Manicaland namely Mutare South and Mutasa-Makoni.⁴⁴² In

⁴³⁷ R. Peadar, "The Methodists in Zimbabwe," in Weller and Linden, *Mainstream Christianity to 1980*, 81. Within the United Methodist Church polity an annual conference refers to an ecclesiastical unit similar to the diocesan synod in the Anglican Church. The annual conference is the top body responsible for receiving reports, debating issues and come up with resolutions. Of course the annual conference meets almost every year and the meeting is called a session. In this case annual conference refers to the leadership body.

⁴³⁸ Peadar, "The Methodists in Zimbabwe," 85.

⁴³⁹ A. Mhondoro, private archives, Rusape, (AM), *Official Journal of the Zimbabwe Annual Conference of the UMC third session*, 2 January 1983, 106-8. See also S. Muzengeza, private archives, Rusape, (SM), Bishop's opening statement, *Official Journal of the Zimbabwe Annual Conference of the UMC fourteenth session*, 8-12 December 1993, 18.

⁴⁴⁰ This was the last conference that gave birth to two conferences. See also Hilltop UMC Centre archives, Mutare, (HCM), District superintendents' composite report to the Zimbabwe annual conference of the United Methodist Church twenty-first session, 13-17 December 2000, 6. Information also supplied to M. Mbona by Simon Muzengeza, Rusape, 16 August 2011.

⁴⁴¹ AM, *Official Journal of the Zimbabwe Annual Conference of the UMC thirteenth session*, 9-13 December 1992.

⁴⁴² AM, *Official Journal of the Zimbabwe Annual Conference of the UMC third session*, 2 January 1983, 1.

1996, the church had ten districts in Zimbabwe and one district in South Africa. By then Manicaland had the following church districts: Makoni-Buhera, Mutare, Mutare South, and Mutasa-Nyanga.⁴⁴³ According to United Methodist Church's polity, an annual conference is an autonomous body of the church under the leadership of a bishop as president. This is almost similar to a diocesan synod in the Anglican Church. It is the highest decision-making body constituted by delegates comprising of all ministers of the church including the bishop and clergy as well as lay representatives. The proceedings of each annual conference session are ratified by the bishop as president of conference and jointly signed by the annual conference secretary and thereafter circulated. This study will analyse reports and resolutions that emerged at sessions of the church's annual conference in Zimbabwe as well as reports generated at district and circuit levels between 1985 and 2007.

Similar to the Roman Catholic and Anglican churches in Manicaland, the provision of educational and healthcare services were trademarks of the United Methodist Church from the days of its inception. The foundation of the church's work was laid down after the Shona and Ndebele rebellion of the late 1890s. Bishop Hartzell who was in charge of the church's mission work throughout Africa and resided at Funchal on Madeira Island visited the colony (now Zimbabwe) in 1897. Hartzell was offered facilities by the British South Africa Company to establish the church as stated: "The Methodist Episcopal Church was offered the site of the existing township, now to be known as Old Umtali, complete with company [British South Africa Company] buildings and 13, 000 acres of land."⁴⁴⁴ Apparently, a close working relationship existed between the first Methodist missionaries and the earliest white pioneer settlers and the same obtained with the Roman Catholic and Anglican missionaries. However, the early years of the mission were difficult. The Americans were in competition with the Anglican mission at St. Augustine's, only a few miles away. The Anglican missionaries had been at work in the area since 1891.⁴⁴⁵ Medicine was also important as noted in the church's appointment of Dr. Gurney to Old Umtali in 1903 where he practised for some time before going to Murewa in 1909. Subsequently, hospitals and

⁴⁴³ SM, *Official Journal of the Zimbabwe Annual Conference of the UMC seventeenth session*, 12-15 December 1996.

⁴⁴⁴ Peaden, "The Methodists in Zimbabwe," 85.

⁴⁴⁵ Peaden, "The Methodists in Zimbabwe," 85.

clinics were established at some of church's mission stations.⁴⁴⁶ Thus, the United Methodist Church in Zimbabwe has a long history in public healthcare.

In 1984 the church owned and administered three hospitals namely, Mutambara, Old Mutare (both in Manicaland) and Nyadire. Other small healthcare centres in Manicaland then were Gatsi, Chinyadza, Nyangombe, and Anoldine.⁴⁴⁷ In 2004 the church's membership stood at approximately 100, 000 nationally and –the United Methodist Church of Zimbabwe is the third largest Christian tradition, behind the Roman Catholic and Anglican churches.”⁴⁴⁸ The church's response to HIV and AIDS is the product of initiatives or lack of thereof spearheaded by the episcopacy, clergy and laity. The present research study will note that the connection between the United Methodist Church in Zimbabwe and its sister annual conferences mainly in the US became a channel for the local church to receive support towards HIV and AIDS interventions.⁴⁴⁹ In the period between 2000 and 2007 the church's authorities established alternative channels for accessing aid in the name of intentions to launch and sustain HIV and AIDS interventions in parts of Manicaland.

2.8. Synthesis

This chapter has shown that HIV and AIDS was not the first epidemic to hit the face of the earth and humankind's responses to epidemics always took a similar pattern as discussed in the work of Rosenberg. The chapter has also indicated that the HIV epidemic in Zimbabwe, since being publicly known in 1985, shared a lot in common with similar HIV epidemics in Africa but particularly in southern Africa. African HIV epidemics were mainly driven by common socio-historical factors such as migrant labour practices, gender relations, political relations, class conflict and economic disparities among the population. The chapter also highlighted some of the key public

⁴⁴⁶ Peaden, “The Methodists in Zimbabwe,” 90. See also Gelfand, “Medicine and the Christian missions in Rhodesia,” 114.

⁴⁴⁷ AM, *Official Journal of the Zimbabwe Annual Conference of the UMC third session*, 2 January 1983, 65-73.

⁴⁴⁸ GBGM of the UMC, “AIDS in Zimbabwe and the United Methodist Church's response,” <<http://gbgm-umc.org/health/AIDSAfrica/zimmaids.cfm/>> [Accessed 10 March 2009].

⁴⁴⁹ E. Kabungaidze, same interview. See also A. Mhondoro, interview conducted by M. Mbona, Nyanga Drive, Rusape, 17 August 2010.

policy developments within the State's response to the HIV epidemic from 1985 to 2007. The Government of Zimbabwe's adoption of foreign-bred economic policies had a negative effect by reducing State budgetary expenditure on healthcare including the care and treatment of PLHIV. The study has taken note of the State's National HIV and AIDS policy for the Republic of Zimbabwe, the establishment of the AIDS levy and the subsequent enactment of the National AIDS Council in 2000 as watershed moments for HIV interventions. Within this chapter, the NGO Act of 2004 whose effect led to a drastic reduction of the number of NGOs involved in AIDS-related home-based care, has been discussed. A periodisation of HIV interventions at the international level has been given. This will assist in locating responses to HIV in Zimbabwe by the State and the churches covering the early (1985-1994), middle (1995-1999) and later (2000-2007) periods of the study. A further graphic illustration of key State and church responses to the epidemic has been drawn up.

The State's move to include the churches within the multisectoral response to the AIDS epidemic as enshrined in the national HIV and AIDS policy appears to have come late. Perhaps the Government became aware of fact that the churches had public influence and could either play a positive or negative role in responding to HIV and AIDS. The State's adoption of multi-sectoral responses to HIV and AIDS at the national level could have been necessitated by a need to ensure that –all sectors play a synergistic role in the fight against the pandemic.”⁴⁵⁰ However, it could also be observed that the multi-sectoral approach in carrying out HIV and AIDS interventions was requested by the donors. In January 2000, this was placed on the agenda of the United States International Development Agency, whereby: –HIV/AIDS was identified as a key challenge requiring interventions in multiple sectors and by multiple actors in the development assistance community.”⁴⁵¹

With regard to Zimbabwe, international pressure was on the State to show transparency and accountability of donor-funded HIV and AIDS interventions especially from the late 1990s onwards. In many ways, this encouraged the State to

⁴⁵⁰ R. G. Mugabe, –Foreword,” NAC, *Zimbabwe HIV and AIDS national strategic plan*, v.

⁴⁵¹ USAID-PVO steering committee, *Multisectoral responses to HIV/AIDS: A compendium of promising practices from Africa*, a publication of the multi-sectoral approaches to HIV/AIDS by the USAID Bureau for Africa, Office of Sustainable Development, (April 2003), vii, <http://sara.aed.org/publications/hiv_aids/aids_in_africa/Multisectoral_Responses-oct03.pdf> [Accessed 7 May 2012].

adopt a multi-sectoral collaborative approach.⁴⁵² Having given a brief historical overview of the Roman Catholic, Anglican, and United Methodist Church, the next chapter will endeavour to show their responses to HIV and AIDS in Manicaland in the period 1985-1994.

⁴⁵² O'Brien, "The prevalence and politics of HIV/AIDS in Zimbabwe," 7.

CHAPTER THREE

THE EARLY YEARS (1985-1994)

3.1. Introduction

This chapter will show that the reaction of the Roman Catholic, Anglican and United Methodist churches to HIV and AIDS in Manicaland was at best, ambiguous. The chapter will illustrate that responses to the HI-Virus by institutional and grassroots structures of the churches took different patterns. This chapter will also show that the initiation of AIDS-related care by the Roman Catholic Diocese of Mutare in Manicaland led to the formation of a FBO. The chapter will proceed by discussing responses to the pandemic by each church and finally give a synthesis.

3.2. The Roman Catholic Church's Response to HIV and AIDS

The Roman Catholic Church's prior experience in social development was critical in determining the input to HIV interventions by the Zimbabwean Catholic Bishops. Briefly, in the early 1980s, the ZCBC enjoyed a favourable working relationship with the new Government of Zimbabwe. This cordial relationship could be dated back to the struggle for independence when the church supported to the liberation movement at different levels including the freedom fighters.⁴⁵³ The new government particularly encouraged the Roman Catholic Commission for Justice and Peace (CJPC) to partner with the State. In 1982 the new Prime Minister, Robert Mugabe, addressed the CJPC in Gweru and thus stated:

...we are partners in the development of our country. The person who we deal with as politicians is the same one who is a Christian as well.
... And politicians and the church are dealing with the same person. ...

⁴⁵³ For a detailed analysis of this see I. Linden, *The Catholic Church and the struggle for Zimbabwe*, (London: Longman, 1980).

And therefore let us join hands to consolidate our hard won independence.⁴⁵⁴

Apparently, the new Government of Zimbabwe was aware of the Roman Catholic Church's ability to outsource funding.⁴⁵⁵ The church also had people who were well trained in various aspects of social development. Thus, the new government sought to use the church's assets and resources for the benefit of the new nation.⁴⁵⁶ According to Christine Mtize who assumed the position of being the ZCBC's HIV and AIDS coordinator in 1988, the diocesan HIV and AIDS interventions throughout Zimbabwe officially began in the late 1980s.⁴⁵⁷ However, while the ZCBC collaborated with the State on the treatment and care of PLHIV and OVC, there was disagreement on the HIV prevention strategy mainly on sex education and the use of condoms. In what follows, the Roman Catholic Church's HIV and AIDS interventions will be explored in the following order: Father Edward Rogers (1986), the ZCBC (1987), the ZCBC HIV and AIDS Desk (1990) and the Catholic Diocese of Mutare Community Home Care project (1992).

3.2.1. Edward T. Rogers: A Pioneer in the Response to HIV and AIDS

Before the publication of the first publicly known case of AIDS by the Zimbabwe Government in 1985, a number of church leaders including some bishops, priests and laity from the Roman Catholic Church were exposed to information on HIV and AIDS. It has already been briefly noted in chapter one that Father Edward T. Rogers became one of the church's first clerics to be involved in HIV and AIDS work in the mid-1980s. Rogers, a Jesuit priest, encountered cases of people suspected to be living with HIV during his errands as a social worker in Harare before his retirement in 1985.⁴⁵⁸ He was probably not only one of the first Roman Catholic Church members to engage with the pandemic, but he also became one of the first clerics in Zimbabwe

⁴⁵⁴ P. Mutume, "Insights from the second Chimurenga," in C. F. Hallencreutz and M. Palmberg (eds), *Religion and politics in southern Africa*, (Uppsala: The Scandinavian Institute of African Studies, 1991), 146.

⁴⁵⁵ P. Mutume, same interview. See also information supplied to M. Mbona by A. Vinyu, Cathedral of the Holy Trinity, Mutare, 10 June 2010.

⁴⁵⁶ Information supplied to M. Mbona by A. Vinyu, Cathedral of the Holy Trinity, Mutare, 10 June 2010.

⁴⁵⁷ Information supplied by C. Mtize through an email to M. Mbona, 26 June 2011.

⁴⁵⁸ T. Rogers, interview conducted by M. Mbona, at ARRUPÉ College, Harare, 13 April 2011

to seek out ways of developing Christian initiatives to counter the effects of HIV and AIDS.⁴⁵⁹

A long history of social work and education lay behind Roger's career in Zimbabwe. Born in Liverpool, England in 1924, he had grown up in a family environment that fostered charity towards the old and the poor. For example, at a tender age Rogers joined his father as a junior member of the St. Vincent de Paul Society at St. Oswald's church, Liverpool, and he used to help the poor and the disadvantaged in the parish.⁴⁶⁰ At the age of 24 years, Rogers joined the Jesuits in 1948⁴⁶¹ and arrived in Salisbury (now Harare) in 1960.⁴⁶² Gundani singled out Rogers for establishing the School of Social Work in Harare in 1964.⁴⁶³ Behind Rogers' passion for social work were two important influences. First, the *Instructions on the Social Apostolate* fostered on the need to provide people with sufficient goods lest they might feel depressed or despised. Second, were the two encyclicals by Pope John XXIII: *Mater et Magistra* (New Light on Social Problems, 1961), and *Pacem in Terris* (Peace on Earth, 1963).⁴⁶⁴ It was against this background that a person like Rogers found himself serving people with unparalleled love and passion. Joshua, whose thesis focussed on AIDS and the Roman Catholic Church in KwaZulu-Natal, South Africa for the period 1984-2005, made a similar evaluation: –Social work therefore became Roger's entry point into AIDS ministry. His understanding of the social fabric of Southern Africa prompted him to act as the church's –warning finger" of the impending Aids catastrophe."⁴⁶⁵

In 1986 Rogers' knowledge and early activism in HIV and AIDS drew the attention of the Roman Catholic Church in Zimbabwe and southern Africa.⁴⁶⁶ Rogers became involved in research and giving talks on HIV and AIDS within southern Africa under the auspices of Inter-Regional Meeting of the Bishops of southern Africa

⁴⁵⁹ Information supplied by V. Chitimbire to M. Mbona in Harare after interview, 5 October 2010. See also C. Napier, interview conducted by S. Joshua, Archdiocesan Chancery, Durban, 15 October 2007.

⁴⁶⁰ Rogers, *Jesuit, social pioneer and AIDS activist*.

⁴⁶¹ Rogers, *Jesuit, social pioneer and AIDS activist*.

⁴⁶² Rogers, *Jesuit, social pioneer and AIDS activist*.

⁴⁶³ Gundani, –The Catholic Church and national development in Zimbabwe," 220. See also C. Chogugudza, –Social work education, training and employment in Africa: The case of Zimbabwe," in *Ufahamu: A Journal of African Studies* 35, 1, (2009), 1-19. <<http://escholarship.org/uc/item/1vm25226/>> [Accessed 28 May 2011].

⁴⁶⁴ Rogers, *Jesuit, social pioneer and AIDS activist*.

⁴⁶⁵ Joshua, –The Catholic response to HIV and AIDS in South Africa," 81.

⁴⁶⁶ W. Napier, same interview.

(IMBISA).⁴⁶⁷ IMBISA, established in 1975, served as an organ of liaison and pastoral cooperation among the bishops' conferences of Angola and São Tomé and Príncipe (CEST), Lesotho (LCBC), Namibia (NCBC), Mozambique, southern Africa which is made up of Botswana, South Africa and Swaziland (SACBC), and Zimbabwe (ZCBC).⁴⁶⁸ For example, Liz Towell, director of Sinosizo, an AIDS care service organisation under the Archdiocese of Durban, became aware of Rogers' visits to South Africa between 1986 and 1987.⁴⁶⁹ The Roman Catholic Church's leaders such as Archbishop Denis Hurley requested Rogers to assist with presentations on HIV and AIDS. In Zimbabwe, Auxiliary Bishop Mutume worked with Rogers in the ZCBC office in 1987 at a time when very few ordinary people were aware of the new disease called AIDS.⁴⁷⁰

The Jesuit cleric became involved in developing HIV and AIDS initiatives for the Archdiocese of Harare, and set up the ZCBC ad hoc AIDS Committee in September of the following year.⁴⁷¹ Rogers was also responsible for drafting the first statement on AIDS published by the ZCBC in October 1987. As Rogers was to recall:

Having written this draft I sent it out to the members of the committee for their comments. The final draft of the statement was presented to the bishops at their meeting ... and the bishops said that, after their amendments, it could be published as a pastoral letter in English, Shona and Ndebele.⁴⁷²

Rogers' interest in the epidemic was recognised by public health experts, church leaders of lay members of other churches to the point of being seen as an expert on HIV and AIDS. Respect for Rogers' work was confirmed when he successfully convened a meeting at St. Anne's hospital attended by forty-two people on 24 March 1987. The participants were from different backgrounds but with interest in AIDS.⁴⁷³

⁴⁶⁷ T. Rogers, same interview.

⁴⁶⁸ Inter-Regional Meeting of the Bishops of Southern Africa, <<http://imbisa.org.zw/ABOUT%20IMBISA.html>> [Accessed 12 June 2009].

⁴⁶⁹ L. Towell, interview conducted by P. Kearney, Durban, 13 January 2004, <archbishopdenishurley.org/index.php?option=com_content&view=id=37&Itemid=54> [Accessed 31 August 2011]. See also Rogers, same interview.

⁴⁷⁰ P. Mutume, same interview.

⁴⁷¹ Rogers, *Jesuit, social pioneer and AIDS activist*.

⁴⁷² Rogers, *Jesuit, social pioneer and AIDS activist*.

⁴⁷³ Information supplied to M. Mbona by C. Gandiya, e-mail, 7 February 2011. See also T. Rogers, same interview. See also Rogers, *Jesuit, social pioneer and AIDS activist*.

This meeting gave birth in 1988 to one of the earliest non-governmental AIDS organisations, namely, the AIDS Counselling Trust (ACT), which was subsequently officially registered with the government in 1989.⁴⁷⁴ The board of trustees of the AIDS Counselling Trust included people from educational, social, medical and Christian backgrounds.⁴⁷⁵ This came a year after the formation of FACT in 1987. Thus it may be concluded that Rogers was instrumental in setting up the ground for the Roman Catholic Church's work in the field of HIV and AIDS. The formation of the AIDS Counselling Trust by Rogers came one year after the establishment of the National AIDS Co-ordination Programme by the State in 1987. Rogers used his position as a Jesuit with long service in social work to the advantage of bringing AIDS to the attention of the church in the hope establishing faith-based interventions. While most people in Zimbabwe were in jubilation, celebrating the birth of a new nation, Rogers focused his attention on the challenges ahead. He knew that AIDS had no cure, and that in the years to come, many of the local people were likely to be infected and affected by the pandemic.⁴⁷⁶

Rogers did not only feature at high profile platforms namely the ZCBC and IMBISA but worked with grassroots Christian groups including women's groups. For example, in February 1988, Rogers presented papers and talks on HIV and AIDS at seminars for the Anglican Church in Harare and the Roman Catholic Women's League in Harare too.⁴⁷⁷ Churchwomen's interest in AIDS might have been related to the fact that women experienced the challenge of providing care to members of their families who were living with HIV. Rogers and the AIDS Counselling Trust were thus instrumental in recruiting voluntary counsellors to serve in public and private healthcare centres and in homes in Harare.⁴⁷⁸ Within Zimbabwe, Rogers strengthened the voice of the Heads of Christian Denominations by acting as a resource person for the church-related HIV and AIDS interventions. For example, in 1989, on behalf of the church leaders, Rogers wrote a book entitled *AIDS: The Christian response*.⁴⁷⁹ The fact that Bishop Peter Hatendi of the Anglican Diocese of Harare as chairperson,

⁴⁷⁴ ACT, <[http://www.zan.co.zw/index.php?option=com_sobi2 &sobi2Task=sobi2Details&catid/](http://www.zan.co.zw/index.php?option=com_sobi2&sobi2Task=sobi2Details&catid/)> [Accessed 11 March 2011].

⁴⁷⁵ Rogers, *Jesuit, social pioneer and AIDS activist*.

⁴⁷⁶ T. Rogers, same interview.

⁴⁷⁷ Rogers, *Jesuit, social pioneer and AIDS activist*.

⁴⁷⁸ T. Rogers, same interview.

⁴⁷⁹ HOCD, *AIDS: The Christian response*.

and Auxiliary Bishop Mutume as secretary signed the book, indicate that ecumenical collaboration on HIV and AIDS existed at the national level. In 1993, Rogers, with support from the national church leaders' forum established an Interdenominational AIDS Committee. He subsequently contributed to the drafting of the first version of the churches' HIV and AIDS policy later known as the Kadoma Declaration, published in 1993.⁴⁸⁰ The said document stated that Christian moral principles as well as African traditional values of sexuality were the only ways of preventing the spread of HIV. There were a number of other platforms at which Rogers participated and that served to indicate that he became a very central figure in responses to HIV and AIDS by the churches in the early period.

Rogers, as director of IMBISA, and Christine Mtize, as coordinator of the national health and AIDS programmes, both being Roman Catholics, were part of the interdenominational AIDS planning committee in Zimbabwe.⁴⁸¹ Rogers was one of the resource persons at the interdenominational AIDS conference held in Kadoma in January 1994. The paper presented by Rogers was entitled: "The Christian, AIDS and Behavioural Change."⁴⁸² Behaviour change among the youth had been a popular approach by the Roman Catholic Church since the late 1980s and Rogers was one of few people to admit to the fact that it was an ineffective strategy. He further observed that behaviour change has limited effects on the rate of transmission of HIV.⁴⁸³ In as much as Rogers sought to change the course of HIV and AIDS, especially between 1984 and 1994, the pandemic also altered his views on condom use. For example, at the beginning of the pandemic, Rogers behaved like a Roman theologian, and was characterised by conservative Christian moral values and unwillingness to explore the use of condoms. From 1995 onwards and as AIDS took its toll on communities, Rogers shifted towards a position of seeing condoms as a lesser evil that could reduce the death of many young productive lives.⁴⁸⁴ In 1996 Rogers founded the Jesuit AIDS Project based in Harare,⁴⁸⁵ and became its director until retirement in 2008.⁴⁸⁶ AIDS

⁴⁸⁰ HOCD, *Conference statement on AIDS*.

⁴⁸¹ Farag, *Interdenominational AIDS conference*, 2.

⁴⁸² T. Rogers, "The Christian, AIDS and behavioural change," in Farag, *Interdenominational AIDS Conference*, 35-39.

⁴⁸³ Rogers, "The Christian, AIDS and behavioural change," 36.

⁴⁸⁴ T. Rogers, same interview.

⁴⁸⁵ ER, African Jesuits responses to HIV and AIDS, *AJA News*, 54, (March 2007), 5.

⁴⁸⁶ Rogers, *Jesuit, social pioneer and AIDS activist*.

provided Rogers with further opportunities to serve the people of southern Africa, particularly Zimbabwe, and this occupied the greater part of his retirement years.

3.2.2. The Zimbabwe Catholic Bishops Conference's Response to HIV and AIDS at National Level

While the Roman Catholic Church having embraced the invitation by the new government to become partners in development, the massacres in Matabeleland in the early 1980s strained the relationship between the State and the ZCBC in the early 1980s. During Easter in 1983, the latter accused the former of heavy-handedness in resolving the problem of the so-called dissidents.⁴⁸⁷ The position taken by the ZCBC was that of seeking peace and reconciliation in the youthful nation. Auxiliary Bishop Mutume spoke of the bishops' concern for peace in Matabeleland by noting:

Through the Catholic Commission for Peace and Justice the bishops kept monitoring the internal conflict in Matabeleland. In 1986 the commission gives its wholehearted support to the unity talks between ZANU (PF) and (PF) ZAPU.⁴⁸⁸

Whereas the ZCBC criticised the State, the bishops undertook to improve the welfare of the citizens whose lives had been affected by the liberation struggle and were now disturbed by unrest in Matabeleland. In this regard, Bishop Muchabaiwa insisted that the church's prophetic role and faithfulness to Jesus Christ entailed that it served the citizens of Zimbabwe freely.⁴⁸⁹ The government's launching of foreign-bred economic reforms presented fresh challenges for the citizens as the public healthcare system experienced decline. Despite the deterioration of the relationship between the ZCBC and the State the bishops maintained their commitment to social responsibility to the nation. Thus, the HIV and AIDS interventions that emerged under the different Roman Catholic dioceses in Zimbabwe were established for the benefit of ordinary people.

⁴⁸⁷ Gundani, "The Catholic Church and national development in Zimbabwe," 215.

⁴⁸⁸ P. Mutume, "The priorities of the Zimbabwe Catholic Bishops' Conference since independence," in Hallencreutz and Moyo, *Church and State in Zimbabwe*, 468.

⁴⁸⁹ Gundani, "The Catholic Church and national development in Zimbabwe," 241.

3.2.2.1. Episcopal Statements on HIV and AIDS

Between 1985 and 1994 the ZCBC issued four statements whose focus was on the HIV and AIDS epidemic. The most critical ones were those issued in 1987 and 1991. In October 1987 the ZCBC was the first religious body in Zimbabwe to issue a statement on the new disease. This came at a time when the nation was grappling with understanding the origins of AIDS, its mode of transmission, prevention of HIV and treatment of AIDS-related illness. The statement was entitled “AIDS and our moral responsibility.”⁴⁹⁰ An overview of the statement indicates that there were six points of emphasis and they include a brief introduction of AIDS, its mode of infection, Christian morality, traditional values, message to youth and the response to the afflicted.⁴⁹¹ The ZCBC held the understanding that the disease was a consequence of the law of nature as stated:

First of all we state that our primary concern is for the AIDS sufferers, their families and friends who also suffer much distress. We consider that this severe disease is a consequence of the law of nature. Misuse of alcohol or drugs creates serious health problems. The misuse of sex is the major cause of the spread of AIDS in our society and this, too, brings most serious health problems. AIDS may be seen, too, as God’s answer to man [man’s] disregard for His moral law (*cf.* Matthew 5: 27-52), but God is the God of compassion who bids us to be compassionate too (*cf.* Colossians 5: 12-15).⁴⁹²

Thus the bishops believed that there was a strong relationship between AIDS and moral decline in Zimbabwe. The statement issued two years after the State openly admitted the existence of AIDS in Zimbabwe gave the impression that the epidemic was a consequence of sin.

The ZCBC also agreed that AIDS, as it was then commonly called, could be contracted by the use of surgical needles and razor blades. While the epidemic was first discovered among gay people in the US, the bishops warned that heterosexual contact was the main mode of its spread in Zimbabwe:

⁴⁹⁰ ZCBCH, ZCBC, “AIDS and our moral responsibility.”

⁴⁹¹ ZCBCH, ZCBC, “AIDS and our moral responsibility.”

⁴⁹² ZCBCH, ZCBC, “AIDS and our moral responsibility.”

But the main mode of transmission of this disease in Africa is by heterosexual contact and it is precisely here that all persons can help to stop its spread. Promiscuity is the root of the problem. The disease is contracted through sexual intercourse with an infected person, male or female. Some medical authorities advocate for the use of a condom during sexual intercourse to prevent infection. However, condoms are not completely reliable and their users still contract AIDS and transmit it to others.⁴⁹³

One could note that according to the bishops' statement, there was a conviction that AIDS could be stamped out through moral purity and not through using condoms. In this regard, the Roman Catholic bishops in Zimbabwe targeted Roman Catholic Christians married or single by warning them against promiscuity and exposed false security in the use of condoms. Each church member was expected to exercise Christian moral responsibility as stated:

In order to face this serious health and moral challenge we have to return to the source of morality and consider our attitude to human relationships and to sexuality within this context. Chastity before marriage, and fidelity in marriage, should not be seen as impossible ideals in spite of prevalent sexual laxity.⁴⁹⁴

The HIV and AIDS epidemic was seen by the ZCBC as a major threat to the youth for the reason that it claimed the lives of the sexually active young adults. The bishops' statement in October 1987 also had a specific message to the church's youth who were seen as the future of the church and the society. Young people were admonished to be resilient in resisting the temptation of sexual indulgence as stated:

We have a special message for our youth, both young men and young women, to resist the fashion of the day in matters of sexuality. They should try to see their companions as persons of immense worth and beauty and not sexual objects. ...We believe that both partners to marriage should feel free to ask for an assurance that their future partner is free of infection even if this may mean taking blood tests to assure themselves.⁴⁹⁵

The vibe of political independence could have led young people to be immoral and therefore contract HIV. While there were very limited HIV testing facilities at that

⁴⁹³ ZCBCH, ZCBC, —AIDS and our moral responsibility.”

⁴⁹⁴ ZCBCH, ZCBC, —AIDS and our moral responsibility.”

⁴⁹⁵ ZCBCH, ZCBC, —AIDS and our moral responsibility.”

time in Zimbabwe, the ZCBC's message indicates the seriousness with which the bishops considered moral purity among young Roman Catholic couples.

The second pastoral statement issued on HIV and AIDS by the ZCBC came in March 1991. It built up on the statement issued four years previously in 1987. The words contained in the statement sounded rather harsh and even confrontational as suggested by the title –Save our Families: Pastoral Letter on Marriage, Family, Sexuality and the AIDS Epidemic.”⁴⁹⁶ Notable changes between the first and second statements were a reflection of the fact that the AIDS scene was evolving. The statement issued in 1991 indicated the intricate relationship between marriage, family, sexuality and the AIDS epidemic. According to the statement, AIDS affected society because of a breakdown in family values whereby married couples were expected to uphold chastity. The bishops pleaded with Roman Catholics to uphold African traditional cultural values on the family as well as the teaching of the church on Holy Matrimony.⁴⁹⁷ The ZCBC echoed the same sentiments as in the previous statement which argued that AIDS was a consequence of humanity breaking the laws of nature as stated: –What was meant to be an expression of personal love has become something impersonal, even inhuman. What was meant to foster lifelong fidelity has become a means of monetary intoxication and excitement.”⁴⁹⁸

Furthermore, the statement repeated the notion that AIDS was a moral issue and critiqued what the bishops described as –blind trust in technological solutions to human problems, combined with moral defeatism that claimed that the use of condoms could prevent HIV.”⁴⁹⁹ There is also sense in which the Roman Catholic bishops in Zimbabwe appeared to appreciate that the use of condoms could prevent the spread of HIV and yet they held the same device in suspicion for undermining the tenets of the Roman Catholic Church on marriage and sexuality:

⁴⁹⁶ ZCBCH, ZCBC, –Save our families,” A pastoral letter on marriage, family, sexuality and the AIDS epidemic, March 1991. Signatories to the said letter included: Patrick F. Chakaipa (archbishop of Harare), Henry Karlen (bishop of Bulawayo), Francis Mugadzi (bishop of Gweru and vice-president of the ZCBC), Alexio C. Muchabaiwa (bishop of Mutare) Ignatius Prieto SMI (bishop of Hwange), Helmut Reckter SJ (bishop of Chinhoyi), and Patrick M. Mutume (auxiliary bishop of Mutare and secretary general of the ZCBC).

⁴⁹⁷ ZCBCH, ZCBC, –Save our families.”

⁴⁹⁸ ZCBCH, ZCBC, –Save our families.”

⁴⁹⁹ ZCBCH, ZCBC, –Save our families.”

We do not deny that, speaking on the level of sheer mechanics, if used correctly and regularly, [condoms] reduce the risk of HIV infection to some extent (but by no means completely). But we deny that the widespread use of such or similar devices is the answer to the deep moral crisis which has caused the rapid spread of AIDS in our country. In fact, propagating condoms is tantamount to admitting moral defeat, and, worse than that, it encourages promiscuity, especially when they are made available to the young.⁵⁰⁰

HIV infected and affected married couples or families mainly because of the common nature of heterosexual relationships. The pandemic also attacked the central nerve of the community of the faithful. The statement appeared to give the impression that morality is the best way of preventing HIV, a position that was consistent with the church's teachings. However, the second statement advised married couples where one of the spouses was HIV positive to seek the services of a counsellor but remained hesitant to prescribe either the use of condoms or to abstain from marital intercourse altogether. This approach was similar to what Baffour Takyi in Ghana viewed as sexual behaviour modification that includes abstinence (where possible), the use of condoms in sexual encounters and the treatment of STDs among those viewed as at higher risk of AIDS.⁵⁰¹

The statement issued in 1991 also drew attention to cases of increased deaths among infants and young children. The bishops responded to the ravages of the AIDS epidemic among mothers and their children when it stated: "Even now many small children die of AIDS, having been infected by their HIV positive mothers in the womb or at birth."⁵⁰² The Roman Catholic Church has always held the view that all human life was sacred and therefore deserves to be respected. As its bishops were to contend:

There have been some voices advocating abortion of children expected by HIV-positive mothers. This is unacceptable. Even children of with a life expectancy of no more than a few years have a right to life. Not every child who is born of an HIV-positive mother will be infected

⁵⁰⁰ ZCBCH, ZCBC, "Save our families."

⁵⁰¹ B. K. Takyi, "Region and women's health in Ghana: Insights into HIV/AIDS preventive and protective behaviour," in *Social Science and Medicine* 56 (2003), 1223.

⁵⁰² ZCBCH, ZCBC, "Save our families."

with AIDS. More than half of such children have a chance of being born healthy and without any infection.⁵⁰³

Members of the ZCBC were also aware of the challenges of caring for such babies and other OVC orphaned by AIDS. In the light of this need, the Roman Catholic families were encouraged to take new roles in caring for OVC. In 1992 the bishops maintained the stance that human life was sacred as noted from a pastoral statement entitled –Even children of HIV-positive mothers have a right to life.”⁵⁰⁴ The bishops thus stated:

Both HIV positive mothers and their children need our care and support. This is a great challenge to society in general and the church in particular. AIDS is killing many people already. We have no right to add to their number by deliberate killing. It is our duty even under these tragic circumstances to preserve and cherish the gift of life.⁵⁰⁵

The ZCBC repeated the same message in 1994 in a pastoral statement entitled –Human life is sacred: Catholic bishops strongly opposed to abortion.”⁵⁰⁶

3.2.2.2. History of the Documents, Context and Reception

The first statement on HIV and AIDS released in October 1987 by ZCBC was one of the earliest statements issued from any part of the Roman Catholic Church including Africa and the Vatican. This statement followed the message of the New Zealand Roman Catholic bishops in May 1987,⁵⁰⁷ the Roman Catholic bishops of Kenya in June 1987,⁵⁰⁸ and the message of Pope John Paul II delivered in California in September 1987.⁵⁰⁹ In some respects, the ZCBC’s statement compared well with that

⁵⁰³ ZCBCH, ZCBC, –Save our families.”

⁵⁰⁴ ZCBCH, ZCBC, –Even children of HIV-positive mothers have a right to life,” A statement issued by Bishop Helmut Reckter SJ of Chinhoyi, President of the ZCBC on behalf of the Catholic Bishops of Zimbabwe, 1992.

⁵⁰⁵ ZCBCH, ZCBC, –Even children of HIV-positive mothers have a right to life.”

⁵⁰⁶ ZCBCH, ZCBC, –Human life is sacred: Catholic bishops strongly opposed to abortion,” A statement was issued by Bishop Helmut Reckter SJ of Chinhoyi, President of the ZCBC on behalf of the Catholic Bishops of Zimbabwe, 1994.

⁵⁰⁷ D. MacLeran, (ed), *The church response to HIV/AIDS: A Caritas internationalis dossier*, 1996, accessed in pdf, 8.

⁵⁰⁸ Kenya Episcopal Conference, <<http://www.kec.or.ke/subsection.asp?ID=97/>> [Accessed 23 June 2011]. See also information supplied to M. Mbona by T. Rogers by email, 27 May 2011.

⁵⁰⁹ MacLeran, *The church response to HIV/AIDS*, 3.

issued from the New Zealand Roman Catholic bishops who argued that the course of AIDS could only be altered by responsible sexual behaviour and not by the use of condoms.⁵¹⁰ The message of the Holy See, delivered in a country long associated with the first cases of AIDS among homosexual men in 1981, appeared to offer hope to PLHIV. For example, Pope John Paul II showed sympathy towards HIV positive people when he stated: “He [God] loves those of you who are sick, those suffering from AIDS.”⁵¹¹ According to Rogers, who was the architect of the ZCBC’s statement, the Zimbabwean bishops were inspired by the Roman Catholic bishops of Kenya in issuing a statement on AIDS.⁵¹² However, the emphasis in the statement by the Roman Catholic bishops of Kenya’s was more toward compassion and care than being moral as stated:

We urge the members of the church in our countries, laity and clergy, cooperating where possible with already existing organizations to search for the most effective means of help, and we ask our bishops to give their active support to this work of Christ: for it is His Body which has HIV/AIDS.⁵¹³

The first statement by the Zimbabwean Catholic bishops also carried a message specifically directed to young people. The bishops held the perception that young people could be effective in preventing the spread of HIV by encouraging them to abstain from immorality. According to Auxiliary Bishop Mutume, “the churches in Zimbabwe were in control of the youth through their schools. They had a golden opportunity to influence their thinking.”⁵¹⁴ The bishops perceived the State’s adoption of liberal approaches to HIV prevention including the indiscriminate distribution of condoms among the youth as a threat to morality.

Furthermore, according to the bishops the State’s introduction of an individualised approach to sexuality, which was totally divorced from African traditional family values and Christian teachings, was a major weakness.⁵¹⁵ The statement could also have had the unintended effect of enhancing stigma by blaming AIDS on human folly.

⁵¹⁰ MacLeran, *The church response to HIV/AIDS*, 8.

⁵¹¹ MacLeran, *The church response to HIV/AIDS*, 3.

⁵¹² T. Rogers, same interview.

⁵¹³ Kenya Episcopal Conference.

⁵¹⁴ Mutume, “Insights from the second Chimurenga,” 143.

⁵¹⁵ P. Mutume, same interview.

The message from the second statement showed elements of continuity with the earlier one of 1987. For example, in 1987 the bishops stated that the church condemned both pre-marital and extra-marital sex in keeping with local African traditions.⁵¹⁶ The Roman Catholic Church in Zimbabwe had mixed membership of both blacks and whites and not all people respected African tradition. Apparently, the reason why the bishops chose to invoke African traditional cultural family values was driven by the reality that in Zimbabwe, AIDS was reportedly more common among blacks than in others.⁵¹⁷ Generally, the ZCBC's moralistic stance on HIV prevention AIDS was similar to the statement issued by the Southern African Catholic Bishops of Conference (SACBC) in 1990.⁵¹⁸

The Zimbabwean Catholic bishops' position that moral weaknesses among Roman Catholic men contributed to the spread of HIV was not unfounded. Elsewhere, in Malawi, a study by Jenny Trinitapoli and Mark Regnerus in 2006 concluded that married men from the Roman Catholic were likely to report recent extramarital sexual behaviour, followed by men from Protestant missionary churches, African initiated churches and Pentecostal churches.⁵¹⁹ The bishops' emphasis on Christian morality and African traditional values as ways of preventing HIV had the unintended effect of undermining women. Within the African traditional worldview women were generally perceived as dirty and men as clean.⁵²⁰ The practice of dry sex placed women at great risk of HIV. In Zimbabwe, some women dried their vaginas using cloth, cotton, shredded newspapers, salt, methylated spirits, herbs, baboon urine, and other various concoctions obtained from traditional health practitioners.⁵²¹ While the practice existed before the HIV and AIDS era, its perpetuity was unsafe and thus increased the likelihood of HIV infection. And some AIDS workers believe the extra friction

⁵¹⁶ ZCBCH, ZCBC, —AIDS and our moral responsibility.”

⁵¹⁷ T. Rogers, same interview.

⁵¹⁸ MacLeran, *The church response to HIV/AIDS*, 4.

⁵¹⁹ Trinitapoli and Regnerus, —Religion and HIV risk behaviours among married men,” 515.

⁵²⁰ S. Leclerc-Madlala, —AIDS in Zulu idiom: Etiological configurations of women, pollution and modernity,” in B. Carton *et al.*, (eds), *Zulu identities: Being Zulu, past and present*, (Scottsville: UKZN Press, 2008), 559.

⁵²¹ A. N. Turner *et al.*, —Vaginal practices of HIV-negative Zimbabwean women,” *Infectious diseases in obstetrics and gynecology*, (2010), 1-7. See also J. H. M. Van de Witjert *et al.*, —Men's attitudes toward vaginal microbicides and macrobicides trials in Zimbabwe,” *International Family Planning Perspectives* 25/1 (March 1999), 15.

makes condoms tear more easily.”⁵²² Beverley Haddad has also pointed out that such practices as virginity testing justified male domination through patriarchy, while women and girls were exposed to unprotected sexual manipulation.⁵²³

The advent of HIV and AIDS gave renewed sustenance to long-established diseases that were dangerous to women’s health:

The infectious bodily fluids talked about in modern AIDS awareness campaigns may be new ideas, but they have been distilled and filtered through not-so-unfamiliar old ideas of women’s pollution and the peril it represents to men and to society in general.⁵²⁴

Roman Catholic married churchwomen took exception to the ZCBC’s position of intolerance to condoms use as a precaution against HIV. Married churchwomen mentioned that all barriers to sex such as following a woman’s menstrual cycle were impracticable because of the high risks of infection if one’s spouse was unfaithful. For example, Teresa Nyawera of St. Paul’s Dangamvura and Eugenia Tichawangana of Triashill mission stated that many young couples found it difficult to practice natural contraception. Women who used natural contraception faced the wrath of HIV because male spouses were not patient and thus became involved in extra-marital sexual relationships.⁵²⁵ It appears that some Christian women were aware of the fact that in the short term condoms could assist in reducing the spread of HIV.

Similarly, at Nyahukwe, two female informants stated that impatience with a woman’s cycle by male spouses forced women to use condoms as a means of contraception, but privately.⁵²⁶ Thus, out of fear of contracting HIV infection from an

⁵²² M. Schoofs, “Death and the second sex,” *AIDS: The agony of Africa*, (December 1999), <<http://www.thebody.com/content/art2762.html?ts=pdf>> [Accessed 4 November 2011]. See also, B. Haddad, “Choosing to remain silent: Links between gender violence, HIV/AIDS and the southern African church,” in Phiri, *African women, HIV/AIDS and faith communities*, 149-166.

⁵²³ B. Haddad, “Gender violence and HIV/AIDS: A deadly silence in the church,” *Journal of Theology for Southern Africa* 114 (November 2002), 95.

⁵²⁴ Leclerc-Madlala, “AIDS in Zulu idiom,” 559.

⁵²⁵ T. Nyawera, interview conducted by M. Mbona, St. Paul’s Roman Catholic parish, Dangamvura, Mutare, 5 September 2010. See also E. Tichawangana, interview conducted by M. Mbona, Triashill mission, 9 September 2010.

⁵²⁶ M. Chitsungo, interview conducted by M. Mbona, St. Paul’s Roman Catholic parish, Dangamvura, Mutare, 5 September 2010. See also M. Mudzimiri, interview conducted by M. Mbona, St. Thomas Roman Catholic Church, Nyahukwe, 26 September 2010. See also V. Chibatamoto, interview conducted by M. Mbona, St. Thomas Roman Catholic Church, Nyahukwe, 26 September 2010.

unfaithful spouse, women in the Roman Catholic Church resorted to illicit means of obtaining and using condoms without the approval of the clerical leadership. The position taken by the ZCBC of openly opposing the prophylactic use of condoms caused the church's leadership to be seen by the general public as being insensitive to the dilemma faced by Roman Catholic married women.⁵²⁷ Denis's study on sexuality and AIDS in South Africa added another perspective by arguing that the patriarchal nature of modern society in which women were expected to submit to the sexual advances of men, played an important role in the transmission of the virus. For physiological reasons women were more vulnerable than men to the virus, hence the higher rate of infection among them.⁵²⁸

While the ZCBC and public health policy makers in Zimbabwe agreed that behaviour change was a key strategy in HIV prevention, the bishop's blamed the government for openly sanctioning the use of condoms without regard for age and marital status. The State preached the ABC method in which abstinence (A) was the first priority, followed by the admonition to be faithful (B) and to use condoms (C).⁵²⁹ Father Joinet, a Roman Catholic priest, in Tanzania in the mid-1990s, invented the ABC method.⁵³⁰ The position taken by the ZCBC was that one could not stop the spread of HIV by using the same device that was responsible for fanning the pandemic. While the State offered condoms as a protection tool against HIV, the bishops argued that condoms led to death from AIDS and that morality led to life. Church followers were urged to choose life: "But you are not trapped. You have a choice. Choose life!"⁵³¹ Women were trapped because they had very limited options in choosing safe sex. The ZCBC appeared to have overlooked this aspect.

Women also carried the burden of supporting and caring for infected spouses, relatives, children and neighbours.⁵³² However, the issues responsible for fanning the spread of the pandemic had deep roots. For example, Basset and Mhloyi argued that women faced with divorce or dire poverty had to choose between social death and

⁵²⁷ V. Chibatamoto, same interview. See also M. Chitsungo, same interview.

⁵²⁸ Denis, "Sexuality and AIDS in South Africa," 75.

⁵²⁹ See NACP, *AIDS questions and answers*, 14. See also, NACP, *Living with HIV and AIDS*, 14-19.

⁵³⁰ The origins of the ABC approach, <<http://www.avert.org/abc-hiv.htm>> [Accessed 10 November 2011].

⁵³¹ ZCBCH, ZCBC, "Save our families."

⁵³² Basset and Mhloyi, "Women and AIDS in Zimbabwe," 147.

biological death: ~~No~~ one involved in caring for HIV-infected women in Zimbabwe, and presumably elsewhere, can fail to be struck by the limited options women have in negotiating their sexual relations.”⁵³³

The continuous rise in HIV and AIDS cases further contributed to the deterioration in the relationship between the ZCBC and the State. This time, the Roman Catholic bishops in Zimbabwe accused the government of not doing enough to mitigate the impact of HIV and AIDS on the population. The ZCBC argued that because cases of HIV were ever increasing the State’s HIV prevention strategies did not work.⁵³⁴ According to the ZCBC, in 1991 half a million people were carriers of HIV, many children were orphaned, and families were in charge of looking after close relatives sick with AIDS, in their homes.⁵³⁵ The estimated adult (i.e., 15-49 years) HIV and AIDS prevalence in Zimbabwe in 1991 was at 15%.⁵³⁶ Given the fact that the population of Zimbabwe was at 10.4 million in by 1992,⁵³⁷ the estimate by the ZCBC was probably less. According to UNAIDS, the number of PLHIV in Zimbabwe in 1991 was at 800,000. The Roman Catholic Church also denounced migrant labour systems that forced married couples to live separately and exposed them to high risks of HIV.⁵³⁸ On the one hand, the ZCBC’s argument that those migrating for work sacrificed the welfare of the family in favour of income, and propelled the spread of HIV and AIDS, was legitimate. On the other hand, the same families stood in great need of income for survival, and that drove men to work far away from home. Perhaps the Zimbabwean Roman Catholic bishops overlooked these realities and therefore the situation could not change easily.

The statements on HIV and AIDS issued by the ZCBC between 1987 and 1994 made no reference to the medical aspects of the epidemic which meant that the treatment of HIV using ARVs was still not a possibility. Generally, in Zimbabwe the treatment of AIDS using ARV medication only became available when ~~the~~ national antiretroviral

⁵³³ Bassett and Mhloyi, ~~Women and AIDS in Zimbabwe,~~” 146.

⁵³⁴ P. Mutume, same interview.

⁵³⁵ ZCBCH, ZCBC, ~~Save our families.~~”

⁵³⁶ UNAIDS, ~~Zimbabwe country report,~~” 9.

⁵³⁷ Van Donk, ~~Development planning and HIV/AIDS in sub-Saharan Africa,~~” 131.

⁵³⁸ ZCBCH, ZCBC, ~~Save our families.~~”

treatment roll out plan was launched in 2004.”⁵³⁹ As a result, between 1987 and 1994 treatment was still largely unavailable to the majority of PLHIV. In Zimbabwe the ZCBC worked closely with the church’s healthcare centres through a diocesan healthcare secretariat.⁵⁴⁰ However, the bishops were not medical experts and at times their statements about HIV and AIDS could differ from those of healthcare service providers at the church’s healthcare institutions.

The Zimbabwean Roman Catholic bishops appeared unaware of the reality that –at least for some married people contracting AIDS had nothing to do with a person’s moral life.”⁵⁴¹ The ZCBC focused on one dimension and left out the others. This was despite Pope John Paul II’s words during a visit in Tanzania in September 1990. The Pope urged that HIV and AIDS initiatives should take into account both the medical aspect of the illness as well as the human, cultural, ethical and religious dimensions of life.⁵⁴² Therefore, as church leaders the bishops could have carried the hopes of the nations on HIV prevention and AIDS mitigation. Denis has noted:

As representatives and interpreters of religious beliefs they [the bishops] influence both public policy-making and popular attitudes. They define moral norms, in matters such as condom use or pre-wedding HIV test requirements, and articulate a religious response to the epidemic.⁵⁴³

In 1992, the State proposed a bill that could legalise abortion for HIV infected pregnant mothers. The minister of Health and Child Welfare, Dr Timothy Stamps, made a presentation to Parliament on this matter in February 1991. In an enraged attack on this bill, the ZCBC expressed dismay that the government did not consider protecting the sacredness of human life. It appeared that the State and the ZCBC were at odds with each other again after the failure of each side to concede to each other’s position on the prophylactic use of condoms. The position taken by the Zimbabwean Roman Catholic bishops was in continuity with the teaching of the church on abortion as contained in *Humanae Vitae*:

⁵³⁹ NAC, *Zimbabwe HIV and AIDS national strategic plan*, 9. See also Madzingira, –The Zimbabwe National AIDS Levy Trust,” 27.

⁵⁴⁰ P. Mutume, same interview.

⁵⁴¹ T. Nyawera, same interview. See also E. Tichawangana, same interview. M. Chitsungo, same interview.

⁵⁴² MacLeran, *The church response to HIV/AIDS*, 2.

⁵⁴³ Denis, –HIV, AIDS and religion in sub-Saharan Africa,” 59.

In conformity with these landmarks in the human and Christian vision of marriage, we must once again declare that the direct interruption of the generative process already begun, and, above all, directly willed and procured abortion, even if for therapeutic reasons, are to be absolutely excluded as licit means of regulating birth.⁵⁴⁴

In fact, the ZCBC's critical voice against abortion could have contributed to the survival of children born to HIV infected mothers.

3.2.2.3. Theological Rationale

The ZCBC did oppose the State's position on prophylactic use of condoms and argued that this was in violation of the tenets of natural law. The present task is not to trace the origins of the concept of natural law in its details. Theologians such as St. Thomas Aquinas shaped the Roman Catholic Church's understanding of natural law in the *Summa Theologica*.⁵⁴⁵ Aquinas argued that human beings were rational creatures who were directed by God towards an end: "In virtue of his intelligence and free will, man is master of his conduct. Unlike all the things of the mere material world he can vary his action, act, or abstain from action, as he pleases."⁵⁴⁶ The Roman Catholic moralists' understanding of natural law states: "God has formulated a plan for the world and has given human beings reason so that reflecting on the human nature made by God they can discern how God wants us to act in this world."⁵⁴⁷

The ZCBC made reference to the principle that human beings can make use of reason to guide them in deciding on actions including matters of sexuality. Some Roman Catholic Christians believe that natural law is universal and therefore applied to all human beings who conformed to the order of God. People's knowledge of the law was "founded in our nature and revealed to us by our reason, the moral law is known to us in the measure that reason brings knowledge of it home to our understanding."⁵⁴⁸

⁵⁴⁴ *Humanae Vitae (On Human Life)*, 25 July 1968, 9

⁵⁴⁵ The natural law tradition in ethics, <http://plato.stanford.edu/entries/natural-law-ethics/> [Accessed 8 July 2011].

⁵⁴⁶ J. Fox, "Natural law," *The Catholic encyclopedia*, (New York: Robert Appleton Company, 1910), retrieved from New Advent, <<http://www.newadvent.org/cathen/090776a.htm>> [Accessed 8 July 2011].

⁵⁴⁷ C. E. Curran, "Natural law," in P. B. Clarke and A. Linzey (eds), *Dictionary ethics, theology and society*, (London: Routledge, 1996), 595.

⁵⁴⁸ Fox, "Natural Law."

Under natural law, reason and conscience made a person to be able to make rational decisions on sexuality without the use of artificial barriers. Within the Roman Catholic sexual ethics, condoms were seen as having the effect of encouraging selfishness and undermined the church's long established notion that sexual intercourse is for procreation.⁵⁴⁹

In *Humanae Vitae*, Pope Paul VI stated that married persons were collaborators with God the Creator in transmitting human life.⁵⁵⁰ Thus the Pope opposed casual sex even within marriage. According to the ZCBC, the stance taken by the Government in Zimbabwe undermined the use of reason and conscience in regard to the sex act. Thus, the ZCBC's statement pointed out that condom use had the effect of reducing the divine purpose of sex into a commodity. The ZCBC invoked Roman Catholic moral theology, which was premised on the prohibition of sex outside marriage, and therefore used it to warn the youth against immorality in view of preventing HIV. On one hand, there was fear and concern among members of the ZCBC that the future of AIDS-free Roman Catholic Christians and young people in general was under threat. On the other hand, the bishops also strived to preserve the church's teachings on matters of human sexuality.

3.2.2.4. The Minority Positions

If there might be anything that the leadership of the Roman Catholic Church has been generally criticised on in recent years, it is the church's official position on the use of condoms in the prevention of HIV. All artificial birth control devices including condoms are considered as illicit. Thus many bishops and theologians including the ZCBC were totally opposed to the use of condoms in the prevention of HIV. While this position reinforced the church's moral teaching, it did not assist people who were in danger of HIV including married couples. However, a crop of Roman Catholic moral theologians and ethicists including Nader Michel argue that HIV and AIDS

⁵⁴⁹ C. E. Curran, "Contraception," Clarke and Linzey, *Dictionary ethics, theology and society*, 175.

⁵⁵⁰ *Humanae Vitae (On Human Life)*, 25 July 1968, 4. This document was downloaded from the Internet in pdf.

endangered the life of parties to a marriage and the same applied to people who shared a sexual relationship. In this case:

AIDS prevention is about that same responsibility for one's own life and for the life of others. This responsibility is love and love begins with responsibility for another's life. ...For HIV/AIDS patients, the use of the condom helps to protect life.⁵⁵¹

The minority of Roman Catholic theologians and bishops who accept the use of condoms as a way of saving lives can be said to have built on an old Roman Catholic tradition in which casuistry allowed for the use of condoms within a marriage where at least one partner is HIV positive.

In 2000 Jon Fuller and James Keenan, some of the most profound Roman Catholic ethicists on HIV prevention pointed out that many Roman Catholic bishops referred to the Roman Catholic moral tradition as the only option for the preventing the spread of the epidemic.⁵⁵² The fact that the ZCBC did not recommend safe sex indicates a conservative stance. Morality and not the use of condoms was seen by the bishops as the safest way of protecting young people from the risks of contracting HIV. In relation to young people and sexuality in the context of HIV prevention, Roger Burggraeve, another Roman Catholic ethicist, wrote in the same volume: –Responsible sexuality, however, not only presupposes that one aptly informs oneself, but also that one is prepared to act accordingly to prevent more serious consequences.”⁵⁵³ However, it must be emphasised that the Roman Catholic moral tradition was not without flexibility, whereby moves to save lives could lead to casuistry. For example, the moral theology of the Roman Catholic Church sought to act out of compassion as the main divine strategy's first imperative and was fluid in the sense that it was sensitive to the conditions that face humanity: –In the face of HIV/AIDS Christians and Catholics, the Catholic community and the Catholic moral

⁵⁵¹ N. Michel, –Fighting AIDS in a society where we Egyptians don't talk about it,” in J. Keenan SJ and J. D. Fuller SJ (eds), *Catholic ethicists on HIV/AIDS prevention*, (New York: Continuum, 2000), 157.

⁵⁵² J. D. Fuller SJ and J. Keenan SJ, –Introduction: At the end of the first generation of HIV prevention,” in Keenan and Fuller, *Catholic ethicists on HIV/AIDS prevention*, 21.

⁵⁵³ R. Burggraeve, –From responsible to meaningful sexuality: An ethics of the growth of mercy for young people in this era of AIDS,” in Keenan and Fuller, *Catholic ethicists on HIV/AIDS prevention*, 305.

theology, must be prepared to take the risk with their own rules.”⁵⁵⁴ This means that Roman Catholic bishops used the existing moral tradition in flexible ways and the use of condoms to prevent further infection in marriage was such an example.⁵⁵⁵

The reluctance to explore new understandings of human sexuality in the context of HIV and AIDS shown by the ZCBC was similar to the position taken by the SACBC. For example, in February 2001 Bishop Kevin Dowling of the Roman Catholic Diocese of Rustenburg’s expressed a personal opinion in favour of using condoms in HIV prevention. While Bishop Dowling argued in favour condom use in the mining town of Rustenburg and other areas where HIV was rife, the SACBC declined the suggestion.⁵⁵⁶ Similarly, in 1991 the members of the ZCBC expressed their reservations on condom use for the purpose of preventing HIV:

No artificial device can make up for a lack of moral insight and effort. If we want to be truly human, then we do not need more such devices to protect us from consequences of uncontrolled behaviour, but more consideration and respect for one another as persons.⁵⁵⁷

However, while this appeared to be the official position of the ZCBC, within pastoral circles, the same bishops tolerated the use of condoms among HIV positive Roman Catholic married couples. Thus, although not publicly known, using the rule of casuistics, the Roman Catholic clergy in Zimbabwe permitted the use of condoms but under strict pastoral circumstances.⁵⁵⁸ Cases of such a nature were considered as pastoral issues that could only be resolved by a priest privately. When couples confided their HIV positive status to the priest, for the sake of conscience, the clergy recommended the use of condoms.⁵⁵⁹

⁵⁵⁴ E. McDonagh, “The reign of God: Signposts for Catholic moral theology,” Keenan and Fuller, *Catholic ethicists on HIV/AIDS prevention*, 323.

⁵⁵⁵ Fuller and Keenan, “Introduction,” 21-38. See also P. Mutume, same interview.

⁵⁵⁶ A. Nolan, “Catholics and condoms,” *Challenge* 66, (October 2001), 3. See also, S. M. Joshua, “The Dowling controversy, the “message of hope” and the principle of Oikonomia: A historical critical reflection of the South Africa’s Catholic Church’s stance on the use of condoms in HIV prevention between 2000 and 2005,” *Journal of Theology for Southern Africa* 137 (July 2010), 4-27.

⁵⁵⁷ ZCBCH, ZCBC, “Save our families.”

⁵⁵⁸ P. Mutume, same interview.

⁵⁵⁹ M. O’Regan, interview conducted by M. Mbona, St. Joseph’s mission, Sakubva, Mutare, 25 August 2010.

To suggest that this position was in apparent discontinuity with the moral tradition of the Roman Catholic Church could be a misinterpretation of the point. Fuller and Keenan observed that it was not necessary to construct a new moral law in a time of HIV and AIDS because, —.the Catholic moral tradition is a supple and balanced legacy that we need to recognise, appreciate, and utilise.”⁵⁶⁰ Some nurses and doctors serving at the church’s healthcare centres in Manicaland encouraged the Roman Catholic couples that tested HIV positive to meet with their priest for further direction. This was done in a spirit of prevention of further infection through possible reduction of the viral load. The practice also gave infected couples the chance to care for their children and plan for their future.⁵⁶¹ The absence of a mechanism of ensuring that all infected couples went to the priest for spiritual guidance created opportunities for Roman Catholic married couples and others to use condoms privately. Consistent with this observation, Charles Curran, although not specifically mentioning condoms, also stated: —In practice Catholic married couples seem to use contraception in about the same numbers as non-Catholics.”⁵⁶²

3.2.3. The HIV and AIDS Commission is Launched

The HIV and AIDS pandemic overwhelmed the ZCBC to the extent that a new commission to handle the church’s initiatives nationally was established. Initially, the HIV and AIDS commission first existed as an Ad Hoc Committee set up by Rogers in September 1987. In 1988 the structure evolved into the ZCBC HIV and AIDS desk and Christine Mtize was employed as a full time coordinator.⁵⁶³ From that time onwards the commission organised seminars on HIV and AIDS for clergy, religious and lay leaders.⁵⁶⁴ In 1994 the HIV and AIDS commission received full recognition from the ZCBC to the point of establishing an independent unit. The new commission, housed at Africa Synod House, Harare, was born out of necessity, mainly in order to give maximum attention to the pandemic. Although the HIV and AIDS commission is stationed in Harare, it carried out interventions throughout

⁵⁶⁰ Fuller and Keenan, —Introduction,” 29.

⁵⁶¹ C. Mukazi, same interview.

⁵⁶² Curran, —Contraception,” 177.

⁵⁶³ Information supplied to M. Mbona by C. Mtize by email, 26 June 2011.

⁵⁶⁴ Rogers, *Jesuit, social pioneer and AIDS activist*.

Zimbabwe including Manicaland. Officers from Harare used to carry out its operations in Manicaland. This accounts for the reason why the commission's work in Manicaland is discussed within the national focus.

One of the major tasks for the commission was to spearhead HIV and AIDS awareness through prevention campaigns and the establishment of orphan care in Roman Catholic Church schools nationwide.⁵⁶⁵ The particular interest in schools was not a neutral move, but one that was driven by an agenda of countering what the church considered were 'immoral HIV prevention messages' from the State. From the ZCBC's perspective, the principle of encouraging condom use was indiscreet and contributed to permissiveness.⁵⁶⁶ Thus, the commission was opposed to condom use and emphasised the promotion of abstinence and values of life that prevented the spread of AIDS. From 1990 onwards, the commission's education unit offered a programme which focused on HIV prevention, care and life skills promotion, AIDS education, basic skills in counselling, behaviour change and peer education.⁵⁶⁷

Access to the country's education system was relatively easy because the church owned schools. Thus, all Roman Catholic Church schools in Zimbabwe were platforms of contact for the church's HIV prevention strategy meant to save future generations from being infected with HIV.⁵⁶⁸ Some research on the safety of condoms in preventing sexually transmission of HIV went on behind the scenes. For example, at some hospitals in Harare, members of the Roman Catholic Church who had a medical background investigated the reliability of condoms imported into the country. Rogers and others detected thousands of boxes of unsafe condoms in the early 1990s.⁵⁶⁹ Apparently, due to AIDS, the business of condom manufacturing and marketing expanded and multinational companies made huge profits from sales of condom used in the prevention of HIV.⁵⁷⁰

The commission appeared not to have trusted the Government mainly due to the formers reservations on the use of condoms. The commission appeared to hold the

⁵⁶⁵ ZCBCH, ZCBC HIV and AIDS desk programme, 2009.

⁵⁶⁶ See ZCBCH, ZCBC, 'AIDS and our moral responsibility.' See also P. Mutume, same interview.

⁵⁶⁷ ZCBCH, ZCBC HIV and AIDS desk programme, 2009.

⁵⁶⁸ R. Chiome, interview conducted by M. Mbona, Rusape, 28 August 2010.

⁵⁶⁹ T. Rogers, same interview.

⁵⁷⁰ P. Mutume, same interview.

view that leaving the government alone to initiate HIV prevention and AIDS awareness programmes in schools might cause more harm than good. This led to the establishment of a ‘Catholic Education Staff Development’ team that was approved by the ZCBC in 1993.⁵⁷¹ Nationally, the initiative enshrined two separate approaches to HIV prevention education in schools; one with a ‘religious’ ethos and the other being secular. Thus, in a time of HIV and AIDS, and out of the need to defend the church’s moral teachings, the leadership of the Roman Catholic Church offered an alternative model of HIV prevention education.⁵⁷² However, the proposed moralistic approach had limitations in the delivery of the expected results. For example, in 1992 and 1993 in Manicaland, it was noted that the communication methodologies used in HIV and AIDS outreach activities were ineffective. The Mutare Community Home Care project reported on the lack of willingness to discuss HIV and AIDS among the youth as a common problem in Zimbabwe.⁵⁷³ The fact that the programme was carried out in Roman Catholic schools did not always mean that there was wide support from the pupil’s home environment.

3.2.4. The Mutare Community Home Care’s HIV and AIDS Interventions

Until 1992 matters related to health, including oversight of diocesan healthcare centres, were under the responsibility of a healthcare secretariat. The church’s hospitals took over the burden of providing for the healthcare needs of people, especially the poor who could not afford to pay market rates. Out of a need to respond to the HIV and AIDS epidemic, a Roman Catholic diocesan FBO known as the Mutare Community Home Care, hereafter also referred to as diocesan project, was crafted in 1992. The project’s purpose was to care for people infected and affected by HIV and AIDS.⁵⁷⁴ The birth of the project was necessitated by the needs of people infected and affected by HIV and AIDS and this initiative targeted communities living

⁵⁷¹ ZCBCH, ZCBC HIV and AIDS desk programme.

⁵⁷² T. Rogers, same interview.

⁵⁷³ Diocese of Mutare Community Care Project archives, Mutare, (DOMCCPM), DOMCCP, Evaluation report, January 1993-June 1995, Mutare Community Home Care to support people with HIV/AIDS, 3 August 1995, 23. See also Rogers, ‘The Christian, AIDS and behavioural change,’ 35-39.

⁵⁷⁴ Information supplied by J. Nyamande to M. Mbona, DOMCCP head office, St. Joseph’s mission, Sakubva, Mutare, 10 June 2010. DOMCCPR, Benyera, *Evaluation of CRS Zimbabwe’s home-based care programme*, 18

around the Roman Catholic centres in Manicaland.⁵⁷⁵ Bishop Muchabaiwa and Auxiliary Bishop Mutume initiated the Mutare Community Home Care project after the realisation that HIV and AIDS interventions had increased the workload of the diocesan health coordinator. The diocesan healthcare secretariat now had to play a leading position in managing the activities of the new project. The most critical issue at that time was the care of PLHIV and OVC since this was an area where the government was struggling to cope.

The Roman Catholic Church in Zimbabwe in general and Manicaland in particular was one of the few churches that complemented government efforts at improving healthcare services. A few factors worked in favour of the church's early involvement in responding to HIV and AIDS. First, the Roman Catholic Church is not a newcomer in the sphere of public healthcare and therefore it took up HIV and AIDS as part of the church's social responsibility agenda. Second, the church has a long history of social development dating from colonial times and had also supported the struggle for liberation.⁵⁷⁶ Third, the church has human resources offering a diversity of skills and could mobilise funding easily.⁵⁷⁷ The church's principle that community and social development could not be separated from people's spiritual lives contributed immensely to the church's implementation of HIV and AIDS interventions.⁵⁷⁸ The HIV and AIDS pandemic unlocked new opportunities for the Roman Catholic Church by enabling it to receive foreign donor funding to carry out HIV interventions during a period when the State's health delivery system was under-funded and started to decline. The fact that the US-based Roman Catholic Relief Services (CRS) funded HIV and AIDS interventions under the Catholic Diocese of Mutare, increased the church's visibility in Manicaland. The Roman Catholic Church knew the CRS as a development partner after it started funding the Zimbabwe country programme at the invitation of the ZCBC in 1989.⁵⁷⁹

⁵⁷⁵ Information supplied by F. Nyatsuro to M. Mbona, Rusape, 3 June 2010, See also DOMCCP reports.

⁵⁷⁶ Gundani, "The Catholic Church and national development in Zimbabwe," 216.

⁵⁷⁷ Information supplied by E. Nyama to M. Mbona, Mutare, 3 May 2010. See also J. Cochrane, information supplied to M. Mbona, CHART seminar, Pietermaritzburg, 31 May 2011.

⁵⁷⁸ P. Mutume, same interview.

⁵⁷⁹ Catholic Relief Services, Zimbabwe, <<http://www.prpzim.info/default/default.cfm?pid=60/>> [Accessed 14 March 2010].

3.2.4.1. Initiation of Home-Based and Orphan Care Interventions

The AIDS-related home-based care activities carried out by the diocesan project became part of the phase in Zimbabwe in which there was a noticeable rise in HIV and AIDS advocacy, care and support of PLHIV between 1990 and 1991.⁵⁸⁰ Generally, the churches delayed to initiate AIDS-related care programmes because they were gripped not only by a sense of fear and confusion, but by stigma and discrimination that was fuelled by moralistic approaches. A retrospective analysis of messages about AIDS between 1986 and 1990 showed that the State and the church were equally at fault as noted:

Messages such as ‘_AIDS kills. ...Beware!’ and pictures of skulls and crossbones were used on posters about HIV. The nature and character of the virus was sensationalised, primarily by service providers, while at the same time, churches moralised about HIV and linked it to promiscuity and sin.⁵⁸¹

This situation was further propelled by the high rate of either ignorance or misinformed messages about AIDS. Caregivers were generally scared of providing assistance to PLHIV due to the fact that there was no clear information about the disease.⁵⁸² Neither the government nor the church was an angel on this issue.⁵⁸³ Whereas the Roman Catholic Church could be blamed for taking an entirely moralistic approach, the government was equally responsible for adopting frightening approaches in the sensitisation of communities on HIV and AIDS.

The practice of volunteerism in providing home-based care to PLHIV was relatively new to members of the Roman Catholic Church as well as among other churches in Manicaland. The FACT organisation was the first institutions to initiate voluntary home-based care at St. Joseph’s TB hospital, Mutare in 1990.⁵⁸⁴ In 1990, when the FACT home-based care project was initiated, volunteers were sceptical about possible contamination through contact with HIV positive people. This was the first time the general public was invited in recent times to volunteer in the context of responding to

⁵⁸⁰ See Irish Aid, *Looking back, mapping forwards*, 30.

⁵⁸¹ See Irish Aid, *Looking back, mapping forwards*, 29.

⁵⁸² HDN, *Caring from within*, 17.

⁵⁸³ V. Chitimbire, same interview.

⁵⁸⁴ Madava, *The FACT story*, 9.

a pandemic such as HIV and AIDS. It is thus not surprising that the concept of volunteerism in the context of caring for PLHIV was met with mixed feelings. Despite untoward feelings and notions about volunteerism, FACT laid a foundation that the diocesan AIDS-related project's voluntary caregivers' programme utilised in Manicaland. This was despite some challenges, including perceptions among the first voluntary caregivers that in return for rendering support services to PLHIV, rewards were seen as an entitlement for the 'sacrifices' they made.⁵⁸⁵

A respondent, Christine Mombe, a member of the Roman Catholic Church in Mutare, explained that many of her friends who enrolled as voluntary caregivers at St. Joseph's mission gave up this service. The reason being that people expected to be remunerated but unfortunately that was not forthcoming.⁵⁸⁶ The people, mainly women, who joined this programme in the early 1990s, expressed frustration at the little recognition of their efforts by the diocesan project. Thus the notion that community members were obliged to support fellow PLHIV voluntarily had limitations. One of the arguments advanced by voluntary caregivers was that home-based care for PLHIV, which was supported by donors including the diocesan project in Manicaland, failed to adequately recognise the 'dirty' work done by unpaid servants. The argument given was that while fellow villagers engaged in productive work for the direct benefit of their families, voluntary caregivers spent time in community service.⁵⁸⁷ Voluntary caregivers perceived AIDS-related care as having created employment opportunities for villagers. Volunteerism opened up prospects of earning money and obtaining household supplies including food.

Before the establishment of FACT in 1987 and the launch of the Roman Catholic Church's diocesan project in 1992, as far as the present study was aware of, there were no other faith-based HIV and AIDS programmes in Manicaland. None of the Anglican and the United Methodist churches in Manicaland had established publicly known HIV and AIDS programmes including home-based care. In Manicaland, the Roman Catholic Church was the first church to initiate a well-structured HIV and AIDS care programme. The FACT is a Christian-oriented organisation but not related

⁵⁸⁵ C. Mombe, interview conducted by M. Mbona, DOMCCP office, Mutare, 19 August 2010.

⁵⁸⁶ C. Mombe, same interview.

⁵⁸⁷ E. Tichawangana, same interview. See also A. Dera, interview conducted by M. Mbona, Triashill mission, 9 September 2010.

to a specific church denomination. Nationally, the initiatives of the Roman Catholic Church in home-based care were among the earliest. By 1994 the number of AIDS service organisations countrywide expanded, leading to the formation of the Zimbabwe AIDS Network. The involvement of the Roman Catholic Church's diocesan project in this forum created a new platform to lobby the State and donors for support.⁵⁸⁸ The participation of the diocesan project in HIV and AIDS issues at the national platform also put the church on the map of HIV and AIDS-related organisations in Manicaland and Zimbabwe.⁵⁸⁹

The philosophy behind the work of the diocesan project was that of providing services to all people regardless of religious or denominational affiliation. However, there was also a perception that the noble intentions of the project's care programmes were at times affected by denominational affiliation and favouritism.⁵⁹⁰ For example, a respondent from the Anglican Church mentioned that within the Roman Catholic Church's project, the process of identifying OVC for care purposes was riddled with nepotism that involved caregivers who ensured that the children closely related to them benefited ahead of others.⁵⁹¹ Arguably, economic decline following the introduction of economic reforms by the State in Zimbabwe reached a point whereby in some families external support for PLHIV and OVC stirred hopes for money and food. Thus, in the 1990s AIDS-related funding under the diocesan project became a new source of hope for communities living in poverty amid an ailing public healthcare system. The HIV and AIDS home-based care interventions popularised the Catholic Diocese of Mutare through its involvement in donor funded community healthcare initiatives. The programmes supported by donor funds through the diocesan project included –HIV and AIDS awareness, home-based care, orphan care, psychosocial support and income generating initiatives.”⁵⁹²

⁵⁸⁸ Zimbabwe AIDS Network, <<http://www.kubatana.net/html/sectors/zim001.asp?sector=HIVAID/>> [Accessed 27 June 2011].

⁵⁸⁹ Information supplied by J. Nyamande to M. Mbona, DOMCCP head office, St. Joseph's mission, Sakubva, Mutare, 10 June 2010. See also DOCCPM, ZAN review: Annual report of the Zimbabwe AIDS Network, (2010), 3.

⁵⁹⁰ A. Dera, same interview.

⁵⁹¹ N. Mushawa, interview conducted by M. Mbona, St. Matthew's Vengere, Rusape, 12 September 2010.

⁵⁹² See DOMCCPM, DOMCCP, Evaluation report, January 1993-June 1995.

The strength of the diocesan project lay in the fact that it was community driven. This made it important to develop collegial relationships at local community level. Theologically, the church's principle of collective participation of church members in seeking to serve one another strengthened the involvement of the community in the care of PLHIV and OVC. This meant that the work of caring for PLHIV and OVC was the responsibility of everyone and not just the few full-time professional church workers running institutions for the population in general.⁵⁹³ In other words, the hallmark of the home-based and OVC care interventions by the diocesan project was the adoption of a transformational approach. The church was the local Christian community living out their Christian vocation by working wholeheartedly for their own and their neighbours' social development.⁵⁹⁴ It therefore followed that as part of Christian community service, the Roman Catholics were obliged by the church's teaching to be involved in HIV and AIDS prevention, care and mitigation.

The Roman Catholic Church's hospitals in Manicaland assumed new status—from being providers of ordinary medical care to being sites used for carrying out the church's HIV and AIDS interventions. This became important for the success of the programme because the healthcare centres provided a point of contact between PLHIV and AIDS-related care and treatment services. The nuclei include Triashill, St. Barbara (Mutasa), Avila, Mt. Mellery and Regina Coeli (Nyanga), St. Michael and St. Therese (Makoni), St. Peter's (Chipinge), St. Joseph's Sakubva (Mutare), and St. Andrew (Marange).⁵⁹⁵ In this light, the healthcare centres contributed to the provision of better services for PLHIV by recruiting and training voluntary caregivers, providing sanitary materials and some food as well as meeting other needs such as drugs. While stigmatisation and discrimination of PLHIV did not disappear immediately, the use of the church's healthcare centres enabled the diocese to also show that the HIV and AIDS pandemic is a biomedical reality and public health issue. This approach to HIV and AIDS interventions by the diocese project in Manicaland became unique because it brought together medical personnel, church members, the community and clients.

⁵⁹³ Mutume, "The priorities of the Zimbabwe Catholic Bishops Conference," 470.

⁵⁹⁴ Mutume, "The priorities of the Zimbabwe Catholic Bishops Conference," 470.

⁵⁹⁵ Information supplied by J. Nyamande to M. Mbona, DOMCCP head office, St. Joseph's mission, Sakubva, Mutare, 10 June 2010. See also DOMCCPM, Evaluation report, January 1993-June 1995.

From 1992 onwards the healthcare centres under the Roman Catholic Church in Manicaland gained more limelight than other healthcare centres in the province. The network of the church's healthcare institutions in Manicaland enhanced access to HIV and AIDS prevention, awareness, care and mitigation for the rural folk. Thus, the introduction of community AIDS-related care programmes at the Roman Catholic hospitals cast a positive image of the church in those communities. However, this had the effect of overloading the nurse-in-charge and doctors who assumed new responsibilities of supervision of community AIDS-related care programmes.⁵⁹⁶

Apart from the aforementioned setbacks, the programme scored some achievements in supporting a target of 600 HIV infected and affected individuals in its first two years, from 1992-1993.⁵⁹⁷ For example, in 1993 a total of 365 people received Z\$ 6,999,576 for painkillers, food, protective wear and school fees.⁵⁹⁸ Some examples of OVC support showed that Avila received Z\$3,100 for food and Z\$1,363 school fees, Mt. Mellery received Z\$2,000 for food and Z\$372 for fees, St. Barbara received Z\$1,700 for food and Z\$1,376 for fees, and St. Therese received Z\$2,100 for food only. Drugs for the amount of Z\$11,915, protective clothing worth Z\$12,861 and linen worth Z\$953,122 were purchased.⁵⁹⁹ By the end of 1993 a few income generation projects were initiated at Mt. Mellery, St. Barbara, St. Peter and Avila for an amount of Z\$1,1184,91.⁶⁰⁰ However, compared to the demand for support, the achievements were almost insignificant. On a positive note, the church showed solidarity by initiating care support for people infected and affected by HIV and AIDS.

Under the diocesan project, twenty-two workshops were held at nine institutions with 1 041 participants in 1992. The initiatives included HIV and AIDS awareness, skills empowerment, and care and prevention measures.⁶⁰¹ Some of the topics and aspects covered include: (a) current trends and facts about AIDS, (b) communication, pastoral counselling skills, (c) moral and cultural issues, (d) sickness, death and dying, (e)

⁵⁹⁶ DOMCCPM, DOMCCP, Evaluation report, January 1993-June 1995, 13.

⁵⁹⁷ DOMCCPM, DOMCCP, First progress report of MCHC CRS project, January 1993- December 1993, 1.

⁵⁹⁸ DOMCCPM, DOMCCP, First progress report of MCHC CRS project.

⁵⁹⁹ DOMCCPM, DOMCCP, First progress report of MCHC CRS project, 2.

⁶⁰⁰ DOMCCPM, DOMCCP, First progress report of MCHC CRS project, 3.

⁶⁰¹ DOMCCPM, DOMCCP, First progress report of MCHC CRS project.

infection control measures, (f) care of the sick at home, and (g) responsible behaviour.⁶⁰² In 1993, workshops were mounted at Avila (1) Mt. Mellery (2) Regina Coeli (2), St. Andrew (2) Triashill (1), St. Barbara (4), St. Michael (5), St. Peter (2) and St. Therese (3).⁶⁰³ At Triashill, the cordial relationship between the nurse-in-charge of the hospital and the priests enabled the smooth imparting of HIV and AIDS awareness messages.⁶⁰⁴ At St. Paul's Dangamvura,⁶⁰⁵ St. Simon Stock, Rusape⁶⁰⁶ and the Cathedral of the Holy Trinity, Mutare the experiences were negative.⁶⁰⁷ The creation of Mutare Community Home Care as an AIDS service organisation transformed the diocesan structures including the recruitment of new employees. Apparently, some Catholics felt that the creation of the diocesan project could have been avoided and did not necessarily hold AIDS-related activities under the semi-autonomous organisation in a positive light.⁶⁰⁸

The diocesan project's AIDS-care interventions made a positive mark on a number of communities, whereby voluntary caregivers were held in high esteem by fellow community members."⁶⁰⁹ Within communities, the visibility of church's HIV and AIDS interventions was reinforced by the fact that the church's integrated care support programme was unique. The findings from a study of home-based care in Zimbabwe between 1991 and 1995 noted that church volunteer groups were formed and driven by Christian values. Care volunteers visited homes to provide spiritual support, "end of life" counselling and welfare support.⁶¹⁰ Even though some of them could have been Christians, volunteers were human beings with specific material needs. It is important to note that studies on voluntary caregivers carried out by external agencies were possibly not fully aware of some of the intricate dynamics within volunteering in a time of AIDS.

⁶⁰² DOMCCPM, DOMCCP, First progress report of MCHC CRS project, 4.

⁶⁰³ DOMCCPM, DOMCCP, First progress report of MCHC CRS project.

⁶⁰⁴ E. Tichawangana, same interview. See also A. Dera, same interview.

⁶⁰⁵ C. Nyemba, interview conducted by M. Mbona, Fern Valley, Mutare, 2 September 2010.

⁶⁰⁶ R. Chiome, same interview.

⁶⁰⁷ G. Maedze, interview conducted by M. Mbona, Cathedral of the Holy Trinity, 25 August 2010.

⁶⁰⁸ Information supplied by A. Vinyu to M. Mbona, Mutare, 10 June 2010. See also J. Nyangadi, interview conducted by M. Mbona, Kriste Mambo, 29 September 2010.

⁶⁰⁹ A. Dera, same interview.

⁶¹⁰ Irish Aid, *Looking back, mapping forwards*, 30.

The fact that HIV either infected or affected everyone also motivated ordinary people to be involved in interventions. This realisation triggered calls for increased workshops, formation of health committees, and drama groups.⁶¹¹ Thus, the Mutare Community Home Care programmes were unique. The project staff fostered teamwork through collaboration among community-based AIDS action teams formed in villages, voluntary caregivers, and medical personnel at the church's hospitals. While the diocesan project posted some scores of success, enough homework was not done on designing programmes and making them accessible in the local Shona or Manyika language. In using the English language only in its programmes, the project was naïve to the fact that language was an important tool in communicating mass-centred HIV and AIDS related messages. HIV and AIDS overwhelmed the project's capacity to meet the high demand for services. The operational environment for the project was not that supportive, given the fact that the State healthcare system was declining while cases of PLHIV and OVC were on the rise.⁶¹²

HIV and AIDS interventions by the diocesan project were community based and thus the recruitment of voluntary home-based caregivers involved the input of traditional community structures. For example, in 1993 at Triashill, the selection of voluntary caregivers was done openly at the community meetings,⁶¹³ and the same situation prevailed at Nyahukwe.⁶¹⁴ This level of transparency enabled communities to select candidates as voluntary caregivers and enshrined a sense of collective ownership and responsibility for the project. However the diocesan project was also overwhelmed by a number of setbacks arising from inadequate planning, poor resource availability, lack of proper guidelines on volunteerism, lack of proper training for volunteers and lack of reference resources such as HIV and AIDS booklets.⁶¹⁵ One of the actions taken by the project in order to deal with some of the challenges is that obtaining technical assistance from FACT whose strength lay in offering specialised and well-structured HIV and AIDS related training programmes.⁶¹⁶ The propensity by the two

⁶¹¹ M. Mudzimiri, same interview. See also T. Nyawera, same interview.

⁶¹² DOMCCPM, DOMCCP, First progress report of MCHC CRS project, 4.

⁶¹³ E. Tichawangana, same interview.

⁶¹⁴ M. Mudzimiri, same interview.

⁶¹⁵ DOMCCPM, DOMCCP, Evaluation report, January 1993-June 1995, 17-22.

⁶¹⁶ DOMCCPM, DOMCCP, Evaluation report, January 1993-June 1995, 14. See also DOMCCPM, DOMCCP, First progress report of MCHC CRS project, 4. G. Foster, "FACT- How it all began: A personal account," in Madava, *The FACT story*, 6. See also Madava, *The FACT story*, 8-9.

organisations not to view each other as competitors appeared to enhance teamwork.⁶¹⁷ Therefore, to a large extent, early HIV and AIDS interventions by the Roman Catholic Church in Manicaland benefited from support gained from FACT.

The two FBOs shared a history of collaborative effort in carrying out HIV interventions. In 1990, FACT benefited from the facilities at St. Joseph's hospital, a Roman Catholic healthcare centre. This enabled training of volunteers in home-based care and counselling services.⁶¹⁸ Some of the church's clergy and laity were also involved in the work of FACT prior to the formation of the diocesan AIDS care project. For example, Father Martin O'Regan, stationed at St. Joseph's mission, Mutare, mentioned that he had been involved in the work of FACT in Mutare since the late 1980s. Accordingly, this opened opportunities for O'Regan to gain first-hand experience of Christian led HIV and AIDS interventions.⁶¹⁹ The FACT worked with urban and rural communities and also trained the first voluntary home-based caregivers in Manicaland.⁶²⁰ To suggest that the diocesan project positioned itself in competition against the State healthcare system in this period (1985-1994) is an inaccurate assertion. In fact there was a high degree of collaboration between the State and the church's healthcare systems. This is evident from networking between the project's staff and the State's provincial medical director for Manicaland.⁶²¹ The Government of Zimbabwe held the diocesan project in high esteem, as noted in a statement in the report. The statement illustrates that the Roman Catholic Church's home-based care projects were of good repute.⁶²²

3.2.5. AIDS-Related Denial and Stigma at the Grassroots Level

Within the Roman Catholic's Diocese of Mutare, HIV and AIDS denial and stigma were hallmarks of the way Christians generally perceived the epidemic during the

⁶¹⁷ See, A. C. Ongaro, "The role of the church in the development market: The case of Zimbabwe," in Hallencreutz and Palmberg (eds), *Religion and politics in southern Africa*, 178.

⁶¹⁸ Madava, *The FACT story*, 9.

⁶¹⁹ M. O'Regan, same interview.

⁶²⁰ G. Foster, same interview. See also C. Mombe, same interview. See also E. Tichawangana, same interview. See also M. Mudzimiri, same interview.

⁶²¹ DOMCCPM, DOMCCP, Evaluation report, January 1993-June 1995, 14.

⁶²² DOMCCPM, DOMCCP, Evaluation report, January 1993-June 1995, 14.

early years. Some respondents expressed a perceived connection between HIV and AIDS awareness and the death of Zimbabwean military personnel guarding the oil pipeline in Mozambique. For example, at St. Paul's Dangamvura in Mutare a respondent mentioned that in late 1980s AIDS was responsible for the death of some Zimbabwean soldiers on national duty in Mozambique.⁶²³ The perception that army personnel in Zimbabwe were understandably prone to high risks of HIV due to the nature of their duties, emerged from another lay Roman Catholic.⁶²⁴ In the early years of the epidemic in Zimbabwe public perceptions that associated HIV with army personnel and promiscuity were common and may have shaped people's responses to the AIDS epidemic. The apportionment of blame on others for having caused the epidemic was also evident in the following statement of Cecilia Mauye who stated: –Promiscuity of both men and women was to blame for the inroads made by AIDS into the community.’⁶²⁵ George Maedze has also pointed out that between 1985 and 1995 at Triashill it was common to hear people, including some of the church's members whispering to each other about a strange disease.⁶²⁶ In Rusape, some Christians became suspicious of those individuals suffering from what people termed a ‘slimming disease,’ or a disease that made one's hair unusually soft.⁶²⁷ These perceptions from some members of the Roman Catholic Church in Manicaland had an effect on HIV interventions at the grassroots level.

Furthermore, between 1985 and 2000 the Manyika people's worldview that witchcraft was the underlying cause of the epidemic enhanced the denial of HIV and AIDS.⁶²⁸ The fact that some Roman Catholic Church followers tended to associated HIV and AIDS with witchcraft and occult forces negatively affected prevention strategies by imparting inaccurate information, and therefore enhancing denial. Since AIDS was a new disease, ordinary people struggled to understand its origins and mode of transmission. For example, in 1993, strong beliefs in traditional myths and spirits, prevented communities from appreciating biomedical explanations of HIV and AIDS. Others associated AIDS with ‘*runyoka*’, a cultural taboo in which a man who

⁶²³ T. Nyawera, same interview. See also information supplied by A. Vinyu to M. Mbona, Mutare, 10 June 2010.

⁶²⁴ M. Mudzimiri, same interview.

⁶²⁵ C. Mauye, interview conducted by M. Mbona, Vengere, Rusape, 21 August 2010.

⁶²⁶ G. Maedze, same interview. See also T. Nyawera, same interview.

⁶²⁷ C. Mauye, same interview.

⁶²⁸ G. Maedze, same interview.

suspected that his wife was unfaithful obtained traditional charms from a traditional health practitioner.⁶²⁹ The charms bring affliction to any man the married woman had sexual intercourse with other than her husband and the ‘trespasser’ wastes away.⁶³⁰ Sex is therefore protected by a number of taboos and *runyoka* was one of them.⁶³¹ The difference between *runyoka* and HIV was that *runyoka* is, however curable with a traditional healer’s intervention; HIV/AIDS is not.”⁶³²

Some Christians including some members of the Roman Catholic Church believed that traditional health practitioners could eradicate HIV. At grassroots level people associated HIV and AIDS with witchcraft and did not accept biomedical explanations. At the same time people also trusted traditional healers who claimed to cure AIDS. This affected the input by the diocesan project in carrying out HIV interventions especially among HIV positive people. The intensity of this problem led the project officers to initiate meetings with traditional leaders as will be discussed in the next chapter. In the wake of HIV and AIDS the Roman Catholic Church in Manicaland was made to re-examine its teachings on sexuality, traditional healing, myths and spirits in the context of the Christian faith.

During the period 1985 to 1994 there was also a general understanding that HIV and AIDS is something outside the church.⁶³³ Women were the first group to seek ways of openly discussing HIV and AIDS-related issues since the early 1990s. For example, within the Roman Catholic Christian women’s guilds, special sessions on HIV and AIDS became a regular feature at weekly meetings in Mutare, Mutasa and Rusape in 1990.⁶³⁴ Fellow guild members, clergy and health experts delivered lessons that focused on HIV and AIDS awareness, stigma and other aspects. The same platforms became space for women from the Roman Catholic Church to encourage each other to

⁶²⁹ G. Maedze, same interview.

⁶³⁰ D. Simmons, —African witchcraft at the millennium: Musings on a modern phenomenon in Zimbabwe,” *The Journal of the International Institute* 7/ 2 (2007), downloaded as a pdf, 20 March 2011. See also R. P. Hatendi, —Shona marriage and the Christian churches,” in Bourdillon, *Christianity south of the Zambezi*, 139.

⁶³¹ See also Hatendi, —Shona marriage and the Christian churches,” 139.

⁶³² Simmons, —African witchcraft at the millennium.”

⁶³³ C. Mombe, same interview.

⁶³⁴ E. Tichawangana, same interview. See also C. Mauye, same interview.

embrace those infected and affected by HIV and AIDS.⁶³⁵ At times AIDS-related stigma was self-imposed by PLHIV and not by the people they lived with. Consistent with this assertion, Chiome mentioned: –The infected person tended to develop feelings of self-guilt and shame due to the tendency of associating AIDS with promiscuity.”⁶³⁶ If there was something about HIV and AIDS that the churches, including the Roman Catholic Church, struggled to deal with in their respective reactions between 1985 and 1994, stigma was one such an issue. Among the Shona speaking people, including the –Manyika” of eastern Zimbabwe, AIDS being similar to sexually transmitted infections is a disease that one could not mention openly. In addition to linking it with witchcraft, AIDS was perceived, as a disease that exposed the evils of a person’s sexual ill discipline.⁶³⁷ Although within the diocese, pastoral agents were trained to provide psychosocial support to PLHIV, stigma mitigation gradually took effect from the late 1990s to mid-2000s.

At the local parish level HIV and AIDS was not a regular item on the formal agenda of parish council meetings. This is noted from parish council meetings held at St. Simon Stock Roman Catholic between 1991 and 1994.⁶³⁸ However, in June 1994 at a meeting of the parish council a proposed HIV and AIDS awareness youth seminar to be held St. Joseph’s, Vengere on 24-26 June 1994 was approved.⁶³⁹ The general absence of HIV and AIDS talks in the priest-in-charge’s ministry to adult congregants at St. Simon Stock shows that there was also lack of cohesion in the manner in which clergy reacted to the pandemic. At the Roman Catholic Church’s Cathedral of the Holy Trinity in Mutare silence on HIV and AIDS was noted from the parish council meetings held in 1987,⁶⁴⁰ 1988,⁶⁴¹ and 1991.⁶⁴² Given the reality that lay members looked up to the clergy for guidance and leadership, low levels of awareness at the parish level therefore caused possible harm.

⁶³⁵ E. Tichawangana, same interview. See also C. Chitsungo, same interview. See also V. Chibatamoto, same interview. See also T. Nyawera, same interview.

⁶³⁶ R. Chiome, same interview.

⁶³⁷ E. Tichawangana, same interview. See also A. Dera, same interview.

⁶³⁸ St. Simon Stock Roman Catholic parish archives, Rusape, (SSCPR), Minutes of parish council meeting, 1991-1994.

⁶³⁹ SSCPR, Minutes of parish council meeting, 10 June 1994.

⁶⁴⁰ The Cathedral of the Holy Trinity archives, Mutare (CHT), Minutes of parish council meetings, 17 November 1987 and 15 December 1987.

⁶⁴¹ See CHT, Minutes of parish council meetings for 16 February 1988, 15 March 1988, 28 April 1988.

⁶⁴² See CHT, Minutes of parish council meeting, 30 March 1991.

Chiome has shown that at St. Simon Stock the priest mainly carried out HIV and AIDS awareness and prevention activities with the youth at the peril of adult church members. Chiome shared a perception that the youth were prey to HIV and AIDS because of they failed to take the Roman Catholic Church's teachings on morality seriously as opposed to the case in former years.⁶⁴³ The 'then' and 'now' trend observed by Ronald Grele among interviewees when speaking about the past in comparison with the present appears to be of relevance.⁶⁴⁴ In another case, at St. Paul's in Dangamvura, there was also a perception among lay people that talking about HIV and AIDS during church services was an embarrassment. For example, Caston Nyemba, a male parishioner, mentioned that one could not discuss AIDS in the church without reference to sex and health.⁶⁴⁵ Nyemba's opinion that matters of sex and health were private and personal—if widely shared—may have led to low-key engagement in HIV and AIDS interventions at the parish level.

3.3. The Anglican Church's Response to HIV and AIDS

This section indicates that despite having three healthcare centres including St. David's Bonda mission hospital, schools and parishes in Manicaland the church's reaction to HIV and AIDS was quite slow and largely negative. The fact that each diocese in the Anglican Church is an autonomous ecclesiastical unit headed by a diocesan bishop gave reason to argue that the diocesan bishop was responsible for the choice of priorities.⁶⁴⁶ A bishop exercised ecclesiastical authority within a diocesan synod.⁶⁴⁷ It was a bishops' choice to consider HIV and AIDS interventions as a priority issue for the Anglican Church in Manicaland.

In the early 1980s some church leaders affiliated to Zimbabwe Council of Churches including Bishop Masuko, held the new political dispensation of Robert Mugabe in suspicion over the possibility of the introduction of communism into the country. The Zimbabwe Council of Churches' affiliate denominations were held in limbo since

⁶⁴³ R. Chiome, same interview.

⁶⁴⁴ R. Grele, *Envelops of sound: The art of oral history*, Second Edition, (Praeger: New York, 1991), 213-241.

⁶⁴⁵ C. Nyemba, same interview.

⁶⁴⁶ MM. CPCA, *Constitution and canons of the CPCA*, 6.

⁶⁴⁷ MM, CPCA, *Constitution and canons of the CPCA*, 7.

none of them were certain of the ideological direction that Mugabe was likely to take. However, the positive attitude taken by the Zimbabwe African National Union Patriotic Front (ZANU PF) and the government towards the churches in independent Zimbabwe since 1980, confounded anti-communist propagandists who thought the new political dispensation was totally opposed to Christianity.⁶⁴⁸ The relations between Bishop Masuko and ZANU PF took a plunge in March 1986 when a Mutare based ZANU PF Member of Parliament, Edgar Tekere, successfully incited a mob to desecrate the Anglican Church's Cathedral of St. John the Baptist in the city of Mutare.⁶⁴⁹ The cautious position taken by the leadership of the Anglican Church in Manicaland on social development issues affected the church's responses to HIV. The study explored the effects of AIDS-related stigma on the way elements of the Eucharistic were distributed. It also examined how spiritual healing exploits by the Reverend Livingstone Nerwande could have been a manifestation of the church's denial of HIV and AIDS.

3.3.1. Delayed HIV and AIDS Interventions by the Leadership

Within the Anglican Church in Harare, Rogers of the Roman Catholic Church reportedly discussed HIV and AIDS at a seminar with the clergy and laity of the Anglican Church in February 1988.⁶⁵⁰ Some members of the Anglican Church in Harare carried out limited HIV and AIDS interventions earlier than fellow Anglicans in Manicaland. For example, in 1988 Chad Gandiya, who was then a priest and currently serves as bishop of the diocese of Harare, joined an AIDS initiative led by Rogers.⁶⁵¹ Gandiya and other Anglican clergy from Harare attended meetings organised by Rogers.⁶⁵² The fact that Anglicans in Harare invited Rogers, and that Gandiya chaired the AIDS Counselling Trust committee from the late 1980s to the early 1990s, serves to indicate that some fellow Anglicans in Harare valued HIV and

⁶⁴⁸ M. Lapsley, —Anglican Church and State from UDI in 1965 until the independence of Zimbabwe in 1980,” in Hallencreutz and Moyo, *Church and State in Zimbabwe*, 125. See also S. Bakare, —Christianity and scientific socialism in Zimbabwe,” in Hallencreutz and Moyo, *Church and State in Zimbabwe*, 477-493.

⁶⁴⁹ D. Maxwell, —The church and the democratisation in Africa: The case of Zimbabwe,” in P. Gifford (ed), *The Christian churches and the democratisation of Africa*, (Leiden: E. J. Brill, 1995), 116.

⁶⁵⁰ Rogers, *Jesuit, social pioneer and AIDS activist*.

⁶⁵¹ See the section on Edward T. Rogers earlier in this chapter.

⁶⁵² T. Rogers, same interview.

AIDS interventions.⁶⁵³ However, the initiatives involving the Anglican Church in Harare and supported by Rogers did not result in institutional diocesan programmes. The attempt by the Diocese of Harare to draw attention to the pandemic was a positive step. Rogers and Gandiya had known each other for some years and this network possibly accounted for why they were jointly involved in the setting up one of the earliest few AIDS service organisations in Zimbabwe.

Apparently, the leadership of the Anglican Church in Manicaland adopted a lukewarm approach to HIV and AIDS-related issues in the late 1980s as was also echoed by Geoff Foster, founding director of FACT. Foster elaborated that the lack of interest in HIV and AIDS interventions by the Anglican Church's leaders in Manicaland indicated that the bishop and clergy did not perceive the epidemic to be a critical life-threatening issue until later years.⁶⁵⁴ Furthermore, Foster's observation that bishops were only interested in HIV and AIDS interventions where their positions could be affirmed could have accounted for Bishop Masuko's unwillingness to join hands with FACT. This lack of interest in HIV and AIDS on the part of the Anglican Church's clergy was also acknowledged by an internal source to the diocese. For example, the Reverend Obert Murakwani who was stationed in Mutare since 1985, alluded to the fact that there was little attention given to HIV and AIDS at diocesan meetings because clergy and laity shied away from talking about the pandemic.⁶⁵⁵ While some Anglicans in Harare had responded early to HIV and AIDS, the initiative did not necessarily translate into widespread action across other Anglican dioceses in Zimbabwe. However, at least a handful of medical personnel serving at some of the church's healthcare centres became aware of the pandemic and carried out limited HIV awareness activities. For example, at St. Peter's Mandeya clinic the nurse-in-charge, Cora Dekker, an expatriate from the Netherlands, successfully organised public HIV and AIDS education and awareness meetings and received support from the community and the State from 1992 to 1994.⁶⁵⁶

⁶⁵³ Information supplied by C. Gandiya to M. Mbona through email. 7 February 2011.

⁶⁵⁴ G. Foster, same interview.

⁶⁵⁵ O. Murakwani, interview conducted by M. Mbona at St. Bartholomew's parish, Rusape, 4 May 2011.

⁶⁵⁶ Information supplied by Cora Dekker to M. Mbona on 7 August 2011. Dekker worked as an expatriate nurse at St. Peter's Mandeya clinic between 1991 and 1994 and was in Durban on holiday in 2011.

Similarly, Bishop Ishmael Mukuwanda of the Anglican Diocese of Central Zimbabwe confirmed the diocese's late involvement in responding to the HIV epidemic. Mukuwanda further noted that it was only in April 2003 that the diocesan HIV and AIDS service organisation called St. Patrick's HIV and AIDS Actions Programme was established.⁶⁵⁷ Thus, at the official level, within the Anglican Diocese of Manicaland and the Anglican Church in Zimbabwe in general, HIV and AIDS received limited attention. The slow pace at which the church's leadership in Manicaland responded to HIV and AIDS was a common trend as obtaining from its sister dioceses in Zimbabwe. Within the Church of the Province of Central Africa, provincially coordinated HIV and AIDS interventions were only established after 2001.⁶⁵⁸ The Anglican Church's polity recognised dioceses as autonomous entities and this entailed that diocesan bishops and synods could either chose to prioritise or not prioritise on HIV interventions. This accounted for the level of diversity found within the Anglican Communion's engagement with HIV and AIDS.⁶⁵⁹

The leadership of the Anglican Church in Manicaland had its priorities set on evangelism and building up financial resources for the new diocese. For example, at the Anglican Church in Zimbabwe centenary in 1991 Bishop Masuko highlighted the evangelism as a major thrust in Manicaland as stated: "The church has a mandate and involvement with the world in its evangelism. It brings healing, reconciliation, and prophetically declares God's judgement against corruption in society."⁶⁶⁰ Growing up as a young adult Anglican in the 1990s, the researcher recalls a strong thrust accorded to evangelism by the diocesan leadership. The focus on evangelism activities at the diocesan level could be traced to the Lambeth Conference of 1988 that declared the years between 1990 and 1999 as the "Decade of Evangelism."⁶⁶¹ However, this could not justify the slow pace at initiating HIV and AIDS interventions that could have assisted Anglicans and other people as well. Consistent with this observation, Lapsley noted that "the Anglican Church [in Zimbabwe] had always been concerned with sin

⁶⁵⁷ Information supplied by I. Mukuwanda, Response to M. Mbona's email: Diocese of Central Zimbabwe, February 2011.

⁶⁵⁸ Anglican United Nations office, *Working together: The Anglican Communion response to HIV and AIDS in Africa* (Geneva, 2007), 10.

⁶⁵⁹ Anglican United Nations office, *Working together*, 9.

⁶⁶⁰ Weller, *Anglican centenary in Zimbabwe*, 25-26.

⁶⁶¹ Decade of Evangelism, Lambeth Conference, <http://en.wikipedia.org/wiki/Decade_of_Evangelism/> [Accessed 23 March 2011].

without addressing the social, political and economic factors responsible for sinful behaviour. The church lacked an analytical theological methodology.”⁶⁶² The Anglican Church’s evangelism campaigns focused primarily on conversion and drew little attention to teachings on Christian living. The latter approach stressed the importance of enabling Christians to live out a new life but it was not supported by regular teachings that stressed strictness on sexual discipline.⁶⁶³ There is nothing unusual for a church to focus on evangelism but the study notes that competing interests could have overshadowed the reaction of the diocesan leadership to HIV and AIDS. Apparently, more emphasis was placed on evangelism and capacity building than on the growing epidemic.

Bishop Masuko attended the Lambeth Conference of 1988 where a resolution on AIDS was passed.⁶⁶⁴ The assembly of bishops from the worldwide Anglican Communion took note of the rapid spread of the catastrophic HIV epidemic and _mandated‘ the bishops to respond to the crisis by giving a lead in:

The promotion, of and co-operation with, educational programmes both of church and State concerned with the cause and prevention of the disease, in a loving and non-judgemental attitude to those who suffer. To develop diocesan strategies: to train and support pastoral helpers; to give direct personal support to those living with AIDS [PLHIV]; to identify and try to resolve the social problems leading to and arising from the disease; to reaffirm the traditional biblical teaching that sexual intercourse is an act of total commitment which belongs properly within a permanent married relationship...to encourage global c-operation between churches, governments and nongovernmental agencies in the fight against the disease, to develop ways in which churches can share information and resources, to press where necessary for political action.⁶⁶⁵

However, HIV and AIDS interventions at the diocesan level in Manicaland were either delayed or existed at a low key. The lack of HIV and AIDS interventions in the Anglican Church in Manicaland appeared common as what obtained from other parts

⁶⁶² Lapsley, —Anglican Church and State,” 125.

⁶⁶³ Marshall and Taylor, —Fackling HIV and AIDS with faith-based communities,” 368-369.

⁶⁶⁴ Anglican Consultative Council, *The truth shall make you free: The Lambeth Conference 1988, The reports, resolutions and pastoral letters from the bishops*, (London: Church Publishing House, 1988), 245.

⁶⁶⁵ Anglican Consultative Council, *The truth shall make you free*, 222-223.

of the Anglican Communion in Africa. In 1993 James Thrall and James Rosenthal of the Anglican Communion News Service observed:

As late as the 1988 Lambeth Conference, bishops from Africa were denying that there was a disease called AIDS. It could well be that the fact Anglicans do meet together internationally and share and consult with each other, that has brought about change in the way some African prelates look at the trauma of AIDS.⁶⁶⁶

After the Lambeth Conference of 1988 some Anglican bishops from Africa went back to their dioceses committed to stamping out the tide of HIV and AIDS. For example, the Archbishop of Uganda mobilised clergy and laity to confront the pandemic.⁶⁶⁷ This did not happen in Manicaland. Bishop Masuko's pastoral letter for Christmas and New Year (1994) appeared to be silent on any reference to HIV and AIDS.⁶⁶⁸ Within Anglican clergy, perceptions regarding HIV and AIDS were altered by first-hand experiences of AIDS-related illness and subsequent death of family members or close friends. When it happened elsewhere, the tendency was ~~to~~ look at the HIV epidemic as something far away."⁶⁶⁹ The church's followers were infected and affected by HIV and AIDS more than the church's efforts at HIV prevention and AIDS mitigation. It has to be noted that the Anglican Church structures in Manicaland appeared to have taken a passive approach to the epidemic.

3.3.2. AIDS-Related Stigma and the Chalice

The Anglican Church in Manicaland was not the first part of the Anglican Communion where concerns of fear of HIV infection from drinking wine from the same chalice were noted. Within other parts of the Anglican Communion, the chalice and HIV became a subject of debate among bishops of the dioceses of Canterbury and York in 1987. Historically, Canterbury is the oldest diocese of the Anglican Communion and is followed after by York. In 1987 Archbishops Robert Runcie and

⁶⁶⁶ J. Thrall and J. Rosenthal, "AIDS," *Anglican World: Special edition of the Compass Rose*, (Lent/Easter 1993), 10.

⁶⁶⁷ Thrall and Rosenthal, "AIDS," 10-11.

⁶⁶⁸ Holy Name parish archives, Sakubva, (HNM), Bishop Elijah Masuko's Christmas and New Year pastoral message, 1994/95.

⁶⁶⁹ K. Nyazika, interview conducted by M. Mbona, Anglican diocesan office, Mutare, 1 September 2010.

John Ebnor of Canterbury and York respectively issued a statement on behalf of the House of Bishops of the Church of England, part of which read:

Public concern about AIDS has aroused fears among some people that the sharing of the common cup might be a possible means of infection. The advice given to us by the highest medical authorities is that such fears are groundless. The virus which causes AIDS may occasionally be present in saliva, but recent research has shown that saliva inhibits the activity of the virus and that it has not been transmitted by being swallowed. ...People who are infected by the virus or who have AIDS will be usually susceptible to other infections and may wish, and should be allowed, to receive communion by intinction or in one kind.⁶⁷⁰

The fact that the House of Bishops of the Church of England issued this statement testifies to the concerns emanating from members of the church. The same concerns could have filtered through to Zimbabwe and were first evident in Manicaland. However, this was not the first time when fears of infection from the chalice were raised from within the Anglican Communion. According to David Gould of the Episcopal Church in the US: “The influenza epidemic in 1917 raised similar concerns and the controversy has surfaced periodically since the sixteenth century.”⁶⁷¹

Until the late 1980s and early 1990s communicants from the Anglican in Manicaland used to drink wine from the same chalice. The practice changed due to a contagion of fear that “contact with blood or saliva of HIV positive persons could lead to contracting the AIDS.”⁶⁷² In Manicaland, the first Anglican parish to discontinue drinking from the same chalice was the Cathedral of St. John the Baptist, Mutare.⁶⁷³ For Anglicans in Manicaland, the cathedral parish is regarded as the mother church that is also seen as setting out best practices on most ecclesiastical matters. Thus, other parishes emulated the changes in drinking wine from the chalice from the cathedral parish. In the late 1980s, the new reality that emerged whereby

⁶⁷⁰ For this see R. Cantuar and J. Ebor, “Administration of Holy Communion during a flu pandemic with annexes A, Hygiene and the chalice (1987), and B, Pandemic flu and the common cup in communion services,” June 2009, <http://www.canterburydiocese.org/swineflu/pandemicflucommunion.23%206%2009.pdf> [Accessed 7 November 2011].

⁶⁷¹ D. H. Gould, “Eucharistic practice and the risk of Infection,” http://www.st-timoth-st-paul.com/images/pdf-forms_articles/ep-risk-of-infection.pdf [Accessed on 7 November 2011].

⁶⁷² K. Nyazika, same interview. See also M. Mafulela, interview conducted by M. Mbona, Anglican Diocesan office, Mutare, 13 August 2010.

⁶⁷³ O. Murakwani, same interview.

communicants received the elements of communion by intinction was a paradox to visitors at the Cathedral of St John the Baptist.⁶⁷⁴ It became apparent to communicants that ~~the~~ chalice was no longer the cup of salvation, but one of deadly poison leading to death through HIV infection from fellow members of the body of Christ.”⁶⁷⁵

Church followers at the cathedral parish comprised of whites, Indians, coloureds and blacks. It was a known fact that generally, many of the early publicly known cases of HIV and AIDS in Zimbabwe were found among blacks. The cathedral parish did not provide safe space to talk about HIV and AIDS and thus indirectly showed denial and stigma of the epidemic. For example, Murakwani mentioned that the parish’s white clergy and parishioners could have been generally aware of HIV and AIDS but had no freedom to speak about it openly. The dean of the cathedral of St. John the Baptist, maintained silence following an AIDS-related death of a young single black woman communicant at the cathedral parish in 1988.⁶⁷⁶ This incident became a first hand encounter of an AIDS-related death case for Murakwani. Within the Anglican Church in Manicaland, the church’s members were afraid of contracting HIV and this gradually but steadily set a new tone especially at the Eucharist.⁶⁷⁷

For the Anglicans, the sacrament of the Eucharist was perceived to be quite central in deepening the relationship between God and the communicants as well as fostering oneness and fellowship amongst Christians.⁶⁷⁸ The fact that the subject of AIDS and the chalice received formal attention at some diocesan clergy meetings and those of the diocesan standing committee from 1989 onwards was an indication of the seriousness given to this matter.⁶⁷⁹ While the discussions shaped decisions regarding the chalice, no diocesan synod resolutions were passed on the issue. According to Murakwani, the diocesan bishop ~~encouraged~~ clergy and lay leaders to seek the

⁶⁷⁴ O. Murakwani, same interview. Communion by intinction is a practise of administering the Holy Communion by dipping bread in wine, <<http://www.canterburydiocese.org/swineflu/pandemicflucommunion.23%206%2009.pdf/>> [Accessed 7 November 2011].

⁶⁷⁵ M. Mafulela, same interview.

⁶⁷⁶ O. Murakwani, same interview.

⁶⁷⁷ M. Mafulela, same interview.

⁶⁷⁸ See Church of the Province of the Southern Africa, *Liturgy: 1975* (Braamfontein: Church of the Province of Southern Africa, 1975), 16-24. The Anglican Church in Manicaland used the same liturgy in its services.

⁶⁷⁹ M. Mafulela, same interview. See also K. Nyazika, same interview.

‘feelings’ of Anglican communicants at the parish level.”⁶⁸⁰ Apparently, the possibility of contracting HIV from drinking from the same chalice was partly informed by the deliberations that were going on in the Church of England on the same matter in 1987.⁶⁸¹ However, the Lambeth Conference of 1988 attended by Bishop Masuko did not address the issue of HIV and the chalice but encouraged Anglican bishops to play a positive role in HIV prevention and AIDS mitigation.⁶⁸² Within Africa, the issue of drinking from the chalice ranked quite high at a conference on “HIV and AIDS and the church,” held in Kenya in 1989. Murakwani who attended the conference as a delegate of Anglican Church in Manicaland stated that the majority of speakers argued that the chances of contracting HIV by drinking from the same chalice were high.⁶⁸³ Similarly, since 1985, the communicants in the Anglican Church of Uganda discontinued the practice of drinking from the same chalice due to fear of contracting HIV.⁶⁸⁴ The links between the Anglican Diocese of Manicaland and the Anglican Church of Kenya might suggest that the Anglicans in Manicaland adopted the change in the ritual of the chalice from East Africa.

The changes introduced to the ritual of the chalice as a consequence of HIV and AIDS among Anglican Christians in Manicaland were also a legacy of the epidemic’s trail of devastation in the lives of the faithful. For example, in the early 1990s at St. Faith’s mission near Rusape, relations among Anglican communicants did not remain the same. On the one hand, the elderly members of the church, now in their late-seventies, blamed the young generation for being ‘unfaithful’ and guilty of spreading HIV.⁶⁸⁵ On the other hand, Nyazika, a senior and elderly priest from the Anglican Church in Manicaland stated that intinction was necessary in the interest of public health and hygiene. The message underneath this pretext was that “any suspected HIV positive communicants were never to be trusted.”⁶⁸⁶ Blaming others as being responsible for contributing to the changes in the ritual of the chalice showed that denial and stigmatisation were inherent.

⁶⁸⁰ O. Murakwani, same interview.

⁶⁸¹ O. Murakwani, same interview.

⁶⁸² See Resolution 29, “Acquired immune deficiency syndrome (AIDS),” Resolution of the Lambeth Conference, 1988, downloaded from the Lambeth Conference website on 28 September 2009.

⁶⁸³ O. Murakwani, same interview.

⁶⁸⁴ M. Mbona was indebted to R. Nyegenye of the Anglican Church of Uganda for sharing with me this information, Pietermaritzburg, South Africa, 15 July 2011.

⁶⁸⁵ Information supplied by T. Mchedzi to M. Mbona at St. Faith’s mission, Rusape, 13 June 2010.

⁶⁸⁶ K. Nyazika, same interview.

3.3.3. AIDS-Related Denial and Witch Hunting

Within the Anglican Church in Manicaland, the denial of AIDS led to the perception that HIV was caused by witchcraft and occult forces. However, the practice of blaming witchcraft and occult forces for illness and or death among the Manyika people was not unique to the HIV and AIDS era.⁶⁸⁷ Though mention has already been given to this subject in relation to the followers of the Roman Catholic Church above, within the Anglican Church, this assumed a different level. Witchcraft is a phenomenon that most black Zimbabweans, including members of the Anglican Church believe in. Generally, witchcraft is a phenomenon that parishioners and families do not speak about openly, especially with the clergy. Similarly, the disclosure of one's HIV and AIDS status was shrouded in secrecy. The fact that at the leadership level there were no open spaces to deal with HIV and AIDS from a biomedical perspective provided fertile ground for perceiving AIDS as product of witchcraft and occult forces. Rarely did Anglican Christians openly admit to the fact that AIDS was responsible for the death of a loved one.⁶⁸⁸ Under such circumstances some members of the Anglican Church blamed witchcraft and occult forces for causing HIV and AIDS.

The case of witch hunting by one of the church's senior priest, Livingstone Nerwande, who served at St. Mary's Magdalene Nyanga, had effects on the church's reactions to HIV and AIDS in the 1990s. Surges in HIV and AIDS-related illness and subsequent deaths coincided with Nerwande's claims to destroy the power of witchcraft, a malevolent force believed to be the cause of sickness. Some Anglican Church members teamed up with Nerwande to form —*Chikwa cheMuchinjiko*” translated as the —Community of the Holy Cross” in 1992. The identification of witches and the destruction of occult forces were common features at healing gatherings. This had the effect of misleading people, including members of the Anglican Church to think that AIDS was the product of witchcraft and occult forces.

⁶⁸⁷ N. Mushawa, same interview. See also C. Matenga, interview conducted by M. Mbona, St. Matthew's parish, Vengere, Rusape, 23 August 2010.

⁶⁸⁸ O. Murakwani, same interview.

Similarly, in Soweto, South Africa, Adam Ashforth's analysis of AIDS as *isidliso* indicates that traditional healers and prophets claimed that they could cure AIDS. Thus the intervention by traditional healers was important due to the public perception that AIDS was a "man-made" illness invented by witches.⁶⁸⁹ As Ashforth explains, witchcraft is associated with people's ability to manipulate evil forces to harm others: "Witchcraft in the South African context typically means the manipulation by malicious individuals of powers inherent in persons, spiritual entities, and substances to cause harm to others."⁶⁹⁰ Elsewhere, in Uganda, Behrend's findings concluded that AIDS-related deaths were responsible for the dramatic reactivation of belief in occult forces. As Behrend has observed: "Thus, the revelation of and fight against occult forces led their being reinstated and growing even more powerful."⁶⁹¹ In the case of Uganda, and similar to Manicaland, increased deaths mainly due to AIDS made some people to believe that witches were responsible for the death of today.

In Uganda the Roman Catholic Church-related Uganda Martyrs guild established in the 1980s, instituted the practice of witch hunting around 1995.⁶⁹² The fact that the Holy Cross guild in Manicaland existed since the early 1990s led to the conclusion that perhaps Nerwande might have influenced a later development in Uganda. The Uganda Martyrs guild called for open confession and destruction of satanic forces and the Holy Cross guild did the same.⁶⁹³ In the case of Nerwande, the clients paid exorbitant fees before services were rendered. This accounted for the dissolution of the guild and the banning of all its activities by Bishop Masuko later in 1996.⁶⁹⁴ Apparently, Bishop Masuko believed that HIV and AIDS was strictly a consequence of moral failure.⁶⁹⁵ Masuko's support for Nerwande's divine healing ministry for almost a decade misled Anglicans in Manicaland to associate AIDS with sin and the work of witchcraft. Nerwande's claims to destroy witchcraft at a time the HIV

⁶⁸⁹ A. Ashforth, "AIDS, witchcraft, and the problem of power in post-apartheid South Africa," Unpublished paper number 10, (May 2001), 1.

⁶⁹⁰ Ashforth, "AIDS, witchcraft, and the problem of power," 5.

⁶⁹¹ Behrend, "The rise of occult powers," 44.

⁶⁹² Behrend, "The rise of occult powers," 40.

⁶⁹³ Behrend, "The rise of occult powers," 40. See also O. Murakwani, same interview.

⁶⁹⁴ HNM, Rt Revd Elijah Musekiwa Masuko, Bishop of Manicaland to the members and supporters of the Community of the Holy Cross Re Dissolution of the Community of the Holy Cross, 27 November 1996. Letter was sent to all parishes and institution of the diocese and to all bishops of the Church of the Province of Central Africa. See also HNM, Church of the Province of Central Africa, Standing Committee's report to synod, Diocese of Manicaland Synod 1997, Agenda and reports, 5-6 December 1997, 15.

⁶⁹⁵ See HNM, Bishop's charge to the eighth synod, "Unity in the body of Christ," 5 December 1997.

epidemic was ravaging the nation drew close parallels with prophetic responses to the influenza epidemic in Southern Rhodesia. Ranger observed that claims to heal disease were quite central to the new prophetic movements whereby –in their prophetic teaching healing came directly to the purified faithful through the descent of the Holy Spirit.”⁶⁹⁶ The fact that Bishop Masuko officially licensed Nerwande to function as a priest and appointed him vicar-general of the diocese meant that the episcopacy was in full support of Nerwande’s spiritual healing exploits.

3.3.4. Moral Rhetoric Undermines HIV Prevention

Generally, the Anglican Church maintained a liberal position on the use of condoms as a method of contraception within marriage. Married couples from the Anglican Church were not duty bound to stick to a particular method of birth control. In fact, since 1958, the Anglican Church considers contraception as a responsibility of married couples to decide on and has to be informed by their God given conscience.⁶⁹⁷ Among the church’s married couples in Manicaland, and prior to the HIV and AIDS era, condoms were strongly associated with promiscuity. For example, a number of female respondents stated that the use of condoms as prophylactics was unpopular among the church’s married members because male spouses became quite suspicious and apprehensive. The fact that women were also shy to talk about condoms, let alone take them home, demonstrates that condoms were seen as unwelcome within a marriage.⁶⁹⁸ Epstein suggested that in Africa condoms were unwanted because they prevented conception when many couples desired to have children and women who opted to use condoms faced resistance.⁶⁹⁹ This could be another reason for the low uptake of condom use within the Anglican Church in Manicaland. According to Martha Nyamwena, there was little done by the leaders of the Anglican Church in addressing the sexual dilemmas faced by married couples

⁶⁹⁶ Ranger, “Plagues of beasts and men,” 267.

⁶⁹⁷ Archbishops’ Council, “Contraception and the Church of England,” *Medical ethics, health and social care policy*, 2011, <<http://www.churchofengland.org/our-views/medical-ethics-health-social-care-policy/contraception.aspx/>> [Accessed 9 July 2011]. See also J. T. Noonan, JR, “Contraception,” in J. F. Childress and J. Macquarrie (eds), *A new dictionary of Christian ethics* (London: S C M Press, 1986), 125.

⁶⁹⁸ B. Makoni, interview conducted by M. Mbona, St. Cuthbert’s Denzva, 15 August 2010. See also J. Chimwaza, interview conducted by M. Mbona, Holy Name parish, Sakubva, Mutare, 24 August 2010.

⁶⁹⁹ Epstein, *The invisible cure*, 71-73.

before and during the HIV and AIDS era.⁷⁰⁰ The lack of regular programmes on marriage and family life, including sexuality and AIDS at diocesan level exposed Anglicans to the risks of contracting HIV.

The Mothers' Union guild, an important wing of the Anglican Church in Manicaland, did not create safe spaces for young women who faced the threat of contracting HIV from their spouses. The situation was further exacerbated by the belief that using condoms to protect oneself from possible chances of contracting sexually transmitted HIV was unchristian. There was a belief that in using condoms the church's married women, mainly members of the Mothers' Union guild, portrayed them as being unfaithful and literally showed mistrust of their husbands.⁷⁰¹ For churchwomen, marriage in the time of HIV and AIDS became a death trap, not only due to the undeniable influence of culture, but also due to teachings received from within church circles. In support of this assertion, Mungwini made an important observation that within Shona culture, married women were relatively disadvantaged due to limited chances of negotiating safe sex.⁷⁰² This situation exposed young women to high risk of contracting HIV sexually and yet the church's leadership Manicaland did little to address it. Generally, society appeared to be tolerant of men's use of condoms with concurrent partners and the practice was accepted as being normal.⁷⁰³ Takyi pointed out that in Ghana, while many Christian women gained important AIDS information from church and other faith-based interactions, they often encountered restrictions at the individual level. As Takyi stated: "Rather than facilitate the diffusion of new ideas, it was possible, however, that the influence of religious organisations could constrain individual actions such as use of condoms because they go against church tenets."⁷⁰⁴

While the subject of HIV and AIDS became a talking point in sermons, teachings and addresses,⁷⁰⁵ the lack of well structured attempts to organise proper presentations at diocesan level could have denied parishioners of opportunities to gain crucial

⁷⁰⁰ M. Nyamwena, interview conducted by M. Mbona, St. Joseph's Samanga, Honde Valley, 14 September 2010.

⁷⁰¹ M. Nyamwena, same interview.

⁷⁰² Mungwini, "Shona womanhood," 209.

⁷⁰³ K. Nyazika, same interview. See also M. Nyamwena, same interview.

⁷⁰⁴ Takyi, "Religion and women's health in Ghana," 1222.

⁷⁰⁵ K. Nyazika, same interview. See also J. Chimwaza, same interview.

knowledge and information. The diocesan leadership appeared to assume that the church's members were aware of HIV and AIDS from the media or other sources. HIV awareness campaigns organised by the diocesan leadership for the benefit of church followers were non-existent or very minimal.⁷⁰⁶ Between 1985 and 1994 very few Anglicans realised that the pandemic had deeper roots than had been imagined. The denial of HIV and AIDS-related stigma could have prevented the church's leadership from using the church's healthcare institutions to initiate responses to HIV and AIDS and enlighten church members on the epidemic. The lack of collaboration between the diocesan leadership and the church's healthcare institutions weakened the general response to HIV and AIDS interventions. One possible factor is that the church's leadership perceived the epidemic largely in moral terms and not as a biomedical reality.⁷⁰⁷

The lack of openness about the AIDS limited the amount and nature of support that could be provided to PLHIV by both the clergy and the laity. Nyazika and Murakwani mentioned that Anglican parishioners rarely confided information regarding a person's HIV status to the priest.⁷⁰⁸ The fact that at times priests were left to guess the causes of death among deceased church members was indicative of the extent to which Anglican Christians were secretive. The perception of AIDS in moralistic terms and the stigma that followed affected the credibility of Anglican clergy in confessional matters that involved PLHIV. For example, Jesmine Mavhima mentioned that some members of the clergy were stumbling blocks to HIV prevention because "a number of Anglican priests were of questionable moral standing."⁷⁰⁹ This is not to suggest that Anglican clergy in Manicaland were immoral but to note that sexual immorality and HIV have links and the clergy were not an exception. The HIV epidemic mainly thrived on flaws in human sexuality and increased in cases where immorality was rampant. According to a South African study conducted by Marshall and Taylor, "It is not only in its lack of response to the crisis that the church is struggling. At the same time, it is failing to lead by example on matters of sex, gender

⁷⁰⁶ Information supplied by P. Z. Dhlomo to M. Mbona, Rusape, 28 September 2010. See also M. Nyamwena, same interview.

⁷⁰⁷ M. Chikukwa, same interview.

⁷⁰⁸ K. Nyazika, same interview.

⁷⁰⁹ J. Mavhima, interview conducted by M. Mbona, Lesape Drive, Rusape, 17 August 2010.

relations and HIV and AIDS in its own behaviour.”⁷¹⁰ It appears that HIV prevention in the Anglican Church in Manicaland was undermined by a perceived lack of moral leadership that generally turned into moral rhetoric.

3.3.5. Responses to HIV at the Grassroots Level

Within the Anglican Church in Manicaland, some respondents stated that they were aware of AIDS among their families, friends and neighbours since the mid-1980s. For example, Edgar Mbutsa, an Anglican parishioner at Holy Name parish, Sakubva, recounted the story of a friend who got ill from an unusual disease that later turned out to be AIDS-related and died in 1987.⁷¹¹ Similarly, in 1988, one of the researcher’s relatives died of AIDS and the corpse was delivered from a provincial hospital morgue wrapped in black plastic in a sealed coffin. Secrecy, denial and stigma surrounded many of the early cases of people who were HIV positive or succumbed to AIDS. This level of denial of HIV and AIDS was also manifest within the Anglican Church in Manicaland. For example, Jessie Chimwaza, a female member of Holy Name parish, Sakubva, mentioned that in the late 1980s, “members of the Anglican Church were secretive about the cause of a ‘slimming disease’ that literally disfigured a person prior to its final conquest.”⁷¹² Thus, elements of secrecy, stigma and discrimination were common among some Anglicans in Manicaland. The situation was not different elsewhere, as observed by Chitimbire who in retrospect has stated: “Generally, the church and the State were not angels in the way Zimbabweans in general responded to HIV and AIDS.”⁷¹³ Chitimbire who worked in the public health sector in Zimbabwe before joining ZACH further stated that the church in general contributed heavily to denial and stigma, as did the State.

At the parish level well-structured HIV interventions were almost non-existent. For example, at Holy Name parish, Sakubva, a handful of written sources indicate that HIV and AIDS rarely featured in the official business of the parish meetings held

⁷¹⁰ Marshall and Taylor, “Fackling HIV and AIDS in faith-based communities,” 369.

⁷¹¹ E. Mbutsa, same interview. See also J. Chimwaza, same interview. See also E. Mbutsa, same interview. See also K. Nyazika, same interview. See also B. Makoni, same interview. See also S. Bakare, same interview.

⁷¹² J. Chimwaza, same interview.

⁷¹³ V. Chitimbire, same interview.

between 1985 and 1994.⁷¹⁴ Chimwaza and Mbutsa in separate interviews concurred that from the time of the first appearance of HIV and AIDS in the 1980s, and the surge in HIV infection between 1990 and 2000, the epidemic received minimum attention at Holy Name.⁷¹⁵ Whereas there were no corporate parish-based HIV and AIDS interventions, some Anglican Christians at the grassroots level were not deterred from supporting and caring for PLHIV and OVC. For example, the church's members who were affiliated to the Mothers' Union guild cared for people infected and affected by HIV and AIDS and operated without diocesan or donor support for PLHIV and orphans.⁷¹⁶ Apparently, FACT trained some Anglican churchwomen as voluntary caregivers in the early 1990s.⁷¹⁷ Chinouya also paid tribute to AIDS-related care initiatives carried out by churchwomen at the grassroots level in the period between the early 1980s and 2007. As Chinouya has observed, "there were many 'hands' at the grassroots emerging and pouring the cooling waters on a community devastated by the HIV epidemic. These 'hands' are women like the grandmothers, the Mothers' Union [guild] members, people infected by HIV and the nuns."⁷¹⁸ The fact that churchwomen also acted as pastoral agents to the sick led to their early involvement in AIDS-related care programmes.⁷¹⁹

Generally, a large proportion of married women in Manicaland including Anglican followers lived separately from their husbands due to migrant labour practices. As already noted above, this exposed women to the risks of contracting HIV from their spouses. Some married women from the Anglican Church appeared helpless in reducing chances of contracting HIV because the church's leadership appeared to underestimate the importance of encouraging married couples to live under the same roof. Whereas women were increasingly exposed to HIV, the leadership of the

⁷¹⁴ HNM, Minutes of parish council meeting, 6 August 1982, Minutes of parish council meeting, January 1990. Minutes of parish council meeting, January 1993, Minutes of parish council meeting, 30 June 1993.

⁷¹⁵ E. Mbutsa, same interview. See also J. Chimwaza, same interview.

⁷¹⁶ M. Nyamwena, same interview.

⁷¹⁷ B. Makoni, same interview.

⁷¹⁸ Chinouya, "Ubuntu and the helping hands for AIDS," 104. The presence of Anglican nuns in Zimbabwe is traceable from the arrival of Mother Anne at St. Augustine's Penhalonga from Grahamstown in South Africa in 1904 and the profession of the first two members of the *Chita cheZita Rinoyera* (Community of the Holy Name) occurred at Penhalonga in 1941. Later another group of indigenous nuns established centres at St. Faith's mission, Rusape, St. Agnes, Gokwe and St. David's Bonda mission. For this see Weller, *Anglican centenary in Zimbabwe 1891-1991*, 10.

⁷¹⁹ B. Makoni, same interview, M. Nyamwena, same interview. See also J. Chimwaza, same interview. See also R. Munakamwe, interview conducted by M. Mbona, Mutare provincial hospital, 1 September 2010. See also J. Mavhima, same interview.

Anglican Church became hesitant to confront cultural traditions that domesticated married women. The phrase *‘Musha mukadzi,’* meaning that a married woman was expected to stay in that home permanently. Thus, married churchwomen existed in a *‘prison.’* Similarly, Deborah Gaitskell argued that the early mission-educated African Christian women only advanced women’s interests in the spheres of social welfare, community projects domestic work. As Gaitskell has further observed: *‘Just as anthropologists *‘saw’* women largely within the family, so a particular view of women’s primarily domestic role was widely current among women activists early in this century.’*⁷²⁰ Nyamwena mentioned that within the Anglican Church in Manicaland, AIDS-related deaths culminated in a numerical increase in the number of young widows. Many of the widows could not access help from the church and lack of diocesan programmes to support young widows and their families *‘exposed them to untold hardships.’*⁷²¹

Within the Anglican Church in southern Africa, the church had a hand in supporting the low status of women in the home and wide society. This situation was part of the early missionary legacy. In 1993 Marc Epprecht studied the influence of missionaries on churchwomen’s movements in Lesotho and concluded that the missionaries in southern Africa prescribed an ideology of domesticity for Christian women, with housewifery, wifehood and motherhood as full time spiritual vocations.⁷²² Similarly, Chinouya argued that the missionary ideology of domesticity compromised the position of women in society: *‘This discourse of good, housewifery, needlework, Christian motherhood often silenced the private voices of churchwomen...in particular on matters related to domestic violence, sex and sexual health.’*⁷²³ The fact that the leadership of the Anglican Church in Manicaland took some time before establishing AIDS sensitisation and prevention programmes at the diocesan level resulted in the exposure of women to the HI-Virus. The women who championed care activities were at great risk of infection from their own spouses.⁷²⁴

⁷²⁰ D. Gaitskell, *‘Introduction,’* *Journal of Southern Studies* 10, 1 (October 1983), 6.

⁷²¹ M. Nyamwena, same interview. See also M. Nyakani, interview conducted by M. Mbona, St. David’s Bonda mission, 22 September 2010.

⁷²² For a detailed discussion of this see M. Epprecht, *‘Domesticity and Piety in colonial Lesotho: the Private Politics of Basotho Women’s Pious Associations,’* *Journal of Southern African Studies* 19/2, (June 1993).

⁷²³ Chinouya, *‘Ubuntu and the helping hands for AIDS,’* 106.

⁷²⁴ B. Makoni, same interview. See also J. Chimwaza, same interview. See also M. Nyamwena, same interview.

3.4. The United Methodist Church's Response to HIV and AIDS

This section will show the HIV and AIDS interventions carried out by the United Methodist Church in Zimbabwe and make particular reference to Manicaland. According to the Reverend Sophirina Sign, the church's connectional ministries director of the Zimbabwe East Annual Conference, in the early period the church's interventions were generally sporadic. This could have been caused by notion that ~~the~~ church's leaders and followers initially having the wrong facts about the HIV and AIDS epidemic."⁷²⁵ The section will explore some of the factors that led to delayed responses to HIV and AIDS by the United Methodist Church. The responses will be discussed in the following order: HIV and AIDS interventions initiated by the church's global Council of Bishops, responses to the epidemic by the leadership of the United Methodist Church in Zimbabwe which include HIV prevention. This will be followed by low key AIDS mitigation efforts, and AIDS related denial and stigma at the institutional and grassroots level to be discussed separately.⁷²⁶

3.4.1. The Global Council of Bishops Engages with HIV and AIDS

Between 1988 and 1992 the United Methodist Church's global Council of Bishops and the church's General Board of Global Ministries issued a few statements and resolutions on HIV and AIDS. All the church's active and retired bishops from North America, Europe, Africa and Asia are members of the Council of Bishops whose administrative office is located in Washington DC, US.⁷²⁷ There Council of Bishops focuses on four main areas which were: (a) combating diseases of poverty by improving health globally, (b) engaging in ministry with the poor, (c) creating new places for new people and revitalising existing congregations, and (d) developing principled Christian leaders for the church and the world.⁷²⁸ The Council of Bishops meets twice every year to reflect on the church's internal work as well as the mission

⁷²⁵ S. Sign, interview conducted by M. Mbona, ZEAC of the UMC office, Mutare, 23 September 2010.

⁷²⁶ S. Sign, same interview.

⁷²⁷ Council of Bishops, <http://www.umc.org/site/c.lwL4KnN1LtH/b.4511279/k.BA1F/Council_of_Bishops.htm> [Accessed November 2011].

⁷²⁸ Council of Bishops.

of the church to the world.⁷²⁹ This implies that Bishop Muzorewa was part of this council for the twenty-four years of his episcopacy in Zimbabwe. The fact that the statements came from the church's global Council of Bishops meant that they expressed the collective voice of all the church's top leadership throughout the world including Bishop Muzorewa.

On 20 April 1988 the church's global Council of Bishops at a conference in the US issued a statement on the church's position on the HIV and AIDS epidemic. The statement was not necessarily binding on the local conferences but it indicates the bishops' commitment at responding to the epidemic. For example, the Council of Bishops dispelled the myth that AIDS was part of God's plan to instigate retributive justice and thus categorically stated: "We do not believe that the God of love, revealed in Jesus Christ, waged germ warfare on the human family, including the unborn and the newly born babies."⁷³⁰ The Council of Bishops took the position that Christian morality, based on abstinence and faithfulness, was the most ideal weapon for HIV prevention as they asserted: "Monogamous, sexual fidelity within the bond of holy matrimony is the standard behaviour expected of United Methodists and recommended to all others as behaviour that comes close to assuring the prevention of the spread of AIDS."⁷³¹ Comparatively, the ZCBC was one of the few ecclesiastical bodies that issued a similar message in October 1987.

However, unlike the ZCBC, and as early as 1988, the Council of Bishops went a step further by accepting the reality of human folly and argued that unprotected sex had the potential effect of increasing the rate of HIV infection.⁷³² Based on recommendations from medical experts, the Council of Bishops confidently suggested that the only alternative and viable option for people who failed to abstain or remain faithful was to use condoms.⁷³³ In Zimbabwe, the leadership of the United Methodist Church discussed the use of condoms among married couples three years later in 1990. The local ecclesiastical and cultural landscape that tended to despise the use of

⁷²⁹ Council of Bishops, "Meetings," <<http://www.gc2004.org/interior.asp?ptid=1&mid=5856/>> [Accessed 7 November 2011].

⁷³⁰ Council of Bishops, "A statement on acquired immune deficiency syndrome," 20 April 1988, <<http://gbgm-umc.org/health/aids/bishops88.stm/>> [Accessed 1 July 2011].

⁷³¹ Council of Bishops, "A statement on acquired immune deficiency syndrome."

⁷³² Council of Bishops, "A statement on acquired immune deficiency syndrome."

⁷³³ Council of Bishops, "A statement on acquired immune deficiency syndrome."

condoms in the prevention of sexually transmitted HIV could have led the church's national leadership to water down the recommendations of the Council of Bishops as noted in the resolutions for 1990 and 1991. The statement by the Council of Bishops' in 1988 was nevertheless quite liberal and accommodating and therefore responded to people's circumstances from a pragmatic position.

In another related development, in 1988 the church's global General Conference drew up a resolution entitled "AIDS and the healing ministry of the church."⁷³⁴ This time the emphasis was on rededicating the church denomination to a ministry of wholeness through compassion and healing, as a means of meeting the needs of humanity. Part of the resolution stated that the United Methodist Church would open up the church's structures for the caring of persons living with HIV, collaborate with communities on priorities for action, lead in education and awareness, provide emotional and physical support to caregivers and use other local church resources to respond to the pandemic.⁷³⁵ Although the resolution showed the urgency with which the church's global body treated AIDS, at the local level in Zimbabwe, the interpretation became different. Zimbabwe was still in a state of AIDS denial and the church's leadership seemed unenthusiastic about launching holistic HIV and AIDS interventions.

Furthermore, five years later, the General Board of Global Ministries submitted a resolution that was approved by the General Conference in 1992.⁷³⁶ The resolution was a follow up to that of 1988. It further re-emphasised the functions of the local congregations, the general programme agencies, the Episcopal leadership and the church's annual conferences in responding constructively to HIV and AIDS. For example, annual conferences were expected to explore opportunities for HIV prevention and care, the scaling up of pastoral work and involvement in HIV and AIDS education programmes. Each bishop was also expected to issue pastoral letters on HIV and AIDS as a public health threat and also provide responsive, decisive,

⁷³⁴ AIDS and the healing ministry of the church, A resolution adopted by the General Conference of the United Methodist Church, 1988, <<http://gbgm-umc.org/health/aids/aidshealingministry.stm/>> [Accessed 1 July 2011].

⁷³⁵ AIDS and the healing ministry of the church.

⁷³⁶ The church and the global HIV and AIDS epidemic, a resolution from the General Board of Global Ministries of the UMC approved by the General Conference in 1992, <<http://gbgm-umc.org.health/aids/globalaids.stm/>> [Accessed 1 July 2011].

compassionate and committed leadership to counter the effects of the epidemic.⁷³⁷ Thereafter, the church's annual conferences were expected to launch HIV and AIDS awareness, care, and prevention programmes.⁷³⁸ However, the fact that at the international or global level the United Methodist Church began to engage openly with AIDS from 1988 indicates a high degree of commitment at seeking to direct and empower local annual conferences to address the deadly pandemic.

3.4.2. Responses to HIV and AIDS by the Church's Leaders in Zimbabwe

The spirit of hope, engagement, acceptance, care and encouragement from the church's global institutions did not immediately translate into the launching of HIV interventions within the church's Zimbabwe Annual Conference. This was led by Bishop Muzorewa. While the church's global institutions enlightened the United Methodist Church's annual conferences across the world on the need to respond positively to HIV and AIDS, little was achieved locally in Manicaland and Zimbabwe. The limited local AIDS-related initiatives undertaken by the leadership of the church between 1988 and 1992 could be a consequence of an understanding that it was a 'persecuted church.' Within church circles, there was a perception that the relationship between Bishop Muzorewa and the State in the early 1980s could have cast a dark shadow on the future participation of the UMC [United Methodist Church] in carrying out HIV and AIDS interventions."⁷³⁹ The role of a head of the denomination in matters such as HIV and AIDS cannot be underestimated. Similar to any ecclesiastical authorities, the church's bishops played a significant role by shaping the common discourse on HIV and AIDS. Consistent with this assertion, Denis has observed: "...the church authorities contributed, sometimes powerfully, to the public discourse on the epidemic and in this way influenced both policy and popular attitudes."⁷⁴⁰

⁷³⁷ Global Ministries of the UMC approved by the General Conference in 1992, <<http://gbgm-umc.org/health/aids/globalaids.htm>> [Accessed 1 July 2011].

⁷³⁸ Council of Bishops, "Statement on acquired immune deficiency syndrome."

⁷³⁹ E. Kabungaidze, same interview. See also S. Sign, same interview. See also I. Chowa, interview conducted by M. Mbona, Rusape, 21 August 2010.

⁷⁴⁰ Denis, "The church's impact on HIV prevention," 69.

Between 1985 and 1994 public knowledge on HIV and AIDS in Zimbabwe was scanty. AIDS was also at its infancy. This explained why the pandemic did not feature officially in the church's recorded local annual conference proceedings in 1984,⁷⁴¹ and 1985.⁷⁴² The major concern at the annual conference session of 1985 was political tension in the Matabeleland provinces. At that time the government had commissioned the army to 'hunt' for the so-called dissidents and thus disrupted peace in the two Matabeleland provinces. The subsequent mass killings were seen in some circles as genocide.⁷⁴³ The State in Zimbabwe considered Bishop Muzorewa's political activities as a threat to national security and linked him with the destabilisation forces of South Africa's Pieter Botha.⁷⁴⁴ State and church relations tumbled between 1981 and 1982 after the State alleged that the Zimbabwe Council of Churches stalled channelling of reconstruction and development funds from the World Council of Churches towards proposed social development and reconstruction projects.⁷⁴⁵ These events could have weakened the input by the United Methodist Church in carrying out HIV and AIDS interventions which also affected the middle and later periods as shown by the present research study. Therefore, while the church's General Board of Global Ministries pledged to support the annual conferences in Africa in launching HIV and AIDS interventions, the church's leadership in Zimbabwe lagged behind until Muzorewa's retirement in 1992.

The church's leadership in Zimbabwe first mentioned the effects of AIDS as noted in the 'Church and Society' report presented at the church's annual conference session in December 1987.⁷⁴⁶ AIDS appeared almost as an afterthought because it was relegated to a comment in the last sentence of the report. The compilers of the report noted:

⁷⁴¹ AM, *Official Journal of the Zimbabwe Annual Conference of the UMC fifth session*, 12-16 December 1984, 15-147.

⁷⁴² United Methodist Church Africa University archives, Mutare, (UMCAUM), *Official Journal of the Zimbabwe Annual Conference of the UMC sixth session*, 12-15 December 1985, 72.

⁷⁴³ UMCAUM, *Official Journal of the Zimbabwe Annual Conference of the UMC sixth session*, 30.

⁷⁴⁴ C. F. Hallencreutz, 'Ecumenical challenges in independent Zimbabwe: ZCC 1980-1985,' in Hallencreutz and Moyo, *Church and State in Zimbabwe*, 270-273. See also S. R. Dorman, 'Rocking the boat?' Church-NGOs and democratisation in Zimbabwe,' (circa 2000), 6. This article was accessed on the Internet and downloaded as pdf.

⁷⁴⁵ For a detailed analysis of this see Hallencreutz, 'Ecumenical challenges in independent Zimbabwe,' 252-275.

⁷⁴⁶ UMCAUM, *Official Journal of the Zimbabwe Annual Conference of the UMC eighth session*, 16-20 December 1987, 47.

Let us continue to uphold the sanctity of Christian marriage and articulate to our members the evils of sexual promiscuity which is a major element in spreading AIDS. Teachings about this disease should be undertaken as this is spreading like grass fire.⁷⁴⁷

The church and society committee's mandate was to act as a link between the church's annual conference and Zimbabwean society in general. Thus the committee became aware of the social issues that were confronting the wider communities in Zimbabwe at that time including HIV and AIDS.

The call by the committee to uphold the sanctity of Christian marriage fitted in well with the statement that had been issued by the ZCBC in October 1987. There was no strong case to argue that since the statement issued by the ZCBC came earlier than the United Methodist's annual conference session in the same year, the former might have influenced the latter. It is a United Methodist Church trend that the most crucial matters were always noted from either the bishop's address or the district superintendents' composite report. The bishop, the district superintendents and the other committees did not mention anything on AIDS. This illustrates the fact that the church's leadership either turned a blind eye on the new epidemic or seriously underestimated the potential effects of HIV and AIDS on communities.

The apparent silence on AIDS as shown by the church's leadership was again noted from the reports submitted at the annual conference session held in 1988.⁷⁴⁸ However, the medical board's report simply mentioned in passing the surge in the number of admissions and outpatients at Old Mutare, Gatsi, and Mutambara healthcare centres among others.⁷⁴⁹ The fact that the medical board's report gave no further explanation on the rise in the number of patients visiting healthcare centres was not helpful to the delegates who attended the annual conference session. Similarly, the district superintendents' composite report also noted the high number of people coming to the

⁷⁴⁷ UMCAUM, J. Mafondokoto and G. Kambarami, "Church and society report," *Official Journal of the Zimbabwe Annual Conference of the UMC eighth session*, 64. See also A statement on acquired immune deficiency syndrome issued by the Council of Bishops of the United Methodist Church, <<http://gbgm-umc.org/health/aids/bishops88.stm/>> [Accessed 1 July 2011].

⁷⁴⁸ UMCAUM, *Official Journal of the Zimbabwe Annual Conference of the UMC ninth session*, 14-18 December 1988. This included reports from the United Methodist Youth Fellowship (UMYF), RRW and United Methodist Church Mubwui (MUMC), a guild for men who are charismatic, district superintendents as well as the church and society committee.

⁷⁴⁹ UMCAUM, "Medical board report," *Official Journal of the Zimbabwe Annual Conference of the UMC ninth session*.

church's healthcare centres in need of medical treatment. This was seen as ~~a~~ strain on financial resources at Old Mutare, Mutambara in Manicaland."⁷⁵⁰ The major concerns of both the medical board and the district superintendents related to the ever-increasing pressure on the church's healthcare resources rather than the need to carry out investigations of the underlying causal factors. HIV and AIDS gradually started to become an important issue to the leadership of the church's annual conference in Zimbabwe later in 1989.

A year after the statement on AIDS issued by the church's global Council of Bishops, the local leadership of the United Methodist Church undertook a few initiatives in reaction to the epidemic. A report by the health and welfare committee presented at the church's annual conference session in December 1989 covered four aspects.⁷⁵¹ First, it was noted that in 1989 Sister Nyamajiwa of Old Mutare Hospital attended a three months course specialising in AIDS healthcare, planning, communication, teaching and management in Atlanta, Georgia in the US. This was funded by Dr Johnson's church support programme. Second, the three hospitals at Nyadire, Old Mutare and Mutambara, with the last two being in Manicaland, started working towards promoting community, patient and staff education and awareness about AIDS. Individual and family counselling was instituted.⁷⁵² Third, a church health education seminar attended by Mutasa-Makoni and Mutare South district chairpersons was held in 1989. Fourth, increased sessions on health education with a special focus on HIV and AIDS and sexually transmitted infections were to be mounted by the church's district health and welfare committees in 1990. The church's members were expected to be aware of how communities could deal with those infected and affected by HIV and AIDS.⁷⁵³ The same report recommended that Nyamajiwa ~~be~~ be available to assist her counterparts at Nyadire, and Mutambara hospitals with the medical skills crucial in addressing the pandemic."⁷⁵⁴ This became one of the first practical steps in responding to the pandemic at institutional level.

⁷⁵⁰ AM, "District superintendents composite report," *Official Journal of the Zimbabwe Annual Conference of the UMC tenth session*, 13-17 December 1989, 60-64.

⁷⁵¹ AM, "Health and welfare report," *Official Journal of the Zimbabwe Annual Conference of the UMC tenth session*, 138.

⁷⁵² AM, "Health and welfare report."

⁷⁵³ AM, "Health and welfare report," 139.

⁷⁵⁴ AM, "Health and welfare report," 139.

At the church's top leadership level, the district superintendents appeared unaware that HIV and AIDS was making inroads into the church. This was noted from the lack of any mention of the epidemic in their report.⁷⁵⁵ It was the health and welfare board whose report noted the board's intentions to "provide awareness to all church members about the killer disease, AIDS."⁷⁵⁶ While the church's annual conference received support for human capacity building from its sister conferences in the US in 1990,⁷⁵⁷ and 1992,⁷⁵⁸ this did not translate into large scale HIV and AIDS interventions. The links between the United Methodist Church's annual conference in Zimbabwe and its sister annual conferences in the US has a long history, dating as far back to the beginning of the twentieth century when the church was first established. Such relationships, enhanced by powerful networks, "continued to serve as a lifeline for obtaining resources for the United Methodist Church in Manicaland and in Zimbabwe."⁷⁵⁹ Thus, the church's leadership in Zimbabwe benefited from its global partners. However, locally, at the annual conference level, HIV prevention and AIDS mitigation activities appeared to have minimum effect apparently because of the church's lack of full time personnel in this field.

3.4.3. HIV Prevention and the Condom Use Controversy

The resolution on the use of condoms passed by the church's annual conference session in December 1990 became a major landmark in the history of HIV prevention. Resolution 43 reads: "That the use of condoms be recommended to married couples as a means of family planning and protection against AIDS and indiscriminate distribution of condoms be condemned."⁷⁶⁰ Significantly, the leadership of the church's annual conference moved beyond mere moralising about the pandemic. The church's leadership took practical steps to safeguard its members who were prone to

⁷⁵⁵ For this see UMCAUM, "District superintendents composite report," and "Conference lay leaders report," *Official Journal of the Zimbabwe Annual Conference of the UMC eleventh session*, 12-16 December 1990, 47-54.

⁷⁵⁶ UMCAUM, "Health and welfare report," *Official Journal of the Zimbabwe Annual Conference of the UMC eleventh session*, 165-172.

⁷⁵⁷ UMCAUM, "Health and welfare report," 166.

⁷⁵⁸ See also AM, "Health and welfare report," *Official Journal of the Zimbabwe Annual Conference of the UMC thirteenth session*, 9-13 December 1992, 187.

⁷⁵⁹ S. Sign, same interview.

⁷⁶⁰ UMCAUM, "Resolutions," *Official Journal of the Zimbabwe Annual Conference of the UMC eleventh session*, 203.

infection, especially women. While three years previously the position of the church's global Council of Bishops had been very pragmatic on this matter, the local church's leadership appeared hesitant to implement the recommendations on the use of condoms. This delay was less helpful to ordinary people.

Within the context whereby local African cultural traditions and Christian morality on sexuality did not support sex outside marriage, the church's leadership treaded cautiously. Also, while the resolution appeared to be helpful to couples at risk of contracting HIV, it overlooked the challenges faced by churchwomen in exercising choices of safe sex. Studies done on women and sexuality on the African continent showed that married women were often not at liberty to negotiate the use of condoms as part of safe sex because it was perceived as 'culturally unacceptable' to their spouses. As Daryl Somma and Claudia Bodiang have observed: "Women talking their male partner about sex may be taboo in certain communities and recommending them to negotiate safe sex may thus be culturally inappropriate and ineffective."⁷⁶¹ The use of condoms in the prevention of sexually transmitted HIV received support from the State in Zimbabwe through the MOHCW.⁷⁶² Within the United Methodist Church, condoms have always been considered to be a contraceptive device within marriage, and the church did not officially discourage couples from using them.⁷⁶³

Generally, the fear of HIV bestowed new value on condoms – that is from being used as a method of contraception to now being used as prophylactics. Jane Makunike of Tsonzo near Watsomba, Mutasa district, stated that from the mid-1980s onwards, condoms suddenly became quite prominent because they reduced the chances of HIV.⁷⁶⁴ Despite this new reality, it was still not easy for married churchwomen to take condoms home for use with spouses. The fact that churchwomen from the United Methodist Church were not at liberty to suggest the use of condoms as prophylactics rendered them at risk of contracting HIV from unsafe sex. Cultural perceptions of a

⁷⁶¹ D. B. Somma and C. K. Bodiang, *The cultural approach to HIV/AIDS prevention*, Social Development Division's Health Desk, Swiss Tropical Institute, (2003), 7.

⁷⁶² This was implied in the Medium Term Plan 1 (MTP1) 1988-1993.

⁷⁶³ J. Makunike, interview conducted by M. Mbona, Makunike farm, Watsomba, Mutasa, 13 September 2010. See also I. Chowa, same interview. See also T. Matsika, interview conducted by M. Mbona, Rukweza UMC circuit, 8 September 2010. For a further perspective on this see: UMC, Responsible parenthood, <http://umc.org/interior_print.asp?ptid=4&mid=991/> [Accessed 9 July 2011].

⁷⁶⁴ J. Makunike, same interview.

—recently married African woman” who could not —suggest” safer sex were still dominant.⁷⁶⁵ However, the noted significant increase in AIDS-related deaths was worrying to some church members. HIV prevalence rate in 1990 was above 10%, only five years since the first public case AIDS in 1985.⁷⁶⁶ As HIV and AIDS infected and affected the church’s members, the leadership was left with limited options and thus had —to intensify their efforts at mounting programmes on HIV and AIDS awareness and prevention.”⁷⁶⁷

In 1991 the United Methodist Church’s districts of Mutasa-Nyanga, Mutare South, Mutare, and Makoni Buhera in Manicaland failed to launch planned HIV awareness campaigns as was previously agreed on.⁷⁶⁸ AIDS awareness activities were only carried out during the church’s health and welfare week once in the year.⁷⁶⁹ There were no on-going initiatives to augment AIDS awareness and educate people on prevention of HIV transmission. Thus, the programme had known limitations and yet HIV and AIDS made life miserable for church members and their families. This can be one of the reasons for pushing a motion to legitimise the use of condoms as resolved at the church’s annual conference session in 1991. An outcry from the health and welfare committee to amend resolution 43 of 1990 resulted in changes and thus now read as follows: —That the use of condoms be legitimised as a means of family planning and protection against AIDS but that the indiscriminate distribution be discouraged.”⁷⁷⁰ The delegates to the church’s annual conference session accepted the proposed changes in the spirit of making the use of condoms widely acceptable. This latest stance on condoms by the church’s leadership set a new tone concerning matters of sexuality. Theoretically, out of fear of HIV infection, coupled with the intention to protect women, condoms gained ground and thus liberated married women. Thus, while AIDS brought misery through infection and death, it also empowered married

⁷⁶⁵ T. Matsika, same interview. See also E. Humure, interview conducted by M. Mbona, Makunike farm, Watsomba, Mutasa, 13 September 2010.

⁷⁶⁶ NAC, *Zimbabwe behavioural change strategy*, 6. A similar figure was noted from a report by United States Aid (USAID) that noted that by the end of the 1980s around 10% of the adult population were thought to be infected with HIV. For this see USAID, *Zimbabwe, HIV/AIDS health profile*. See also —HIV decline in Zimbabwe due to reductions in risky sex? Evidence from a comprehensive epidemiological review,” *International Journal of Epidemiology* 39 (2010), 1312.

⁷⁶⁷ AM, —Health and welfare report,” *Official Journal of the Zimbabwe Annual Conference of the UMC twelfth session*, 11-15 December 1991, 174.

⁷⁶⁸ AM, —Health and welfare report,” 176-177.

⁷⁶⁹ T. Matsika, same interview.

⁷⁷⁰ AM, —Health and welfare report,” 177. See also AM. —Resolutions,” *Official Journal of the twelfth session*, 210.

churchwomen by making it legitimate for them to insist on safe sex through using condoms.

The church's leadership in Zimbabwe displayed mixed reactions to the government's messages that encouraged the use of condoms as protection against contracting HIV sexually. While the churches perceived increased condom use to be the worst enemy of morality, an inherent weakness was that the position was unhelpful to women in particular including those who were in danger of contracting HIV from unfaithful spouses. Consistent with this assertion Ana Langerak has stated that ~~the~~ moral admonitions (for example by the churches), to remain faithful has its limitations because its emphasis is more on the individual rather than the community.⁷⁷¹ On the one hand, the leadership of the church's annual conference in Zimbabwe were opposed to the indiscriminate distribution of condoms arguing that this practice weakened the moral integrity of society. On the other hand, the church conceded that using condoms within marriage could prevent sexual transmission of HIV. However, the annual conference session's resolutions on condom use protected the first position, that of preserving a good image of the church. Isabel Chowa, a member of the United Methodist Church stationed in Rusape, who served with the youth for many years, stated that the prohibition of condom use in prevention of HIV among the youth showed that the church's leaders were in denial of sexual realities.⁷⁷² The church's leadership overlooked the fact that church followers were indulging in unprotected sex including the youth. Thus, the present research study concludes that this stance by the leadership of the church directly fuelled the spread of HIV and AIDS.

The State's introduction of antenatal clinic surveillance initiated in 1990 served as an eye-opener to women's knowledge of the extent of HIV prevalence. For example, a study by Gregson *et al.* indicated that the introduction of antenatal clinic (ANC) based surveillance in 1990 in Zimbabwe revealed that HIV prevalence exceeded 10%.⁷⁷³ The fact that this figure was based on ANC surveillance serves to illustrate the levels of HIV among women. According to Chowa, ~~that~~ caused alarm among married

⁷⁷¹ A. Langerak, ~~Foreword~~, "Facing AIDS: The challenge, the churches' response: A WCC study document (Geneva, WCC Publications, 1997), viii.

⁷⁷² I. Chowa, same interview.

⁷⁷³ S. Gregson *et al.*, ~~HW~~ decline in Zimbabwe due to reductions in risky sex?," 1312.

women who were members of the UMC [United Methodist Church].⁷⁷⁴ Mary Saungweme, a nurse by training and also a member of the United Methodist Church, stated that married males preferred using condoms with concurrent partners and not with their spouses. Saungweme further pointed out that ~~in~~ 1993 married men from the UMC [United Methodist Church] were shy and unwilling to admit to possibilities of involvement in concurrent partnerships.⁷⁷⁵ Saungweme, who served on the Hilltop circuit healthcare committee between 1990 and 1994, mentioned that a number of married men were interested in knowing about HIV prevention. This was shown by high attendance at meetings where HIV awareness and prevention were discussed and yet ~~sadly~~ church members continued to die of AIDS.⁷⁷⁶

The statement issued by the church in June 1993, after the church's consultation on HIV and AIDS, was also an important step towards a victory for pro-condom advocates working in the field of prevention of HIV. The proper and consistent use of condoms in situations where people failed to restrain themselves from sex outside of marriage was recommended.⁷⁷⁷ Furthermore, the statement also recognised some of the challenges faced by the youth in preventing HIV and thus recommended that young people be allowed to use condoms. Part of the statement observed:

Peer pressure among youth encourages them to become sexually active at an early age. Many of them do not believe in their mortality and therefore fail to postpone their sexual activity or to utilise precautions which would reduce their risk for contracting HIV.⁷⁷⁸

The church's leadership and clergy stationed at the grassroots level did seldom agree on the use of condoms. For example, a pastor had this to say: ~~W~~Within the church a liberal policy on the use of condoms was a threat to Christian morality and the institution of marriage.⁷⁷⁹ Thus, the church's position on the use of condoms was veiled in controversy. In 1993, at a national church leaders' forum on AIDS, of which the top leadership of the United Methodist Church was a part, a collective stance was

⁷⁷⁴ I. Chowa, same interview.

⁷⁷⁵ M. Saungweme, interview conducted by M. Mbona, Mutare, 17 September 2010. See also I. Chowa, same interview; E. Kabungaidze, same interview.

⁷⁷⁶ M. Sangwene, same interview.

⁷⁷⁷ SM, ~~Statement from HIV/AIDS consultation,~~ 271.

⁷⁷⁸ SM, ~~Statement from HIV/AIDS consultation,~~ 271.

⁷⁷⁹ A. Mhondoro, same interview.

taken which thus stated: –Chastity before marriage and faithfulness to one’s spouse are not impossible ideals. ...The indiscriminate use of condoms is not the answer.”⁷⁸⁰ The position of the leadership of the United Methodist Church on the use of condoms in the prevention of sexually transmitted HIV was ambiguous and sent mixed messages to the church members and the rest of the public.

While the statement also highlighted awareness of the acute challenges faced by women, it fell short of identifying practical ways of addressing economic pressures that separated married couples.⁷⁸¹ There was already a growing feeling that keeping married couples under one roof as far as possible could reduce the spread of HIV and thereby contribute to a decline in AIDS. However, it was remarkable to observe that the church’s leadership appeared to be enlightened not only to the issues of individual morality but also to structural sin. The consultation report further stated:

Because of economic pressures many men are forced to leave their families for work in towns or in neighbouring countries. This often leads men to develop sexual relations with other women, some of whom are infected with the HIV. When the men return home, their sexual partner is placed at increased risk for contraction of HIV. Married persons who indulge in extra-marital sex places their spouses at risk.⁷⁸²

The statement shared some degree of commonality with an earlier one issued by the ZCBC in 1991.⁷⁸³ Thus in the wake of HIV and AIDS, some of the churches in Zimbabwe including the United Methodist Church became a voice for encouraging married couples to live under one roof. While it was difficult to measure the short term benefits of this action, we might confidently state that some people gradually realised that the chances of contracting HIV through sexual contact could be reduced if married couples lived together. According to Chief John Rukweza who worked in Harare in the early 1990s, some couples were saved from contracting HIV by taking heed of the church’s calls ~~to~~ abandon the practice of living separately.”⁷⁸⁴

⁷⁸⁰ HOCD, *Conference statement on AIDS*.

⁷⁸¹ SM, –Statement from HIV/AIDS consultation,” 270-271.

⁷⁸² Statement from the HIV and AIDS consultation, Harare, 21-25 June 1993, <<http://gbgm-umc.org/health/aids/harare.stm/>> [Accessed 1 July 2011].

⁷⁸³ For this see earlier section on the statements issued by the ZCBC under the Roman Catholic Church.

⁷⁸⁴ J. Rukweza, interview conducted by M. Mbona, Rukweza service centre, 8 September 2010.

3.4.4. The Launch of AIDS-Related Care Interventions

Bishop Jokomo's remarks at the annual conference session that he addressed as head of the United Methodist Church in Zimbabwe in 1992 did not make any specific reference to HIV and AIDS. Part of Jokomo's remarks read as follows:

Our hospitals can empower our communities to address health issues from a socio-economic, spiritual and medical perspective. Our hospitals must take the lead in advising the church and local authorities about the new trends in healthcare.⁷⁸⁵

The new bishop had served under Bishop Muzorewa as secretary to the church's annual conference and in that capacity →Jokomo had access to the different forums of the church globally at which HIV and AIDS was a major focus."⁷⁸⁶ Jokomo was therefore conscious of possible shortcomings in the church's response to HIV and AIDS. A delay by the church's leadership to establish well-structured HIV and AIDS interventions could have been connected to →fear of being seen as undermining or interfering with the State."⁷⁸⁷ Apparently, hesitant to take bold steps, and without a fully-fledged HIV and AIDS department, the only viable and user-friendly option for the church's leadership appeared to be the care of OVC. For example, in 1992, *Rukwadzano RweWadzimai* (RRW) hereafter called Rukwadzano guild donated money and clothes to Fairfield Orphanage Old Mutare, established in 1903.⁷⁸⁸ According to Farai Muzorewa, since the formation of Rukwadzano guild at Old Mutare mission in 1929, the members were involved in works of charity including the care of orphans by donating clothes, food and money for education.⁷⁸⁹ However, AIDS challenged the other church members to also consider giving support to OVC at institutions and elsewhere within localities.

⁷⁸⁵ AM, →Bishop Christopher Jokomo, Episcopal address: A statement evaluating the past performance of the church and setting broad goals for the future," *Official Journal of the Zimbabwe Annual Conference of the UMC thirteenth session*, 9-13 December 1992, 25.

⁷⁸⁶ A. Mhondoro, same interview. See also S. Sign, same interview.

⁷⁸⁷ E. Kabungaidze, same interview. See also I. Chowa, same interview.

⁷⁸⁸ AM, →Rukwadzano report," *Official Journal of the Zimbabwe Annual Conference of the UMC thirteenth session*, 182. See also Background to Fairfield Children's Home, <<http://www.gardens-of-hope.org/FCH.html>> [Accessed 5 March 2011].

⁷⁸⁹ F. D. Muzorewa, →Through prayer and action: The Rukwadzano women of Rhodesia," in Ranger and Weller, *Themes in the Christian history of Central Africa*, 259.

The church's annual conference in Zimbabwe faced difficulties in launching sustainable home-based care programmes. Low attendance at meetings, the lack of teaching materials, and the unavailability of drugs at church's healthcare institutions and shortage of doctors at Old Mutare hospital were cited as common challenges.⁷⁹⁰ The shortage of medical personnel in mission hospitals including Old Mutare presented unique problems for service delivery and also affected the church's HIV and AIDS interventions. The State's introduction of financial cuts in government spending on public health following the introduction of economic reforms dealt a major blow on staff retention. The salaries of workers at mission hospitals were paid by the State's health ministry through the "mission section" department and were therefore affected by cuts in public spending. Consequently, a large proportion of doctors and nurses shunned working in rural mission hospitals where "conditions of service were at times deplorable."⁷⁹¹ The healthcare delivery system was dire to an extent that an expatriate medical doctor based at St. David's Bonda mission hospital under the Anglican Church served at a number of mission hospitals including Old Mutare hospital. The same doctor used to pay monthly visits to Old Mutare and several other clinics in Mutasa district.⁷⁹² While the HIV epidemic expanded, unfavourable working conditions for medical staff affected service delivery and thus compromised the HIV and AIDS interventions initiated by the church's leadership.

3.4.5. AIDS-Related Denial and Stigma at Leadership level

The fact that the leadership of the church's annual conference only started to address AIDS-related denial stigma in 1993-1994 indicated that the church had nurtured the notion that AIDS was a punishment from God. However, there was a shift towards a new understanding of HIV and AIDS at the annual conference in December 1993. According to the church's HIV and AIDS consultation report, to which reference will also be made later, the myth that AIDS was a punishment from God was dispelled:

⁷⁹⁰ SM, "Health and welfare report," *Official Journal of the Zimbabwe Annual Conference of the UMC fourteenth session*, 8-12 December 1993, 223.

⁷⁹¹ T. Manyeza, same interview.

⁷⁹² T. Manyeza, same interview.

The origin of this virus is still in question in the medical community, we in the religious community are certain that it is not sent as a punishment from God upon those whose lifestyle is called into question. Humankind does indeed face a crisis in the wake of AIDS. We speak with hope that those who may not have taken seriously the impact and implications of AIDS will now do so.⁷⁹³

The report contained two significant issues. First, the report offered a theological stance on responding to HIV which was characterised by tolerance, urgency and hope. Second, the report exposed crucial information on the extent of HIV prevalence and the effects of the pandemic on children. It appears that Bishop Jokomo was more aware of the way HIV and AIDS infected and affected ordinary people than his predecessor. Jokomo was elected to the office of bishop at the age of fifty and –appeared to be enthusiastic to lead the UMC [United Methodist Church] in Zimbabwe into engagement with social issues that affected ordinary people.”⁷⁹⁴ The fact that the church’s efforts to address the HIV and AIDS pandemic came largely after 1993 suggests that the previous leadership under Bishop Muzorewa might have contributed little to the church’s HIV and AIDS interventions.

The hosting of an HIV and AIDS consultation conference held in Harare, 21-25 June 1993 strengthened the capacity of church’s annual conference in responding to the pandemic. The delegates to the meeting were drawn in from the United Methodist Church’s annual conferences of West Angola, Mozambique, and Zimbabwe.⁷⁹⁵ An eight-member committee that was comprised of two clergy, including Bishop Jokomo, and six lay people including medical professionals, represented the church’s Zimbabwe Annual Conference.⁷⁹⁶ An important step taken by the consultation was that physical and mental health were considered inseparable from spiritual well being. This position meant that HIV and AIDS interventions were to be an integral part of the church’s spiritual work and therefore the church was obliged to undertake HIV awareness, prevention and care programmes.⁷⁹⁷ This meeting also observed that the

⁷⁹³ SM, –Statement from HIV/AIDS consultation,” 272.

⁷⁹⁴ T. Manyeza, same interview. See also United Methodist News Service, –Former bishop of Zimbabwe dies at 64,” <<http://www.umc.org/site/apps/nl/content3.asp?c=1wL4KnN1LtH&b/>> [Accessed 8 November 2011].

⁷⁹⁵ SM, –Statement from HIV/AIDS consultation,” 269.

⁷⁹⁶ SM, –Statement from HIV/AIDS consultation,” 273.

⁷⁹⁷ Statement from the HIV and AIDS consultation, Harare, 21-25 June, 1993, <<http://gbgm-umc.org/health/aids/harare.stm/>> [Accessed 1 July 2011].

church's annual conferences from the three participating countries needed to boost responses to HIV and AIDS. Part of the statement reads as follows: –Governments and private social service and healthcare institutions will face incredible, if not impossible, demands for care for those suffering from HIV disease and their families.”⁷⁹⁸ According to Mhondoro, the consultation was purposefully designed to attract donor funding in which –the African UMC [United Methodist Church] annual conferences could stand to benefit under HIV interventions programmes.”⁷⁹⁹ By extension, HIV interventions had a potential to boost the income of local churches.

The HIV and AIDS epidemic ‘forced’ the church’s leadership in Zimbabwe to form an HIV and AIDS task team. Representatives were drawn up from the following departments: Christian Education, Evangelism, Stewardship, Church and society, Rukwadzano guild, Mubvuwi guild, youth, health and welfare committee. The team’s mandate entailed focus on the following six objectives:

- (1) Education targeting youth, men, women, clergy, health personnel, community leaders,
- (2) Sex education including anatomy, physiology, sexuality, church’s view on sexuality, birth control,
- (3) Fundraising for HIV and AIDS related work,
- (4) Establishment of AIDS care Centres,
- (5) Support to Orphan Care Centres, and
- (6) Advise the bishop on the need to appoint a full time HIV/AIDS coordinator.⁸⁰⁰

The same annual conference session witnessed the setting up of a HIV and AIDS committee that reported directly to the bishop. Approval was also given for the appointment of a full time HIV and AIDS coordinator.⁸⁰¹ Some reasons accounted for Bishop Jokomo’s radical devotedness to HIV and AIDS. First, the timing of the new bishopric coincided with an increase in deaths that were associated with AIDS. Second, Jokomo was aware of the minimal attention given to the pandemic by the previous Episcopal leadership in the earlier years. Bishop Jokomo was thus committed to make a difference. Third, over the years some church members accumulated knowledge and information about the pandemic. Fourth, Bishop Jokomo, as a new leader, could have sought to project a positive image of the United Methodist Church to the State in Zimbabwe.

⁷⁹⁸ SM, –Statement from HIV/AIDS consultation,” 270.

⁷⁹⁹ A. Mhondoro, same interview.

⁸⁰⁰ SM, –Statement from HIV/AIDS consultation,” 272.

⁸⁰¹ SM, –Statement from HIV/AIDS consultation,” 278.

At the church's annual conference session in December 1994 the new bishop pushed the boundaries of the annual conference's reaction to the HIV epidemic. Jokomo told the delegates attending the annual conference session that it was not enough to show awareness of the existence of PLHIV and OVC without taking practical steps to assist. In praise of the Rukwadzano guild Jokomo remarked:

We are proudly aware that our Rukwadzano RweWadzimai have participated seriously in the provision of services to the street dwellers and to people living with AIDS. ...This conference needs to be more responsive to the plight and needs of those who are suffering.⁸⁰²

The Rukwadzano guild was not a newcomer to care that is driven by religious conviction, seeking to make life better for others including orphans.⁸⁰³ However, AIDS had an effect of increasing the number of OVC. According to a consultation report tabled at the church's annual conference session in December 1993, between 1988 and 1992 the number of OVC nationally grew from 10,000 to 200,000.⁸⁰⁴ This figure was way below the estimate by another source that put the figure of OVC at 350,000 in 1988 and 500,000 in 1993.⁸⁰⁵ The fact that AIDS-related deaths had the effect of increasing the number of OVC exponentially forced the church's leadership to explore new models of OVC care. With AIDS claiming the lives of families and close relatives, the church's members faced a new reality of caring for OVC within one's neighbourhood.⁸⁰⁶

In 1994 for the first time the district superintendents' composite report proposed that the annual conference designs suitable AIDS programmes.⁸⁰⁷ Two possible reasons could explain why the district superintendents' raised alarm. First, the lack of solid action taken on HIV and AIDS meant that the work of a previously constituted AIDS committee had been futile. Second, the district superintendents reacted in shock as

⁸⁰² Makoni-Buhera UMC District archives, Rusape, (MBDR), C. Jokomo, "Bishop's opening statement," *Official Journal of the Zimbabwe Annual Conference of the UMC fifteenth session*, 7-11 December 1994, 19.

⁸⁰³ E. Humure, same interview. See also S. Sign, same interview. See also E. Kabungaidze, same interview. See also G. Gunderson, "What is worth knowing about religious health assets in Africa at this particular time," *African Religious Health Assets Programme*, Papers and proceedings, Willow Park, South Africa, (July 2005), 13-15.

⁸⁰⁴ See figures cited in SM "Statement on HIV/AIDS consultation," 273.

⁸⁰⁵ NAC, *The HIV and AIDS epidemic in Zimbabwe*, 43.

⁸⁰⁶ E. Nezomba, interview conducted by M. Mbona, Chitombo, Honde Valley, 14 September 2010.

⁸⁰⁷ MBDR, "Districtsuperintendents' composite report," *Official Journal of the Zimbabwe Annual Conference of the UMC fifteenth session*, 33-34.

they became aware of increased AIDS-related deaths. In support of the second observation, it was estimated that the number of number of deaths due to AIDS rose from 25,000 in 1990 to above 60,000 in 1994.⁸⁰⁸ With the district superintendents being in charge of the church's affairs at district level, it is unbelievable to imagine that they were unaware of the effects HIV and AIDS on church members.

A respondent stated that the church's leadership appeared uneasy to discuss HIV and AIDS –because sexuality was at the centre of the epidemic.”⁸⁰⁹ Elsewhere, Messer has noted that a great deal of secrecy surrounded the subject of sex as though it was not a God-given gift. He thus observed: –It is almost as if we have been programmed into a conspiracy of silence about sexuality, lest we be misunderstood or misinterpreted as less than spiritual persons and leaders.”⁸¹⁰ At the end of the first decade of AIDS in Zimbabwe a marked shift in denial and stigma of HIV was witnessed among the church's leadership from a state of panic to one of accepting the epidemic.⁸¹¹ The district superintendents appeared ready to make meaningful contributions towards HIV prevention programmes for young people. However, their approach to HIV prevention was still moralistic.

Similar to the ZCBC, the district superintendents despised the State's HIV and AIDS awareness and prevention education interventions. Part of their report read: –The sex education that is on offer is quite unacceptable to us because emphasis is being put on preventive contraceptives rather than total abstinence from sex outside marriage. Such a trend we deplore.”⁸¹² In 1994, for the first time home-based care patients were provided with financial support amounting to Z\$4,583 and this was used for food and sanitary provisions.⁸¹³ The church's leaders were drawn into adopting HIV and AIDS interventions not by choice, but because the pandemic infected and affected them. Families within the church reportedly lost loved ones and a huge amount of time was spent either caring for the PLHIV, mourning the dead or both. HIV and AIDS became

⁸⁰⁸ WHO *et al.*, *Epidemiological fact sheet on HIV and AIDS: Zimbabwe 2008 update* (October 2008), 5.

⁸⁰⁹ I. Chowa, same interview.

⁸¹⁰ Messer, *Breaking the conspiracy of silence*, 34-35.

⁸¹¹ S. Sign, same interview.

⁸¹² MBDR, –Districtsuperintendents' composite report,” *Official Journal of the Zimbabwe Annual Conference of the UMC fifteenth session*, 79.

⁸¹³ MBDR, –Council on ministries report,” *Official Journal of the Zimbabwe Annual Conference of the UMC fifteenth session*, 179.

a reality that had the potential to decimate whole United Methodist Church families if no appropriate action was taken.⁸¹⁴

3.4.6. AIDS-Related Denial and Stigma at the Grassroots Level

Initial responses to HIV and AIDS from the United Methodist Church's congregants and clergy were characterised by denial and stigma. Kabungaidze of Hilltop Circuit, Sakubva, mentioned that "when AIDS first made inroads into the youthful nation of Zimbabwe in 1983/4 people perceived it as a disease that was associated with the United States (US) and the United Kingdom (UK)."⁸¹⁵ Another respondent, the Reverend Peter Mufute, stated that AIDS-related deaths of young people in the mid-1980s were "politically induced by those colonialists defeated at the war front."⁸¹⁶ Such perceptions indicated the level of blame and denial, which were hallmarks of the HIV epidemic in Zimbabwe. Denial of the biomedical nature of HIV also led some people to accuse women involved in cross-border trade for "having contracted AIDS from sexual intercourse with dogs in South Africa."⁸¹⁷ An informant mentioned that he first heard about AIDS at a convention of a Rukwadzano guild held in Murewa in 1983. Pius Hlahla further stated that Eben Nhiwatiwa, who then was coming from the US, was a guest preacher and during his sermon at that convention Nhiwatiwa mentioned AIDS.⁸¹⁸ Thus, at the grassroots level some church members were exposed to information on AIDS epidemic quite early but denial and stigma might have held them back from launching HIV interventions.

One of the possible factors that contributed to the delayed HIV interventions by grassroots communities was the issue of complacency and that exacerbated denial and stigma. Generally, some of the church's members in Manicaland could not believe

⁸¹⁴ A. Mhondoro, same interview.

⁸¹⁵ E. Kabungaidze, same interview.

⁸¹⁶ P. Mufute, interview conducted by M. Mbona, Old Mutare mission, 24 August 2010.

⁸¹⁷ T. Matsika, same interview.

⁸¹⁸ Information was supplied by P. Hlahla to M. Mbona, Makoni Buhera UMC district office, Rusape, 22 June 2010. The name of Eben Nhiwatiwa also appeared as one of the guest speakers at a south-north convention of the Rukwadzano guild as reported at the annual conference of 1985. For this see also UMCAUM, "Rukwadzano RweWadzimai report," *Official Journal of the Zimbabwe Annual Conference of the UMC sixth session*, 69.

that Christians, especially members of the United Methodist Church, were not immune to the epidemic. As Kabungaidze stated:

You know, the problem with us church people is that we practice self-righteousness. We get to a point where we do not see ourselves as part of this world. With a disease like AIDS many of our Christians never thought it might come to them but it did.⁸¹⁹

Similarly, another church member, Adulight Mapa of Mutare, stated that between the early 1980s and mid-1990s AIDS was never talked about because: –As Christian churchwomen we thought that none of us including our families could be infected or affected by HIV.”⁸²⁰ Hence, at the grassroots level AIDS was understood as a disease associated with promiscuity. People who were suspected of having AIDS were thus stigmatised by other Christians and the public in general.

Within the United Methodist Church, when HIV first appeared, some married churchwomen confused it with sexually transmitted infections including syphilis or gonorrhoea and hoped that with regular treatment from healthcare centres one could fully recover.⁸²¹ The fact that some church members at grassroots level confused HIV with sexually transmitted infections led to delays in recognising that this was a new disease.⁸²² HIV and AIDS became associated with immorality. Against such perceptions, Ronald Nicolson warned:

Insisting, as we should, that the only totally reliable defence against AIDS is a lifestyle of fidelity, we must be very careful to make clear that having AIDS does not mean that one has been –promiscuous.” Many, even most, of those who contracted AIDS in South Africa [as well as elsewhere] are not promiscuous.⁸²³

Limited knowledge regarding HIV and AIDS was exacerbated by the fact that the grassroots communities in Zimbabwe were misinformed about the new disease. HIV and AIDS also challenged biomedicine in the sense that local medical experts

⁸¹⁹ E. Kabungaidze, same interview. See also S. Sign, same interview; A. Mhondoro, same interview; T. Matsika, same interview.

⁸²⁰ A. Mapa, interview conducted by M. Mbona, Dangare, Mutare, 13 August 2010.

⁸²¹ T. Matsika, same interview. See also E. Humure, same interview.

⁸²² J. Rukweza, same interview.

⁸²³ R. Nicolson, *AIDS, A Christian response*, (Pietermaritzburg: Cluster Publications, 1995), 24.

engaged in clinical studies under pressure from an otherwise confused public.⁸²⁴ This was not unique to Manicaland and Zimbabwe. In the US, doctors took a long time before acquainting themselves with the symptoms of AIDS in the early 1980s.⁸²⁵ While the members of the United Methodist Church were in denial and stigmatised PLHIV, Kabungaidze mentioned that “by openly acknowledging AIDS for the first time as late as 1985 the government was dishonest and fuelled denial”⁸²⁶

The initiatives undertaken by the church’s leaders at the annual conference level in responding to HIV and AIDS in 1992 remained sporadic and therefore yielded low achievements. For example, the programmes initiated by the medical staff at Old Mutare hospital to provide lectures on AIDS, and pamphlets for use with school children, became isolated cases that only benefited a small proportion of the public. In another case, in Mutare South, lectures on AIDS awareness were mainly conducted during the church’s health and welfare week.⁸²⁷ Such initiatives were restricted to people who were physically residing at the church’s institutions. As Makunike noted, “in the absence of any community outreach programme the effectiveness of the AIDS awareness campaigns was minimal.”⁸²⁸ To say the very least, this strategy was positive but not sustainable and its achievements were limited. In 1993, while the United Methodist Church’s health and welfare committee was committed to responding to HIV and AIDS, statements of intention did not translate into positive tangible action. In this period, there was little evidence of holistic engagement with the epidemic other than HIV interventions carried out at the church’s healthcare centres. Thus, grassroots church members benefited less because HIV and AIDS programmes were not mainstreamed and did not run throughout the year.⁸²⁹

3.5. Synthesis

In this chapter the researcher has indicated that HIV crept into Zimbabwe at a time when the nation was still celebrating the joys of its newly attained independence and

⁸²⁴ T. Manyeza, same interview.

⁸²⁵ Bayer and Oppenheimer, *AIDS doctors*, 12.

⁸²⁶ E. Kabungaidze, same interview. See also A. Mhondoro, same interview.

⁸²⁷ AM, “Health and welfare report,” *Official Journal of the Zimbabwe Annual Conference of the UMC thirteenth session*, 191.

⁸²⁸ J. Makunike, same interview. See also E. Humure, same interview.

⁸²⁹ T. Matsika, same interview.

it took some time before the public, including Christians, accepted the epidemic as a new reality. At the beginning of the 1990s the public healthcare system faced a gradual decline mainly because of the introduction of economic reforms under the IMF. As a result, the churches' healthcare centres began to carry the burden of responding to the healthcare needs of the poor including PLHIV. It became critical for the churches to be involved in public healthcare and especially HIV and AIDS. According to Gelfand, this engagement with diseases had a history among the Western missionary-initiated churches in Zimbabwe. In Manicaland the churches including the Roman Catholic, Anglican and United Methodist continued with the legacy of involvement in public health and served some communities.

Politically, on the one hand, in 1980 the new democratically elected Government extended an olive branch to the churches to partner the State in the field of healthcare, education and community development.⁸³⁰ This gave the churches the opportunity of becoming involved in HIV interventions. On the other hand, the churches under the auspices of the Zimbabwe Council of Churches were hesitant to support the new government because of its choice of a socialist ideology.⁸³¹ Generally, the church healthcare centres were well stocked in terms of medicines and served their clients in a Christian spirit. During the first two years of independence, this reluctance on the part of the Zimbabwe Council of Churches led the State to accuse the council for taking a 'wait and see approach' to issues of national importance.⁸³² While the relationship between the Roman Catholic Church and the State could be described as harmonious immediately following independence, this was to change dramatically over time.⁸³³ Given this context, this chapter has explored church responses to the pandemic by analysing the input by different ecclesiastical players. The present study has shown that all the three churches had external links, which in a number of ways exerted an influence on their responses to the HIV epidemic. However, within Manicaland, all the three churches rarely collaborated with each other on HIV and AIDS interventions and this affected efficacy.

⁸³⁰ For this see P. Mutume, "Insights from the second Chimurenga."

⁸³¹ See Bakare, "Christianity and scientific socialism in Zimbabwe," See also Hallencreutz, "Ecumenical challenges in independent Zimbabwe," 251-311.

⁸³² C. F. Hallencreutz, "Church and State in Zimbabwe and South Africa," in Hallencreutz and Palmberg, *Religion and politics in southern Africa*, 163.

⁸³³ For this see Gundani, "The Catholic Church and national development in Zimbabwe," 215-249.

While Denis asserted that the leadership of a church tends to exert influence on church responses to HIV and AIDS, it appears that the main actor in the story of church responses to HIV was the Jesuit, Ted Rogers. Rogers first drew the attention of the bishops of the Roman Catholic Church in Zimbabwe and Southern Africa towards HIV and AIDS and worked with church leaders at similar forums. He became an AIDS activist and a theological consultant of church responses to HIV. The ZCBC benefited tremendously from working with Rogers and with his assistance issued the first statement on AIDS from the Christian community in Zimbabwe in 1987. The leadership of the Roman Catholic Church benefited from the church's prior experience of engagement with social issues and thus released pastoral letters and statements on HIV and AIDS. Within the Roman Catholic Church, the existence of a central body, the ZCBC, became advantageous because it acted as a platform for the bishops to debate on matters of national interest and HIV became one of the issues. The leadership of the Anglican Church in Manicaland and that of the United Methodist Church made statements on HIV and AIDS jointly under the auspices of the Zimbabwe Council of Churches in 1989 and 1993. Within the Roman Catholic Church, the ZCBC streamlined the responses to the epidemic by creating an HIV and AIDS commission in 1988. This had the advantage of increasing the church's attention towards HIV and AIDS. The delay by the Anglican and United Methodist church in establishing similar structures until after 2000 indicates that these churches were lagging behind in responding to the pandemic.

The statements on HIV issued by the leadership of all the three churches indicate blame, denial and stigma. Generally, the leaders of the Anglican and United Methodist churches appeared to be in full agreement with the bishops of the Roman Catholic Church that AIDS was the result of moral failure. Hence, by using moral language and strongly insisting that in order to stop the spread of HIV sexual abstinence and faithfulness were the only two ideals, the church leaders played a negative role in HIV prevention. The church leaders cast blame on PLHIV. The Government of Zimbabwe and other team players encouraged the use of condoms in the prevention of sexually transmitted HIV to which church leaders generally disagreed. The Roman Catholic Church in Southern Africa and Zimbabwe clearly

upheld and taught its followers on the importance of the sanctity of sex within the commitment of Christian marriage.⁸³⁴

It appears that the Catholic bishops were not highly sensitive to the challenges faced by grassroots members of the Roman Catholic Church especially married churchwomen. Thus, by upholding a long-held moral tradition, and doing little to address the realities faced by society due to HIV, the ZCBC exacerbated the spread of HIV. It must be noted however, that officially, the Anglican and the United Methodist churches did not share a common position with the Roman Catholic Church on barring the use of condoms as part of birth control. For example, the Anglican Church and more specifically the Church of England, subscribed to the view that artificial contraception including the use of condoms is not a sin. Hence, the bishops of the Church of England stated: –Sexual love can be seen as good in itself, and it provided an essential way for a husband and wife to express their love for each other.”⁸³⁵ As a result, the Anglican Church took a more liberal stance on contraception by allowing married couples to enjoy sex freely without committing themselves to the procreative agenda. At the Lambeth Conference of 1968, the Anglican bishops disagreed with *Humanae Vitae* on abstinence from sex and keeping the rhythm method, on the premise that these tended to impose restrictions on the pleasure derived from sex and were thus contrary to Gods’ will.⁸³⁶

Similarly, the United Methodist Church adopted a resolution on artificial contraception in 1976 that was amended and readopted in 1996 and readopted in 2004. Part of the resolution read: –Each couple has the right and the duty to prayerfully and responsibly control contraception according to their circumstances. They are, in our view, free to use those means of birth control considered medically safe.”⁸³⁷ The fact that the United Methodist and the Anglican churches shared a common official ecclesiastical position on the use of condoms in the realm of birth control demonstrated that they had a more tolerant attitude towards condoms for the

⁸³⁴ A. Munro, OP, —Responsibility: The prevention of HIV/AIDS,” in S. C. Bate (ed), *Responsibility in a time of AIDS: A pastoral response by Catholic theologians and AIDS activists in southern Africa*, (Pietermaritzburg: Cluster Publications, 2003) 37.

⁸³⁵ Archbishops’ Council, —Contraception and the Church of England,” See also Noonan, —Contraception,” 124-126.

⁸³⁶ Archbishops’ Council, —Contraception and the Church of England.”

⁸³⁷ UMC, —Responsible parenthood,” See also Noonan, —Contraception.”

prevention of sexually contracted HIV. The Roman Catholic Church appeared to be totally opposed to the use of condoms and suggested instead a behaviour change approach. However, at times the position of the Roman Catholic Church tended to override the others, especially on Christian morality. Within the context of HIV and AIDS, condoms if properly and consistently used, offered a short term solution to prevention. However, in the long term, abstinence and faithfulness could prevent the spread of HIV and that accounts for the position taken by the church leaders.

Under the leadership of Bishop Muzorewa the church did not fully utilise the resolution allowing for the use of condoms in the prevention of sexually transmitted HIV taken by the church's global Council of Bishops in 1988.⁸³⁸ Similarly, while the Lambeth Conference of 1988 resolved that Anglican bishops should support State led HIV prevention programmes,⁸³⁹ HIV prevention under Bishop Masuko took on a distinctly moralistic rhetoric. However, the church's teaching on sex and fidelity in marriage deserved some respect: "It is undeniable that any couple who come together when uninfected by AIDS, and whose relationship is marked by fidelity, will not acquire the disease as a result of their sexual activity."⁸⁴⁰ Moralising the epidemic translated into denial, stigma and discrimination of PLHIV including church followers. The church leaders behaved like some of the Western missionaries in the time of the leprosy epidemic as postulated by Niehaus.⁸⁴¹ The reinforcement of the sinner versus righteous moralistic paradigm prevented some people including Christians from knowing their HIV status. Thus, between 1985 and 1994 the denial of AIDS by the churches accounted for the delay in setting up of HIV interventions. If the church leaders had acknowledged the effects of HIV and AIDS early they could have motivated others within religious groups to respond positively to those infected and affected by HIV/AIDS."⁸⁴²

⁸³⁸ Council of Bishops, "Statement on acquired immune deficiency syndrome."

⁸³⁹ Anglican Consultative Council, *The truth shall make you free*, 222-223.

⁸⁴⁰ A. Lovegrove, "AIDS: Some theological reflections," in B. Almond (ed), *AIDS: A moral issue: The ethical, legal and social aspects*, (New York: Palgrave, 1996), 143.

⁸⁴¹ Niehaus, "Leprosy of a deadlier kind," 318.

⁸⁴² L. Oxlade, (ed), "Responding to HIV: Why have some faith-based organisations responded more quickly than others?" *AIDS action: The international newsletter on AIDS prevention and care* 49 (July-September 2000), 2.

Within religious contexts such as churches, stigma was attached to HIV and AIDS mainly due to the notion that HIV was perceived to be a consequence of promiscuity. Hence, according to Parker and Birdsall:

Stigma is a process that may occur at individual level, but it is also influenced by social processes related to assumptions, stereotypes, generalisations and labelling of people as falling into a particular category on the basis of associations.⁸⁴³

There is self-stigmatisation in which a person lives with feelings of guilt towards his or her condition as well as stigmatisation experienced from others, often leading to discrimination. Concerning stigma towards HIV, Mawadza has observed: –In the case of HIV/AIDS, stigma may be applied to actual infection or to the behaviour believed to lead to the infection. Speaking ill of the person with HIV/AIDS is one of the common manifestations of stigma.”⁸⁴⁴ Again, Ezra Chitando has also noted: –When the HIV epidemic first broke out in Africa in the 1980s, the church fuelled stigma and discrimination. The Bible was read in ways that condemned people living with HIV. The issue was reduced to one of individual or personal morality.”⁸⁴⁵ Thus the theology of divine retribution that perceived AIDS as a consequence of the sin of promiscuity shaped the earliest reactions to HIV and AIDS by the churches in Manicaland in the years 1985-1994.

The early interest in the epidemic shown by the ZCBC, the bishops’ tradition of social engagement, and access to foreign funding led to the formation of diocesan HIV and AIDS structures in Zimbabwe. Within Manicaland, the launch of the Catholic Diocese of Mutare’s AIDS care-related project in 1992 turned church hospitals into centres for carrying out HIV interventions. The main activities included the treatment of AIDS-related symptoms, HIV awareness, and the provision of care of PLHIV and OVC services. While there were other on-going forms of home-based care, the Roman Catholic Church in Manicaland joined FACT in providing formalised home-based care programmes in communities. The launching of the diocesan project under Bishop Muchabaiwa and Bishop Mutume coincided with a period that witnessed a rise in advocacy, care and support of PLHIV in Zimbabwe. As Irish Aid has observed:

⁸⁴³ Parker and Birdsall, *HIV/AIDS, stigma and faith-based organisations*, 5.

⁸⁴⁴ Mawadza, —Stigma and HIV/AIDS discourse in Zimbabwe,” 422.

⁸⁴⁵ Chitando, *Living with hope*, 19.

The period 1991-1995 was very eventful in the nation's commitment to respond to the epidemic, with more HIV and AIDS focussed NGOs being formed, donors becoming more generous in funding HIV and AIDS activities and churches coming on board to give and care and support to PLHIV.⁸⁴⁶

While the leadership of the Roman Catholic Church in Manicaland took a lead in caring for PLHIV and OVC, there was no change in their theological messages on HIV prevention. Consistent with this observation, Denis has stated:

The gradual emergence of HIV and AIDS as a theme for theological discussion, however, did not change the fact that, at the local level, the discourse on HIV/AIDS remained moralistic in tone, as if the areas of prevention on the one side and of support and care on the other were totally disconnected.⁸⁴⁷

The lack of HIV desks at the diocesan or annual conference levels in the Anglican and United Methodist churches respectively suggested that the attention given to the epidemic was limited. The denial of HIV and stigmatisation of PLHIV could have accounted for the failure by the leadership of Bishop Masuko to launch AIDS-related home-based care as well as HIV and AIDS awareness programmes as carried out by the Roman Catholic Church. The treatment of people with AIDS-related illness at the Anglican Church's healthcare institutions failed to highlight incidence of HIV. The church lacked a deliberate strategy to respond holistically to HIV. The case of St. Peters Mandeya clinic at which members of the community were sensitised on HIV and AIDS was rather isolated from the general routine of silence.

While FACT and the Catholic Diocese of Mutare's project carried out HIV and AIDS interventions, the leadership of the Anglican Church appeared to have lacked criticality in the real issues that affected ordinary people's lives, including HIV and AIDS. Ranger's study on the rise of prophetic movements and witchcraft hunting during the influenza epidemic in Southern Rhodesia resonates well with the situation that developed in the Anglican Church in Manicaland. Ranger's observation that within Christianity, influenza invoked interpretations in which prophets usually

⁸⁴⁶ Irish Aid, *Looking back, mapping forwards*, 30.

⁸⁴⁷ Denis, "The church's impact on HIV prevention," 73.

identified sin within African circles as the root cause of the epidemic...strangers were often blamed”⁸⁴⁸ In Manicaland the denial of HIV as a biomedical reality by the leadership of the Anglican Church was enhanced by witch hunting that was led by the vicar general. Stigma led to changes in the distribution of the chalice in which people perceived to be living with HIV were discriminated against.

The United Methodist Church’s response to HIV in Manicaland suffered from dilemmas that surrounded Bishop Muzorewa’s political career and his involvement with the Zimbabwe Council of Churches. The United Methodist Church’s strategy of initiating HIV interventions through the church’s healthcare system had severe limitations because there were no fulltime personnel involved in managing the church’s HIV and AIDS interventions. The fact that within the United Methodist Church, a major shift in HIV interventions was experienced after the retirement of Muzorewa in 1992 indicates that the role of a church leader was critical in responding to HIV. Bishop Jokomo’s election to the helm of the United Methodist Church yielded dramatic changes in the church’s approach to HIV and AIDS. The regional HIV and AIDS consultative meeting held in Harare in June 1993 became an opportunity for Bishop Jokomo to network with other annual conferences in southern Africa.⁸⁴⁹ Similar networking exercises existed within the Roman Catholic Church at the IMBISA. The Anglican Church in Manicaland was less organised at this level and HIV interventions were solely in the hands of dioceses. While the ZACH and Heads of Christian Denominations provided local opportunities for ecumenical collaboration on HIV interventions, the initialisation of each member denomination’s response to the epidemic was the responsibility of each church leader. The statements issued by the Heads of Christian Denominations and the activities launched by ZACH did not always translate into visible action within local ecclesiastical units.

The general pattern emerging at the grassroots level showed that denial of HIV and the stigmatisation of PLHIV became common throughout the first phase. The church followers from the Roman Catholic and United Methodist churches shared a common perception that connected AIDS with situations of war. Within the United Methodist Church, some people perceived HIV as a US or British-born disease politically

⁸⁴⁸ Ranger, “Plagues of beast and men,” 243.

⁸⁴⁹ SM, “Statement from HIV/AIDS consultation,” 269.

introduced to Africans at the end of colonialism.⁸⁵⁰ Another emerging common perception was the association of HIV and AIDS with sexual promiscuity. Given the situation of families living apart due to migrant labour practices and cases of STIs as having been common among married Christian women, married churchwomen from all the three churches were prey to HIV. In all the three churches cultural factors and Christian teachings that reinforced patriarchy undermined married women's choice of safe sex were not adequately addressed. These issues were not unique to the HIV and AIDS epidemic and thus mirrored how societies conceived earlier epidemics. As Rosenberg has shown, the eighteenth and nineteenth century epidemics attracted –class-oriented moral hegemony. Epidemics did tend, for example to be associated with place of residence and occupation as well as behaviour.”⁸⁵¹ Religions have always been important forms of social control of sexuality. But many religions, especially in the past, also respected and even celebrated the powerful forces that come with sexuality, whether for reproduction or for eroticism.⁸⁵²

At the grassroots level church followers from the Roman Catholic and Anglican churches in Manicaland commonly held the perception that AIDS was synonymous with *runyoka* and that witchcraft caused AIDS. These perceptions were so deeply entrenched among some Christians at the grassroots level. The claims to cure AIDS by some traditional healers and emerging prophets worsened the situation. Unlike the Roman Catholic and Anglican churches, the members of the United Methodist Church maintained a high level of Christian pietism. This had a bearing on the way members of the church perceived and responded to the HIV and AIDS epidemic. There was a lot of complacency in which the United Methodist Church's members thought of HIV and AIDS as something outside their families and congregations and this fanned denial and stigma. Hence, while at the grassroots level some United Methodist Church congregations donated cash and goods in support of PLHIV and OVC, the same members exacerbated the spread of HIV by adopting the ‘righteous’ versus ‘guilty’ approaches. Generally, churchwomen from all three denominations formed the earliest teams of primary and voluntary home-based caregivers having been inspired by the values of their guilds. Unfortunately, the missionary legacy of the domesticity

⁸⁵⁰ P. Mufute, same interview.

⁸⁵¹ Rosenberg, *Explaining epidemics*, 284.

⁸⁵² The Editor, “Religion and HIV/AIDS,” *The international newsletter on HIV/AIDS prevention and care, Asia-Pacific edition*, 47, (April-June 2000), 1.

of Christian married women undermined their ability to challenge culture and thus exposed the caregivers to HIV. Further steps taken by the three churches in responding to HIV and AIDS in Manicaland (1995-1999) will be analysed in the chapters that follows.

CHAPTER FOUR

THE MIDDLE YEARS (1995-1999)

4.1. Introduction

This chapter will show that while the three churches gradually scaled up HIV and AIDS interventions in Manicaland, this was carried out within the context of a declining social, economic and political environment in Zimbabwe. What is also apparent for this present chapter though, will be to investigate whether or not the declining relations between some church leaders and the Government of Zimbabwe affected church-led HIV and AIDS interventions in Manicaland. This chapter will discuss responses to HIV and AIDS by the three churches following the order as set in chapter three of the present study.

4.2. The Roman Catholic Church's Response to HIV and AIDS

This section builds upon the previous responses to HIV and AIDS by the ZCBC, the ZCBC HIV and AIDS commission and the Catholic Diocese of Mutare. It also indicates the wariness of the ZCBC over the government's economic policies that failed to support the needs of the citizens including the care of the PLHIV and OVC.⁸⁵³ While the State invested limited resources in healthcare, the burden of caring for the PLHIV and OVC fell on the shoulders of churches and NGOs. The ZCBC maintained its previous stance of being the voice against the State denouncing the latter's neglect of public healthcare in general. At the same time the ZCBC was committed to the provision of caring for PLHIV and OVC and carrying out other HIV and AIDS interventions. The statements on the epidemic issued by the ZCBC between 1995 and 1999 expressed the bishop's frustration at some of the State's policies that affected the general welfare of the public. For example, in 1997 the ZCBC opposed

⁸⁵³ ZCBCH, ZCBC, "Responsibility – honesty – solidarity."

the State for the government's compulsory land acquisition policy.⁸⁵⁴ This section also explores areas in which the HIV and AIDS interventions under the Roman Catholic Church were in collaboration with those of the State as well as indicate aspects where the two contradicted each other.

4.2.1. The ZCBC's HIV Advocacy Statements at the National Level

The statements issued by the ZCBC in the period 1995-1999 showed the understanding that HIV prevention and AIDS mitigation were to be taken in the wide context of declining public healthcare in Zimbabwe. There was deliberate effort by the ZCBC to shift towards calling the Government to address the socio-political and economic factors responsible for fanning HIV and AIDS. The ZCBC also reminded the State to commit itself to the care of PLHIV and OVC. In January 1996, the ZCBC issued a pastoral statement entitled *Male and Female He Created Them*.⁸⁵⁵ While the statement focused on the views of the ZCBC regarding homosexuality and the sterilisation of women, HIV and AIDS did not receive direct attention.⁸⁵⁶ The relationship between homosexuality and the spread of HIV in Zimbabwe was not something locally established.⁸⁵⁷

It should be noted that perhaps the Zimbabwean Catholic bishops intended to use such statements simply to remind the State that the spread of HIV should not be blamed on people's sexual orientation. The ZCBC was concerned at the socio-economic decline experience in the country and the high number of cases of HIV infection and AIDS-related deaths. To demonstrate this, in 1997, the bishops grew apprehensive at the realisation that there was little concern for the welfare of ordinary people on the part of the Zimbabwe Government.⁸⁵⁸ The availability of medicines at State hospitals declined and medical services became unaffordable to the majority of Zimbabweans. Whereas the healthcare centres under the Roman Catholic Church and those of the

⁸⁵⁴ ZCBCH, ZCBC, *Statement on land reform*, 8 December 1997.

⁸⁵⁵ ZCBCH, ZCBC, *Male and female He created them*, A pastoral statement of ZCBC, January 1996.

⁸⁵⁶ ZCBCH, ZCBC, *Male and female He created them*.

⁸⁵⁷ M. Epprecht, *Heterosexual Africa? The history of an idea from the age of exploration to the age of AIDS*, (Pietermaritzburg: UKZN Press, 2008), 1-34.

⁸⁵⁸ ZCBCH, ZCBC, *Responsibility – honesty – solidarity*.

other churches strived to serve the general population, the burden of responding to the medical needs of PLHIV became insurmountable.

The failure to offer adequate treatment and care to PLHIV by the Government of Zimbabwe was a major concern to the ZCBC. In the pastoral letter issued in April 1997 the Zimbabwean Catholic bishops called upon the government to show responsibility, honesty and solidarity with people who could not afford payment for basic healthcare services.⁸⁵⁹ In the face of such a calamity the ZCBC warned the government of the need to consider human beings ahead of ill-conceived economic reform policies: —People are the entire purpose of all our economic activity. If they are not served by the economy, then the entire economy does not serve any purpose.⁸⁶⁰ The position adopted by the ZCBC was informed by Vatican II whereby in *The Church in the Modern World*,⁸⁶¹ Pope Paul VI could state:

The social order and its development must constantly yield to the good of the person, since the order of things must be subordinate to the order of persons, and not the other way round, as the Lord suggested when he said that the Sabbath was made for men and not man for the Sabbath.⁸⁶²

The economy of Zimbabwe was shrinking because economic reforms made thousands of workers redundant. There were a few voices that linked the plight of the people infected and affected by HIV and AIDS with the State's poor economic policies in Zimbabwe and the ZCBC was one.

Generally, the governments of most developing countries such as Zimbabwe failed to invest sufficiently in healthcare in general and AIDS in particular. Dean Peacock and Mark Weston made the important, yet general observation that: —Even when the HIV prevalence rates had become shockingly high, many authorities delayed — still delay — in making antiretroviral treatment available.⁸⁶³ In a blatant attack on the inadequate

⁸⁵⁹ ZCBCH, ZCBC, —Responsibility — honesty — solidarity.”

⁸⁶⁰ ZCBCH, ZCBC, —Responsibility — honesty — solidarity.”

⁸⁶¹ Pope Paul VI, —Pastoral constitution on the church in the modern world,” (*Gaudium et Spes*), 7 December 1965, <http://www.vatican.va/archive/hist_councils/ii_vatican_council/> [Accessed 14 July 2011].

⁸⁶² Pope Paul VI, —Pastoral constitution on the church in the modern world.”

⁸⁶³ D. Peacock and M. Weston, —Men and care in the context of HIV and AIDS: Structure, political will and greater male involvement,” (October 2008), 5. This paper was accessed as a pdf.

allocation of funds to the health delivery system, the ZCBC expressed grievous concern:

We, the bishops of Zimbabwe, deplore that the health budget has decreased in real terms over the last ten years. We ask the government to cut drastically any expenditure on unnecessary travel, mere prestige projects, and the army and armaments so as to boost the inadequate health budget.⁸⁶⁴

The priority for the poor in any economic activity formed a backbone of the Roman Catholic Church's social teaching. For example, the teaching of the Pontifical Council in *World hunger, A challenge for all: Development in solidarity*,⁸⁶⁵ was consistent with this position. The Pontifical Council thus stated: "Embarking upon difficult and costly social and economic policies, without taking account of the perception of reality by the most humble members of society, can eventually lead to extremely costly dead-ends for the whole world."⁸⁶⁶ The churches, FBOs and NGOs were the main role players in the provision of AIDS-related care. The government faced challenges of inadequate funding as well as the lack of political will towards committing resources to the care of PLHIV.

In 1997 the Zimbabwean economy witnessed a downturn and the churches found it difficult to sustain public health funding including HIV interventions. This was also related to the collapsing power of the Zimbabwe dollar. The situation was worsened by a series of public sector strikes and evidence of a systematic high level corruption, the government's acquiescence to war veterans' demands for substantial pensions led to a rapid devaluation of the Zimbabwe dollar in November."⁸⁶⁷ The budgets of donor supported HIV and AIDS projects under the churches; FBOs and NGOs were severely affected. Amidst declining State support, the bishops called for solidarity "with PLHIV, their families, and those who had been made orphans by the death of their parents, and the promise of care."⁸⁶⁸ In May 1998, the bishops blamed the State again for not allocating enough resources towards healthcare and people

⁸⁶⁴ ZCBCH, ZCBC, "Responsibility – honesty – solidarity."

⁸⁶⁵ Pontifical Council, *World hunger, A challenge for all: Development in solidarity*, <http://www.vatic.va/roman_curia/pontifical_councils/cororum/html/> [Accessed 15 July 2011].

⁸⁶⁶ Pontifical Council, *World hunger, A challenge for all*.

⁸⁶⁷ S. R. Dorman, "NGOs and the constitutional debate in Zimbabwe: From inclusion to exclusion," *Journal of Southern African Studies* 29, 4 (December 2003), 847.

⁸⁶⁸ ZCBCH, ZCBC, "Working for the common good," A joint pastoral statement, May 1998.

were dying of AIDS in hospitals. In this regard, the bishops highlighted the fact that in the city of Harare alone one in every nine infants born was HIV-positive.⁸⁶⁹ Apparently, the State was already faced with public strikes and the bishops added pressure by declaring that the State was corrupt. The ZCBC linked the shortages of funds for HIV interventions with corruption on the part of the State.⁸⁷⁰ The HIV interventions carried out by the Roman Catholic Church and NGOs became quite significant within the public healthcare system.

The Catholic bishops in Zimbabwe were wary of the dangers of taking over the State's obligation to provide healthcare to all its citizens and they argued that such a development could only make the government more irresponsible than before. The bishops thus stated: "To work in partnership, and with a special concern for the poor, church-related hospitals should, at the very least, be treated no different to government hospitals with respect to finance and personnel administration."⁸⁷¹ While the ZCBC was outspoken against the State, the ZCBC availed its healthcare services to people in need. The bishops argued that the State should honour its responsibility to the citizens by supporting church-related healthcare institutions financially. The church's motivation for partnering with the State in healthcare lay in the need to serve the poor but on condition that "the government provided support such as finance and personnel resources as in State hospitals."⁸⁷² According to David Kalemu of the African Forum for Catholic Social Teachings, the church that acted out of an understanding of its prophetic role in society is "... a church that understands its social context and discerns its historical role."⁸⁷³ The ZCBC considered the pandemic as a *kairos* moment to show solidarity with ordinary people. The church-related healthcare institutions in Zimbabwe also used the ZACH to outsource funds and medicines.⁸⁷⁴ This was not the case at the State's healthcare centres. The existence of church-based HIV interventions in Manicaland increased the church's visibility while at the same time this could have undermined the State.

⁸⁶⁹ ZCBCH, ZCBC, "Working for the common good."

⁸⁷⁰ ZCBCH, ZCBC, "Working for the common good."

⁸⁷¹ ZCBCH, ZCBC, "Working for the common good."

⁸⁷² ZCBCH, ZCBC, "Working for the common good."

⁸⁷³ D. Kalemumu, "The role of the church in society," in Churches in Manicaland, *The truth will set you free*, xii.

⁸⁷⁴ V. Chitimbire, same interview.

In 1997, the total number of church-related healthcare centres in Zimbabwe stood at 126, the majority of which belonged to the Roman Catholic Church.⁸⁷⁵ The church-related healthcare centres accounted for approximately 35% of all beds nationally and 70% of rural hospital beds.⁸⁷⁶ Similarly, Oliver Mudyarabikwa and Angelbert Mbengwa's study on healthcare worker distribution in Zimbabwe for 1997 reported: "Missions came second after the public sector in health worker contributions and in public coverage of healthcare."⁸⁷⁷ Thus all church-related healthcare centres were placed in a very precarious position in responding to the needs of PLHIV. What also attracted large numbers of patients to some church healthcare centres was a perception that "they offered good quality services as opposed to State hospitals because the staff were known for upholding the Christian ethos of care and compassion in the treatment and care of the sick including PLHIV."⁸⁷⁸ The ZCBC attempted to show responsibility, honesty and solidarity towards PLHIV within the context of an ailing public healthcare system.

4.2.2. The ZCBC's HIV Prevention Strategy at National Level

In relation to HIV prevention, the ZCBC held on to its previous position that the best remedy to end the epidemic was the restoration of the family to its former glory. For example, the bishops proposed:

- (a) That the government supports marriage and family life in its schools through establishing a clear moral based AIDS awareness, family life religious and moral education, (b) that children should be left without doubt that sexual intimacy is not for them, (c) that government must adopt a family-friendly housing policy that allows married couples to live under one roof, (d) that working parents receive special credit for children under their care including OVC, and (e) that married couples write wills to protect widows against loss of property.⁸⁷⁹

⁸⁷⁵ ZACH information brochure, 2008. See also HOCD, *HIV and AIDS policy 2005*, 1.

⁸⁷⁶ V. Chitimbire, same interview. See also T. Manyeza, same interview.

⁸⁷⁷ O. Mudyarabikwa and A. Mbengwa, "Zimbabwe: A challenge for equity in health," Equinet Discussion Paper, (April 2006), 5. The document was accessed as a pdf.

⁸⁷⁸ V. Chitimbire, same interview. See also T. Manyeza, same interview.

⁸⁷⁹ ZCBCH, ZCBC, "Responsibility – honesty – solidarity."

The failure by the bishops to explore other HIV prevention options such as the prophylactic use of condoms exposed people to infection. HIV prevention was a complex matter that the church had to face. It also took many years for people such as Rogers to realise that ~~the~~ rigid position of the Roman Catholic Church on using condoms failed to save people's lives."⁸⁸⁰ Within the ZCBC, the belief that upholding morality within marriages guaranteed the safety of couples from lethal dangers of AIDS was deeply entrenched. However, there was always a discrepancy between the official teachings of churches and how members lived out their faith convictions.

Between 1995 and 1999 the approaches used by ZCBC at preventing sexually transmitted HIV still took a moralistic stance. In 1998 the prelates of the Roman Catholic Church together with fellow church leaders under the banner of the Heads of Christian Denominations forum maintained the position that the scourge of HIV and AIDS could be eradicated by simply being moral.⁸⁸¹ An extract from a joint statement thus stated:

Christian and traditional morality as well as sound medical opinion coincide to tell us that the best way of combating AIDS is chastity before marriage and faithfulness in marriage. The indiscriminate issuing and use of condoms is not the answer.⁸⁸²

There were no changes to the first statement on HIV and AIDS issued by the ZCBC in 1987. However, the joint statement did little to acknowledge that some church members including faithful married women contracted HIV from unfaithful spouses. Similarly, as Denis has pointed out: ~~Faithful~~ wives are vulnerable to infection if their husbands see, as a culturally sanctioned right, the multiplication of sexual partnerships."⁸⁸³

In 1999 at the dawn of the new millennium the ZCBC repeated its old message on the prevention of sexually transmitted HIV by stating that the epidemic could be stopped through the restoration of the sanctity of family life. Nothing changed in respect of the

⁸⁸⁰ T. Rogers, same interview.

⁸⁸¹ AM, A statement on AIDS by HOCD and ZCC, 1998.

⁸⁸² AM, A statement on AIDS by HOCD and ZCC, 2.

⁸⁸³ Denis, ~~The church's impact on HIV prevention and mitigation,~~" 74.

bishop's position regarding Christian morality and family values as noted from their statements issued in 1987 and 1991. In December 1999 the ZCBC stated:

As if this were not enough, our society is, along with other countries of the world, facing the deadly challenge of AIDS and its multifarious effects on society. While we support the work of scientists and their pursuit of sociological and medical solutions to the problem, we still maintain the call to spiritual rearmament as the lasting solution. We need God in our life. We need to take seriously the call to love through mutual respect, chastity and fidelity.⁸⁸⁴

The gap between the messages from the ZCBC and that of the government on prevention of HIV also widened. Christian morality could serve as a long term solution to the spread of HIV but this alone could not contain the spread of the epidemic in the short term. It emerged that the members of the ZCBC as was also the case with church leaders from other denominations failed to appreciate the need to adopt a double pronged approach to HIV prevention.

Ronald Nicolson has suggested that churches should consider a holistic approach to HIV prevention by laying emphasis on moral values together with the use of condoms. Nicolson showed two realities: –Churches need to make it clear that only lifelong monogamy is absolute protection. ...There will always be casual sex. Unless churches promote the use of condoms the death rate will be much higher.”⁸⁸⁵ The churches have always preached, taught, and admonished church followers to adhere to high moral principles. The fact that the ZCBC strongly opposed the prophylactic use of condoms meant that the bishops in Zimbabwe were at odds with the State. According to Auxiliary Bishop Mutume, –condoms increased the risks of contracting HIV because they gave a false sense of protection.”⁸⁸⁶ The Episcopal leadership of the Roman Catholic Church in Zimbabwe continued to shape the HIV prevention discourse in moralistic ways. As Denis has observed, such an approach by churches was to prove detrimental:

Promoting abstinence and faithfulness can have the unintended effect of encouraging denial, stigma and discrimination even though

⁸⁸⁴ ZCBCH, ZCBC, –Jesus Christ the same yesterday, today and forever (Hebrew 13: 8),” A pastoral letter for the new millennium 2000 A.D., December 1999.

⁸⁸⁵ Nicolson, *AIDS: A Christian response*, 53.

⁸⁸⁶ P. Mutume, same interview.

adherence to the Christian norms of sexual behaviour, when it is observed, demonstrably reduces the rate of infection.⁸⁸⁷

4.2.3. The HIV and AIDS Commission's HIV Prevention Strategy

Between 1995 and 1999 the ZCBC HIV and AIDS commission was in opposition to the government over the State's HIV prevention education materials that were perceived as anathema to the teachings of the church.⁸⁸⁸ This triggered the question of whose responsibility it was to educate young people about the prevention of sexually transmitted HIV. The State's introduction of HIV and AIDS education in schools resulted in tension between the family, the church, the school and the State. The extent to which all the players could collaborate and assist one another was unclear. Within Roman Catholic Church's schools, the government-backed HIV prevention and AIDS education programmes became unpopular due to the allegation that ~~the~~ intervention strategy encouraged promiscuity.⁸⁸⁹ In some of the church's schools, some teachers expressed the opinion that it was unsuitable for students to be exposed to the State's programme because of their exposure to the subject of sex. As an oral source was to report: ~~Sex~~ was an exciting and attractive matter to young people and students could end up experimenting.⁸⁹⁰

The behaviour change programme restricted young people's knowledge about sexuality and HIV prevention. In 1996 the commission introduced a booklet entitled *The Christian approach to sexuality*. This new resource formed the basis of sexuality education for the prevention of sexually transmitted HIV in all the Roman Catholic schools as well as the two colleges countrywide.⁸⁹¹ The adoption of the new resource by the church's schools suggested that the church was committed to pursuing an alternative approach to HIV prevention education. Similarly, within the Roman Catholic Church's parishes in Manicaland, HIV prevention education programmes for the youth were left into the hands of elderly church members. They were identified by

⁸⁸⁷ Denis, "The church's impact on HIV prevention and mitigation," 81.

⁸⁸⁸ V. Chitimbire, same interview.

⁸⁸⁹ R. Chiome, same interview.

⁸⁹⁰ R. Chiome, same interview.

⁸⁹¹ ZCBCH, ZCBC HIV and AIDS desk programme, 2009.

special Shona family titles such as *Tete* (Aunt), *Sekuru* (Grandfather) and *Mbuya* (Grandmother).⁸⁹² The use of different approaches to sexuality in the Catholic schools and in church youth groups undermined the State sex education strategy.

The targeting of the church's schools with a different HIV prevention programme was met with resistance. Under the leadership of Christine Mtize, the commission organised workshops for teachers, heads of schools and other interested mission personnel throughout 1997 and 1998.⁸⁹³ However, the programme faced a degree of resistance from some members of the clergy and teachers: "It was noted that many schools did not implement the 'AIDS Action Programme,' even with the assistance of workshops and teachers' supplements. It was seen that direct monitoring was necessary."⁸⁹⁴

This indicates that the Roman Catholic Church was divided over the value of the new programme. Pockets of resistance to HIV prevention education and AIDS-related care were a common feature among the Roman Catholics. Father Rogers mentioned that the low numbers of black clergy who attended meetings organised by the ZCBC since the late 1980s showed a negative attitude towards HIV interventions.⁸⁹⁵ However, at St. Killian's mission in a rural part of Makoni district and St. Joseph's secondary school in Rusape town the programme was well received. Ordwell Kanyere, a former teacher at St. Killian's primary school stated that "the mission staff and students were enthusiastic about the AIDS sessions."⁸⁹⁶ Kanyere's involvement in the HIV and AIDS awareness and prevention activities at St. Killian's in the late 1990s created opportunities for him to be employed later as one of the programme managers at FACT (Rusape).

The programme on HIV prevention education for schools was further consolidated after the commission identified school-based AIDS coordinators to assist school heads

⁸⁹² M. Chitsungo, same interview. See also Chitando, *Living with hope*, 33.

⁸⁹³ Information supplied by C. Mtize to M. Mbona by email, 26 June 2011, See also Rogers, information supplied to M. Mbona, ARRUPE, Harare, 13 April 2011.

⁸⁹⁴ ZCBCH, ZCBC HIV and AIDS desk programme, 2009.

⁸⁹⁵ T. Rogers, same interview.

⁸⁹⁶ O. Kanyere, interview conducted by M. Mbona, FACT Rusape office, 23 August 2011. See also R. Chiome, same interview.

in its implementation.⁸⁹⁷ Apparently, the commission was the only ecclesiastical organisation that went as far as initiating a school-based HIV prevention programme. As far as this study was aware of, none of the other churches in Zimbabwe developed a school based HIV prevention education programme. The programme also incorporated aspects of counselling and psychosocial support to students and staff in areas such as illness, care, death due to AIDS, and child sexual abuse.⁸⁹⁸ Very few schools in Zimbabwe and Manicaland assisted HIV positive pupils and OVC who were traumatised by the loss of parents in this way. However, within schools, the implementation of the commission's programme overwhelmed the teachers due to increased workloads.⁸⁹⁹ On a positive note, the availability of funding towards educational costs for OVC attracted pupils from other schools who then joined Roman Catholic Church run schools.

The commission's HIV prevention strategy was designed following the principles of: obtaining accurate information about HIV and AIDS, the understanding of personal risks and responsibility, the confidence to recognise and choose preventive options within a supportive environment, and the need for God's assistance in order to persevere.⁹⁰⁰ The approach was premised on the tenets of abstinence before marriage and faithfulness in marriage as opposed to sex before marriage, infidelity and the use of condoms as prophylactics. A commission from Uganda adopted the moral behaviour change model of preventing sexually transmitted HIV.⁹⁰¹ For example, the Roman Catholic Church, the Anglican Church and the Muslim community in Uganda successfully implemented the moral behaviour change model in 1987. In Uganda the approach had shown that religion could positively influence people to exercise abstinence, faithfulness and delay the age of sexual debut.⁹⁰² Uganda was one of the first countries in Africa to use the behaviour change model in the prevention of sexually transmitted HIV. In 1999, Halperin *et al.* partly attributed the decline in HIV

⁸⁹⁷ ZCBCH, ZCBC HIV and AIDS desk programme, 2009.

⁸⁹⁸ ZCBCH, ZCBC HIV and AIDS desk programme, 2009.

⁸⁹⁹ O. Kanyere, same interview.

⁹⁰⁰ ZCBCH, ZCBC HIV and AIDS desk programme, 2009.

⁹⁰¹ Information supplied by A. Vinyu to M. Mbona, Mutare, Cathedral of the Holy Trinity, 10 June 2010. See also J. Nyamande, information supplied to M. Mbona, DOMCCP head office, St. Joseph's mission, Sakubva, Mutare, 10 June 2010. See also T. Rogers, same interview.

⁹⁰² See E. Green, "The impact of religious organisations in promoting HIV/AIDS prevention." This paper was presented in May 2001, 4. See also E. Green, *Faith-based organisations: Contributions to prevention*, USAID, (September 2003), 7.

in Zimbabwe from the mid-1990s to widespread access to information about HIV and AIDS and stated that the churches had played a positive role: “In addition, national survey data suggest that between the mid-1990s and the early 2000s, Zimbabweans increasingly received information about AIDS from their friends, the churches and other interpersonal sources.”⁹⁰³

In 1994 the Catholic Bishops’ Conference of England and Wales issued a statement on social and moral education in schools.⁹⁰⁴ The statement emphasised the need for moral reflection as a basis for behaviour change: “Teaching about HIV should be situated within a broader context that affirms the dignity and destiny of the human person, the morality of human actions and considers the consequences of individual actions and choices for the whole society.”⁹⁰⁵ In September 1996 a church programme set up by FACT in Manicaland spearheaded a behaviour change strategy in opposition to using condoms.⁹⁰⁶ Some church leaders including those from the ZCBC and the Zimbabwe Council of Churches joined the nationwide marches organised by FACT. The said marches denounced the State’s position of openly encouraging people to use condom in preventing sexually transmitted HIV. The churches offered limited options in reducing sexually transmitted HIV and the moral or behaviour change strategy appeared to have made sense to some church followers. First, AIDS related deaths and HIV prevalence rate peaked in the period 1997-1999. Consistent with this assertion Halperin *et al.* observed that “high AIDS mortality appears to have been the dominant factor in stimulating behaviour change. Both empirical and modelling-derived estimates indicate that AIDS death increased dramatically during the mid-to-late 1990s before stabilising after 2000.”⁹⁰⁷ The second factor was that HIV had no cure and without changing sexual behaviour death was imminent.⁹⁰⁸ In the long term, the commission’s strategy could have yielded positive results.

⁹⁰³ Halperin, “Surprising prevention success,” 5.

⁹⁰⁴ MacLaren, *The Church Responds to HIV/AIDS*.

⁹⁰⁵ MacLaren, *The church responds to HIV/AIDS*.

⁹⁰⁶ FACT, Mutare archives, A million member memorial service for the thousands who died of AIDS in Zimbabwe, simultaneously conducted at designated venues established by each area throughout Zimbabwe on Sunday 22 September 1996 at 10:30am.

⁹⁰⁷ Halperin, “Surprising prevention success,” 3.

⁹⁰⁸ For a detailed discussion on this see Gregson, “HIV Decline in Zimbabwe due to reductions in risky sex?”

The process of achieving positive changes in peoples' sexual behaviour is complex. In admitting to this reality the commission stated: "Changing one's behaviour is not that easy. This is the only option in Zimbabwe if we are to stop the spread of HIV. Because there is no vaccine, there is no cure for AIDS."⁹⁰⁹ The leadership of the Roman Catholic Church and the government continued to read from different pages on the issue of preventing sexually transmitted HIV. The tendency among the two role players to undermine each other's HIV prevention strategies existed. On the one hand, the government's stance on using condoms was motivated by the need to be realistic about the different situations encountered by people within the realm of sexuality. On the other hand, Foster stated that the moralistic stance held by the churches had "the consequence of strengthening the innocent-guilty paradigm and reinforces discrimination and stigma against people living with HIV/AIDS, including women or men whose only sexual partner has been a spouse."⁹¹⁰ The national church leaders took the same position, as did the ZCBC. This undermined the State's HIV prevention approach, which encouraged the use of condoms in the prevention of sexually transmitted HIV by stating:

The underpinning of the HIV and AIDS prevention programme in Zimbabwe is faulty. The wholesale promotion of condoms has developed a false sense of security in the population and blunted the fear of HIV infection.⁹¹¹

The commission and the State were reluctant to strike any compromise. However, at the launching of the *National Policy on HIV/AIDS for the Republic of Zimbabwe* in December 1999, President Mugabe emphasised the need for behaviour change in reducing sexually transmitted HIV.⁹¹² This stance by the head of State could have been understood by the church leaders as reinforcing the moralistic HIV prevention approaches used by churches in general and the ZCBC's HIV and AIDS commission in particular. From the State's point of view, behaviour change was quite broad and included the use of condoms.

⁹⁰⁹ ZCBCH, ZCBC HIV and AIDS desk programme, 2009.

⁹¹⁰ Foster, "Religion and responses to orphans in Africa," 169.

⁹¹¹ AM, A statement on AIDS by HOCD and ZCC, 4.

⁹¹² See Mugabe, "Foreword," iv.

4.2.4. The Catholic Diocese of Mutare's HIV and AIDS Interventions

In 1999 the Mutare Community Home Care project changed its name to become the Diocese of Mutare Community Care Project.⁹¹³ The expanded project had its headquarters at St. Joseph's, Sakubva and Bishop Muchabaiwa officially opened the new project centre on 22 October 1999.⁹¹⁴ The diocesan project staff comprised of a full time project administrator and four others. The transformation of the project was necessitated by the need to expand HIV and AIDS interventions. This was against the backdrop of declining State healthcare. This section will show that despite some challenges, the diocesan project attained success in HIV and AIDS awareness, stigma mitigation and care of PLHIV and OVC. HIV and AIDS interventions implemented by the project were affected by the declining purchasing power of the local currency.

4.2.4.1. The Home-Based Care and the Treatment of AIDS-related Illness

Between 1995 and 1999 Government of Zimbabwe appeared not to consider AIDS-related home-based care as critical healthcare intervention.⁹¹⁵ Meanwhile, there was an escalation of the number of PLHIV who needed care support compared to what the diocesan project originally envisaged. Terminally ill patients had to rely on the family and the community for care. Families took up the care of PLHIV but –without resources such as food, medical drugs and sanitary materials.”⁹¹⁶ Food parcels donated by the diocesan project to PLHIV turned out to be a lifeline for families many of who were reeling under poverty. Thus, within families, having HIV positive members registered under the project became a blessing in disguise because that created chances of receiving scarce donor-funded food resources. In December 1996, at least 497 out of 600 PLHIV were supported by the diocesan project and 159 clients were reported to have died. The support comprised of food, ordinary pain relief drugs,

⁹¹³ DOMCCPM, DOMCCP, MCHC project report, March 1999-December 2000, 3-7. See also, DOMCCPR, DOMCCP strategic plan 2002-2005, October 2002, 3.

⁹¹⁴ DOMCCPM, DOMCCP, MCHC project report, March 1999-December 2000, 3-7.

⁹¹⁵ See also HDN, *Home-based care in Zimbabwe*, 7. See also HDN, *Caring from within*, 17.

⁹¹⁶ M. Biriwasha, –Home based care: struggling to meet overwhelming needs,” in HDN *et al.*, *Inside stories: Local experiences of home based-care in Zimbabwe*, (2008), 17. See also V. Chitimbire, same interview.

sanitary materials, blankets, mattresses and bedding sheets.⁹¹⁷ The fact that the AIDS patients were cared for by relatives in the village –presented a crisis for rural communities and church hospitals.”⁹¹⁸ Given the fact that the project’s home-based care intervention focused on 600 PLHIV in the province, covering less than 10% of people in need, the researcher observes that the achievements of the initiative were modest.

The movement of PLHIV from urban to rural areas in order to access care from relatives and families overwhelmed the diocesan project.⁹¹⁹ Whereas the project was initially established for the benefit of women and OVC living in rural areas, it was overwhelmed by an influx of HIV positive adult males. The HIV positive males who were originally living at work places on farms, or in urban areas and mining establishments affected the dynamics of care:

The pattern of our clientele in the home based-care indicate that more than half of our clients come from urban areas after being discharged from their employment due to their illness. The widow or orphans in our programme also indicate that either or both parents resided in urban area or other work places. Our STD hospital statistics also confirm that most of the women seen in our mission hospitals presenting signs and symptoms are legitimate wives of men working in town and they usually show up after public holidays when their husbands visit them.⁹²⁰

The workers and voluntary caregivers from the project expressed disappointment at the lack of cooperation of visiting males who shunned attending some of the HIV awareness meetings.⁹²¹ There were complaints to the effect that the adult males who joined their families periodically tended to undermine the project’s efforts at HIV prevention and AIDS mitigation. Furthermore, the loss of jobs and escalating cost of living in urban areas forced some of the people to move back to rural areas and that overstretched the resources earmarked towards AIDS-related care and treatment under the project.

⁹¹⁷ DOMCCPM, DOMCCP, MCHC progress report, 31 December 1996.

⁹¹⁸ V. Chitimbire, same interview. See also E. Tichawangana, same interview.

⁹¹⁹ DOMCCPM, DOMCCP, MCHC progress report, 31 December 1996.

⁹²⁰ DOMCCPM, DOMCCP, MCHC progress report, 31 December 1996.

⁹²¹ A. Dera, same interview. See also G. Maedze, same interview.

Apparently, the families and rural communities appeared to draw resources together and provided for the material needs of PLHIV. In the urban areas and other work places the cost of living was generally high and made it difficult for people to provide AIDS-related care services. It was common knowledge that unemployed breadwinners who were HIV positive struggled to pay for basic needs including medical care, food and accommodation. In some cases the landlords in urban areas asked the sick to vacate rented accommodation.⁹²² In the majority of cases urban areas did not offer sustainable support to AIDS-related home-based care clients as compared to the rural areas where the community ethos of solidarity was generally quite visible. Consistent with this observation, one of the reports on the diocesan project has noted: “The urban community has not been successful in living as a community and in most cases people do not know each other within the same radius compared to a rural community village.”⁹²³ Within African traditional settings, people who live in the same community practise a form of social solidarity in which they assisted each other especially when members of the community are affected by adverse situations such as illness and death. The care of PLHIV emerged as an opportunity in which traditional community ethos meant that — assisting each other in a time of need was always considered as being reciprocal.”⁹²⁴

The project put in measures that shielded PLHIV and OVC from the effects of the harsh socio-economic environment in Zimbabwe. In 1996, the diocesan project decentralised its operations and trained nine local home-based care coordinators and ten local trainers in holistic care.⁹²⁵ This was achieved with support from Mutare provincial hospital. The medical personnel from the State’s MOHCW assisted the diocesan in various skills training initiatives. In 1997, a further 56 voluntary caregivers and 223 primary caregivers were also trained in holistic care. Support visits to the PLHIV in 1997 were as follows: local coordinators: 427 visits, pastoral agents: 498 visits, local trainers: 1,502 visits and voluntary caregivers: 1,876 visits.⁹²⁶ The importance of support visits to the PLHIV and their families provided the much

⁹²² DOMCCPM, DOMCCP, MCHC progress report, 31 December 1996.

⁹²³ DOMCCPM, DOMCCP, MCHC progress report, 31 December 1996. See also Dera, same interview.

⁹²⁴ E. Tichawangana, same interview.

⁹²⁵ DOMCCPM, B. Muchini, CRS: Zimbabwe project progress report for MCHC Phase II for the period 1 March 1997 to February 1998, (15 April 1998), 6.

⁹²⁶ DOMCCPM, Muchini, CRS: Zimbabwe project progress report, 6-7.

needed moral encouragement. AIDS-related sicknesses appeared to be a dreaded condition especially without access to ARVs. Thus, voluntary caregivers were of great value in lightening the burden of care on the part of the medical staff and families as well as enlivening the feelings of the PLHIV. However, at times and in some areas voluntary caregivers were accused of having failed to exercise confidentiality,⁹²⁷ which had the effect of undermining their work.

The Christian ethos of loving service to others might have also inspired some voluntary caregivers to serve their clients honourably. Some respondents involved in home-based care stated that Christian charity towards the sick and needy made them to assist fellow community members living with HIV. A passion to serve others in fulfilment of Jesus Christ's words in the Sermon on the Mount was seen as underpinning the spirit of Christian volunteerism.⁹²⁸ Another respondent stated that providing care to the PLHIV was part of Christian charity and that to expect payment for such a service undermined the Christian spirit of joyful service towards the sick.⁹²⁹ Some Christian voluntary caregivers also expressed the opinion that at times the diocesan project failed to appreciate their services. At Nyahukwe, one voluntary caregiver stated that they expected the diocesan project to provide regular allowances.⁹³⁰ Similar sentiments were expressed at Triashill mission. Some of the volunteers were widows aged between 40-45 years of age and had no other sources of income. The lack of regular incentives such as T-shirts, soap, and tennis shoes also affected Christian voluntary caregivers. However, at Dananai Home-Based Care under Murambinda mission hospital –the majority of individuals trained were church members who felt spiritually called upon to serve.”⁹³¹

Within some communities, voluntary caregivers were held in high esteem because they offered compassionate services. Male voluntary caregivers including Augustine Dera of Triashill mission stated that fellow community members respected him because few males sacrificed their time towards the care of PLHIV.⁹³² In 1996 the

⁹²⁷ G. Maedze, same interview. M. Mudzimiri, same interview.

⁹²⁸ E. Tichawangana, same interview. See also C. Mombe, same interview. See also A. Dera, same interview. See also Matthew 5: 1-13.

⁹²⁹ C. Mauye, same interview.

⁹³⁰ M. Mudzimiri, same interview.

⁹³¹ Irish Aid, *Looking back, mapping forwards*, 16.

⁹³² A. Dera, same interview.

home-based care programme had 358 active voluntary caregivers serving in various communities. This number was small considering the high demand for services and consequently voluntary caregivers were also affected by burnout. In the same period the total number of home visits by voluntary caregivers was 2,007 and they covered 3,455 families of people infected and affected by HIV and AIDS.⁹³³ The smooth running of the programme was affected by the lack of transport to follow up on patients, the lack of incentives for volunteers, and at times did not receive cooperation from the families of clients.⁹³⁴ Some of the problems were resolved later when a full time coordinator and a team of staff members were appointed at the end of 1999.⁹³⁵ Apparently, the delay in the appointment of full time staff members by the management of the diocesan project and the escalating demands for the care of the PLHIV and OVC undermined its effectiveness.

At times HIV positive people abandoned some of the prescribed medical remedies in favour of the advice given by African traditional health practitioners locally known as *n'anga*.⁹³⁶ The African traditional health practitioners took advantage of the situation by claiming that they had a remedy for HIV and AIDS.⁹³⁷ Gordon Chavhunduka has observed that African Christians consulted traditional health practitioners and that ~~many~~ African Christians have dual membership in the Christian church and membership in African religion."⁹³⁸ However, the contribution of traditional health practitioners to health and wellness at the family and community level could not be underestimated. Within the context of HIV and AIDS and disease in Africa in general:

Traditional health practitioners were often the first interface between patients and the healthcare system, they have a potential to educate patients on HIV transmission and prevention and to endorse risk-reduction strategies in a culturally acceptable manner.⁹³⁹

⁹³³ DOMCCPM, DOMCCP, MCHC progress report, 31 December 1996.

⁹³⁴ A. Dera, same interview. See also E. Tichawangana, same interview. See also M. Mudzimiri, same interview. See also DOMCCPM, DOMCCP, MCHC progress report, 31 December 1996.

⁹³⁵ See DOMCCPM, DOMCCP, MCHC project report, March 1999-December 2000, 3-7.

⁹³⁶ DOMCCPM, DOMCCP, MCHC progress report, 31 December 1996.

⁹³⁷ G. Maedze, same interview. See also A. Dera, same interview. See also T. Nyawera, same interview.

⁹³⁸ Chavunduka, "Christianity, African religion and African medicine."

⁹³⁹ Somma and Bodiang, *The cultural approach to HIV/AIDS prevention*, 14.

In Manicaland traditional health practitioners provided concoctions of herbs that treated skin rashes and diarrhoea. The caregivers appreciated the *_muti* because it was effective in AIDS mitigation and brought some noticeable relief to some PLHIV.⁹⁴⁰ Subsequent to that, in the late 1990s joint workshops were organised and brought together biomedical practitioners, traditional health practitioners and midwives as well as clergy. The forum opened up space for constructive engagement on the cautious use of sharp objects in the light of preventing contact with infected blood. This included safe ways of using razor blades, knives and needles.⁹⁴¹ Thus, HIV and AIDS initiatives strengthened the relationship between traditional and biomedical health practitioners and the Roman Catholic Church in Manicaland. The pandemic enabled the personnel from the diocesan project to propagate new understandings of HIV and AIDS among traditional health practitioners who were previously perceived as a threat to HIV prevention.

Between 1995 and 1999 the diocesan AIDS-related project was still one of the few FBOs with well-established HIV interventions in Manicaland. Local communities were consulted on the choice of programmes.⁹⁴² This practice enhanced good working relations between the project and the community. At the community level traditional leaders and their subjects were responsible for the initiative to establish central committees and similar structures at ward and village levels. The fact that members of committees were drawn up from people of diverse backgrounds led to a well-balanced consultancy and collaborative support network.”⁹⁴³ Three factors might have enhanced the willingness of local communities to be involved in AIDS-related home-based care committees. First, it was common knowledge that most families were caring for sick relatives. Second, the support received through the Catholic Diocese of Mutare’s hospitals combined with the FACT’s home-based care programme in remote areas could not be obtained at government healthcare centres. Third, the project’s

⁹⁴⁰ Mombe, same interview. See also J. Nyamande information supplied to M. Mbona, DOMCCP head office, St. Joseph’s mission, Sakubva, Mutare, 10 June 2010.

⁹⁴¹ See DOMCCPM, DOMCCP, MCHC progress report, 31 December 1996. See also DOMCCPM, DOMCCP, MCHC progress report, 1 March to 30 June 1999. See also F. Nyatsuro, information supplied to M. Mbona in Rusape, 3 June 2010. See also C. Mukazi, same interview.

⁹⁴² DOMCCPM, DOMCCP, MCHC progress report, 1 March to 30 June 1999.

⁹⁴³ See DOMCCPM, Muchini, CRS: Zimbabwe project progress report, 7, 11. See also J. Nyamande, information supplied to M. Mbona, DOMCCP head office, St. Joseph’s mission, Sakubva, Mutare, 10 June 2010.

decentralised planning of AIDS-related care interventions ensured flexibility in the choice of priority areas for community benefit.⁹⁴⁴

The demand for home-based care services in Manicaland led to the escalation of the number of beneficiaries under the diocesan project from 600 in 1996 to 739 between March 1997 and April 1998.⁹⁴⁵ In that period various essential sanitary and protective materials were given to 490 PLHIV. Essential drugs were given to 799 PLHIV and 210 of them were supplied with bedding requirements.⁹⁴⁶ A caring spirit at the helm of the Catholic Diocese of Mutare appeared to have underpinned the operations of the project. In line with this assertion, Auxiliary Bishop Mutume mentioned: “There was no way the Catholic Diocese of Mutare could separate the spiritual and physical needs of people because the problems faced by the society were the same challenges faced by the church.”⁹⁴⁷ It could also be stated that the HIV and AIDS pandemic provided opportunities for the Catholic Diocese of Mutare to offer unparalleled holistic care services through its AIDS care project. Some of the achievements for 1998 included visits to 739 PLHIV by voluntary caregivers and spiritual leaders, and the further formation and funding of twenty support groups.⁹⁴⁸ During the same period 1,504 primary caregivers and family members were constantly counselled to reduce burnout.⁹⁴⁹ Furthermore, between January and October 1999 a total of 826 PLHIV were supported by the diocesan project.⁹⁵⁰ Under the harsh economic environment in Zimbabwe, the church’s healthcare institutions in some parts of Manicaland gained visibility especially due to their unique support towards PLHIV.

Whereas the interventions carried out by the diocesan project mainly focused attention on the poor, events in June 1999 set in a new trend. The untimely dishonour of medical claims by the Public Service Medical Aids Society at the end of June 1999 increased the demand for healthcare services at church hospitals nationwide including

⁹⁴⁴ See also F. Nyatsuro, information supplied to M. Mbona in Rusape, 3 June 2010. See also J. Nyamande, information supplied to M. Mbona, DOMCCP head office, St. Joseph’s mission, Sakubva, Mutare, 10 June 2010.

⁹⁴⁵ DOMCCPM, Muchini, CRS: Zimbabwe project progress report, 5.

⁹⁴⁶ DOMCCPM, Muchini, CRS: Zimbabwe project progress report, 14.

⁹⁴⁷ P. Mutume, same interview.

⁹⁴⁸ DOMCCPM, Muchini, CRS: Zimbabwe project progress report, 14.

⁹⁴⁹ DOMCCPM, Muchini, CRS: Zimbabwe project progress report, 14.

⁹⁵⁰ DOMCCPM, DOMCCP, MCHC project report, March 1999 to December 2000, 8.

Manicaland.⁹⁵¹ Clientele who previously afforded payment for medical services at private hospitals were now competing with the poor at the church hospitals in rural areas. HIV positive people were among the affected clients who need regular care, support and treatment. The increase in public health fees at the Mutare provincial hospital, and at the city's clinics coupled with the general shortage of medicines nationwide, severely affected the PLHIV.⁹⁵² In this particular case, the CRS donor funded diocesan healthcare institutions became beacons of hope for the people of Manicaland.⁹⁵³

Similarly, Richard Hore of the Cimas Medical Aid Society in Zimbabwe stated that the AIDS epidemic overwhelmed the funding capacity of medical aid societies. The Cimas Medical AID Society served clientele from private companies and individuals while the Public Service Medical AIDS Society mainly catered for State employees. Hore mentioned that AIDS was a resource drainer. For example, the cost of AIDS-related treatment drugs at Z\$1,400 per month in 1993 was beyond the reach of Cimas.⁹⁵⁴ Furthermore, Hore suggested that home-based care remained the only medical costs saving plan for the PLHIV: “It is understood that a similar situation exists with both government and missionary hospitals. The answer lies in having these patients removed from hospital, and nursed at home.”⁹⁵⁵ HIV and AIDS negatively affected the operations of medical aid societies and made them to consider home-based care as a favourable option. The outsourcing of medical drugs by missionaries and expatriate health professionals serving at church-related hospitals in the late 1990s also assisted the PLHIV.⁹⁵⁶ However, in that period none of the Roman Catholic Church's healthcare centres in Manicaland offered ARVs.

There were noticeable changes in stigma and discrimination of PLHIV as society slowly became acquainted with the epidemic. These changes were as a result of intensified HIV and AIDS education and awareness campaigns run by the State

⁹⁵¹ DOMCCPM, DOMCCP, MCHC progress report, 1 March to 30 June 1999.

⁹⁵² DOMCCPM, DOMCCP, MCHC progress report, 1 March to 30 June 1999.

⁹⁵³ DOMCCPM, DOMCCP, MCHC progress report, 1 March to 30 June 1999.

⁹⁵⁴ R. Hore, “The medical costs of AIDS in Zimbabwe,” in S. Cross and A. Whiteside (eds), *Facing up to AIDS: The socio-economic impact in southern Africa*, (London: Macmillan Press, 1993), 241.

⁹⁵⁵ Hore, “The medical costs of AIDS in Zimbabwe,” 258.

⁹⁵⁶ V. Chitimbire, same interview.

through the public media.⁹⁵⁷ While this went on, the diocesan project also organised community sensitisation meetings and workshops in support of AIDS care programmes throughout the diocese. At least fifty-two additional home-based care sub-committees and one central committee were formed in 1998.⁹⁵⁸ Fifty-five workshops and sixty-one meetings on the importance of quality holistic care to PLHIV were also held in Manicaland during 1998. The total number of participants was 15,670.⁹⁵⁹ A number of the planned programmes achieved the set goals. This was attributed to the fact that the project was well funded and had an enthusiastic team of workers as opposed to the situation in the other two churches. It also appears that voluntary caregivers we

4.2.4.2. The Care of Orphans and Vulnerable Children

A surge in the number of OVC from 345,000 in 1988 to over 820,000 in 1998,⁹⁶⁰ serves to illustrate that AIDS-related deaths left behind a trail of distress. In Manicaland alone the estimated number of OVC in 1991 was at 47,000. This figure increased tremendously to 120,000 by the end of 1999.⁹⁶¹ The lack of a national OVC policy framework in Zimbabwe suggests that the State dragged its feet on this critical issue. Only as late as 1999 did the government launch a National Orphan Care Policy.⁹⁶² The drawing up of the policy appeared to be part of a crisis management strategy. The State in Zimbabwe realised too late that the ever-increasing number of OVC overwhelmed traditional family support systems. The policy was intended to

Mobilise communities to provide care and support to orphans living in the community with some assistance from the Government and non-governmental organisations [NGOs]. This enables orphaned children to remain in their communities under voluntary adult supervision.⁹⁶³

⁹⁵⁷ E. Tichawangana, same interview.

⁹⁵⁸ DOMCCPM, Muchini, CRS: Zimbabwe project progress report, 6, 7.

⁹⁵⁹ DOMCCPM, Muchini, CRS: Zimbabwe project progress report, 11.

⁹⁶⁰ NAC, *The HIV and AIDS epidemic in Zimbabwe*, 43.

⁹⁶¹ FACT archives, Mutare (FACTM), S. C. Mukufa, Progress report on families, orphans and children under stress, July-December 1999.

⁹⁶² Kaseke and Demba, "Zimbabwe country report," 14. See also MOHCW, *National HIV/AIDS policy*, 22.

⁹⁶³ Kaseke and Demba, "Zimbabwe country report," 15.

However, the policy did not translate into the immediate care and support of OVC by the Government because the State was battling to secure adequate financial resources. Therefore, much of the burden of OVC care remained on the shoulders of NGOs including the churches. In fact the OVC interventions under the diocesan project, FACT, and others served as a model for the State's policy on OVC care.

Between 1996 and 1999 the demand for OVC care and support overwhelmed the capacity of the diocesan project. For example, in 1996 a total of 595 OVC from all mission stations were supported with school fees and other requirements.⁹⁶⁴ In the period between 1997 and 1998 the number of the OVC beneficiaries under the diocesan project dropped. Only 161 orphans received school fees from the diocesan project, the local committees supported 100 orphans with school needs such as uniforms and books, and fifty-five OVC were provided with bedding.⁹⁶⁵ The hyperinflationary environment in Zimbabwe affected HIV interventions by the diocesan project and this became evident from the sharp drop of the OVC under the scheme in 1998. However, the funding of operations improved in 1999. Consequently, in June 1999 a total of 1,000 OVC received financial support and the number increased to 3,003 in the period between July and October of the same year. However, the project was overwhelmed by the ever-increasing demand for financial support towards OVC. In 1999, a total of 2,000 OVC were on the original budget but the figure escalated to over 10,000 OVC.⁹⁶⁶ With AIDS-related deaths claiming the lives of either parents or close relatives, the need for OVC care and support became more apparent than before.

The diocesan project relied on the positive contribution by members of the community and the extended family towards the welfare of OVC. This was done through the provision of necessities in cash and kind.⁹⁶⁷ The model thrived on the fact that in Africa the community was an extended-extended family. In support of this model, Stanley Phiri and David Tolfree have observed: –The close links of families,

⁹⁶⁴ DOMCCPM, DOMCCP, MCHC progress report, 31 December 1996.

⁹⁶⁵ DOMCCPM, Muchini, CRS: Zimbabwe project progress report, 19.

⁹⁶⁶ DOMCCPM, DOMCCP, MCHC Project report, March 1999 to December 2000, 8.

⁹⁶⁷ Information supplied by S. Mabunu to M. Mbona, Triashill mission, Mutasa, 24 July 2010. See also F. Nyatsuro, information supplied to M. Mbona, St. Joseph's mission, Rusape, 3 June 2010.

clans and communities in Sub-Saharan Africa made for an enduring resource.”⁹⁶⁸ The value of the model was based on the assumption that the network of family ties and community ethos of caring could provide a safety net for OVC.

In some parts of Manicaland traditional leaders including kraal heads, headmen and chiefs had a programme of caring for the disadvantaged members of the society and all members of the community were expected to support this cause. In this regard, the need for the OVC support also revived the old practice of collective communal fields known locally as *zunde ramambo*, implying a common field belonging to the local traditional leadership. The community worked on a demarcated piece of land and produced food that was given to the OVC.⁹⁶⁹ The personnel from the diocesan project provided inputs such as crop seed and fertilizer. Thus, in Manicaland OVC care fostered the old traditional spirit of social solidarity through community involvement in supporting its vulnerable members. This could have been motivated by a sense of expected reciprocal altruism: If I care for orphans today, someone will care for my children when I die.”⁹⁷⁰

According to the second model of OVC care, the church’s members volunteered to adopt some of the OVC. This was consistent with Foster’s observation that some religious groups in Africa were involved in the care of underprivileged people: “Religious groups have a theological commitment to work with the poor, the sick, the underprivileged, and with vulnerable children.”⁹⁷¹ From 1998 onwards, some groups of Catholic churchwomen assisted with the care of OVC by giving them part of the produce from their vegetable gardens. Examples of such projects existed at Triashill and St. Babra’s missions.⁹⁷² Similarly, church members at St. Simon Stock in Rusape,⁹⁷³ and St. Paul’s Danganvura,⁹⁷⁴ donated used and new clothes, paid school fees for primary and secondary school going OVC and distributed food parcels. This was not the case at the Cathedral of the Holy Trinity in Mutare. The parishioners at

⁹⁶⁸ S. N. Phiri and D. Tolfree, “Family and community-based care for children affected by HIV/AIDS: Strengthening the front line response,” in Foster, *A generation at risk*, 16.

⁹⁶⁹ P. Mutume, same interview.

⁹⁷⁰ Phiri and Tolfree, “Family and community-based care,” 17. See also A. Dera, same interview. See also S. Mabhunu, information supplied to M. Mbona, Triashill mission, Mutasa, 24 July 2010.

⁹⁷¹ Foster, “Religion and responses to orphans in Africa,” 160.

⁹⁷² E. Tichawangana, same interview.

⁹⁷³ C. Chiome, same interview.

⁹⁷⁴ T. Nyawera, same interview.

the cathedral appeared unconcerned with the plight of AIDS-related OVC. An oral source stated that the parishioners at the cathedral parish had limited exposure to the hardships encountered by the OVC.⁹⁷⁵ This is not to deny the fact individual members based at the cathedral parish cared for the OVC privately in line with Christian charity. Given these realities, the contributions towards the support of the OVC or the lack of therefore by the church's members affected the public image of parishes belonging to the Roman Catholic Church in Manicaland.

The diocesan project further supported programmes that encouraged the acquisition of practical skills and income generating projects with the OVC being beneficiaries. At Triashill practical skills training programmes, which included welding, dressmaking and woodwork, were established.⁹⁷⁶ Some of the OVC who received training in practical skills were thereafter able to establish small businesses such as sewing school uniforms and coffin making at the mission centre and in Rusape.⁹⁷⁷ The focus on sustainable skills development was unique to the diocesan project at that time. Thus, the AIDS-related OVC care interventions transformed the lives of young people from being dependents to self-supporting individuals. An important observation was that the diocesan project supported those HIV interventions that were identified as priorities areas by particular communities. For example, at St. Peter's mission in Chipinge, financial support towards the educational needs of OVC was a top priority intervention for the community. A community based decision to channel all the funds obtained from the United Nations International Children's Fund towards the payment of school fees for the OVC in 1999 indicated this.⁹⁷⁸ This approach enhanced a health partnership between the diocesan project and the community and this became beneficial to the carrying out of HIV and AIDS interventions.

The decline in the State of Zimbabwe's budgetary support towards schools led the AIDS-related OVC interventions by the diocesan project to improve educational facilities at some schools. This was particularly significant at schools that received

⁹⁷⁵ G. Maedze, same interview.

⁹⁷⁶ The present researcher visited some of the income generating projects at Triashill in 2010.

⁹⁷⁷ This information was supplied by S. Mabhunu to M. Mbona, Triashill mission, Mutasa, 24 July 2010.

⁹⁷⁸ DOMCCPM, DOMCCP, MCHC progress report, 1 March-30 June 1999.

fees for OVC under the diocesan project through the payment of block grants.⁹⁷⁹ New building projects, additional furniture, textbooks and stationery for the whole school were purchased using funds from the OVC-related block grants. The school management committees and the local project officers worked out school fees for all pupils on the OVC scheme and the money was channelled towards an identified school project.⁹⁸⁰ Thus, block grants paid out to beneficiary schools enabled the improvement of educational infrastructure and other resources. According to Shakespear Mabhunu who served as the project's manager for Mutasa district, the communities were quite appreciative of the system of block grants.⁹⁸¹ The resources donated towards maintaining high quality educational facilities through AIDS-related OVC care led to the flourishing of some schools. While some people considered large numbers of OVC in community as a burden, others including heads of schools found it to be beneficial.

4.2.5. Mixed Reactions to HIV and AIDS at the Grassroots Level

Between 1997 and 1998 the diocesan project hosted 230 AIDS related education sessions that were attended by over 31 051 people. This was mainly on occasions such as the World AIDS Day, the World Health Day and the International Day of the Sick.⁹⁸² Unfortunately, the diocesan project failed to address matters of sexuality in ways that were adequate. A respondent, Matilda Chitsungo stated that ~~at~~ the parish level open discussions about HIV and sexuality remained largely unknown and this led to the spread of HIV. If the clergy had sought ways of addressing this subject many souls could have been saved from AIDS-related deaths."⁹⁸³ However, there were reasons to explain why the clergy appeared reluctant to engage in public discussions on the prevention of sexually transmitted HIV. By and large, the church's official position on the use of condoms to prevent HIV remained conservative. This was the case despite perceptions that ~~marital~~ marital unfaithfulness was responsible for the

⁹⁷⁹ Information supplied by S. Mabhunu to M. Mbona, Triashill mission, Mutasa, 24 July 2010.

⁹⁸⁰ Information supplied by J. Nyamande to M. Mbona, DOMCCP head office, St. Joseph's mission, Sakubva, Mutare, 10 June 2010.

⁹⁸¹ Information supplied by S. Mabhunu to M. Mbona, Triashill mission, Mutasa, 24 July 2010.

⁹⁸² DOMCCPM, Muchini, CRS: Zimbabwe project progress report, 7, 11.

⁹⁸³ M. Chitsungo, same interview. See also R. Chiome, same interview.

spread of HIV among married Catholics.”⁹⁸⁴ The clergy were in a precarious position because they could not comfortably handle teachings on safe sex practices without making reference to condoms. Some of the church’s lay members were of the opinion that the ZCBC could have shown sensitivity to the challenges faced by Roman Catholic married women in respect to choice of safe sex.⁹⁸⁵ The fear of contracting HIV and the Roman Catholic Church’s position of public intolerance to use of condoms haunted married churchwomen.

Some Roman Catholic churchwomen in Manicaland attempted to influence the church’s clergy towards the integration of HIV and AIDS into the liturgical services and other platforms of the church. They approached the clergy and begged them to address particular aspects of the epidemic including HIV awareness.”⁹⁸⁶ In 1999 a few of the church’s clergy stationed at some parishes began to address the subject of sexuality in the context of HIV and AIDS. This change was noted at St. Joseph’s, Sakubva,⁹⁸⁷ and St. Thomas’ Nyahukwe,⁹⁸⁸ and Triashill mission.⁹⁸⁹ Given the fact that the Roman Catholic Church priests were celibate, parishioners, especially women struggled to find a suitable language to effectively express their experiences.⁹⁹⁰ However, Chiome mentioned: “HIV and AIDS made Roman Catholic Church to talk about sexuality out of a realisation that many people were dying due to AIDS. It became necessary to seek ways of saving the lives of people.”⁹⁹¹ In Manicaland, the effects of the HIV pandemic on the church’s members slowly forced some of the clerics to launch teachings on sexuality.

The HIV and AIDS pandemic also influenced members of the Roman Catholic Church to shift their position on widow inheritance. In the late 1990s, there was a notable refrain about the cultural practice of widow inheritance among Catholic churchwomen and married men in Manicaland. Some female respondents stated that even without knowledge of a person’s HIV status, widow inheritance was seen as

⁹⁸⁴ C. Mauye, same interview. See also M. Mudzimiri, same interview.

⁹⁸⁵ T. Nyawera, same interview.

⁹⁸⁶ T. Nyawera, same interview.

⁹⁸⁷ C. Mombe, same interview.

⁹⁸⁸ M. Mudzimiri, same interview.

⁹⁸⁹ E. Tichawangana, same interview.

⁹⁹⁰ M. Mudzimiri, same interview.

⁹⁹¹ R. Chiome, same interview.

being unsafe and a possible cause of a person's future death.⁹⁹² Similarly, in the Luo tribe of Kenya, in the late 1990s 'saved' Christian married women refused the traditional practice of widow inheritance or *tero*, mainly due to the AIDS crisis. However, in Kenya a compromise between saved Christians and traditionalists was reached later, leading to an evolution of *tero*. Prince did observe: "The crisis of AIDS and the need to regenerate life and growth after death is also leading to negotiations between saved and traditional pathways, some of which involve the creation of new traditional rules that accommodate salvation."⁹⁹³

There was also a relationship between saved Christians' resistance to widow inheritance and the values of the Catholic Charismatic Renewal Movement that took root in Uganda in the 1980s. Within the Roman Catholic Church in Manicaland, some churchwomen drew inspiration to resist widow inheritance from the Roman Catholic Charismatic Renewal Movement.⁹⁹⁴ Some of the clergy delivered messages against the practice of widow inheritance and legal personnel from the government were invited to educate churchwomen on the writing of wills.⁹⁹⁵ This action, taken by the Roman Catholic Church, came after realising the passionate plight of some widows and orphans who lost family property to relatives after the passing on of a breadwinner.

In some parishes, responses to the HIV and AIDS pandemic were sporadic. The streamlining of HIV interventions to fall under the diocesan project, left a few people with the responsibility to carry out an enormous task. For example, HIV interventions were not a regular subject of discussion at some of the parish council meetings held at the Cathedral of the Holy Trinity. This was confirmed by the lack of mention of anything about HIV in the minutes of parish council meetings held in 1997.⁹⁹⁶ However, in May 1999 the pandemic was the subject of discussion at a parish council meeting. This was noted by way of recording a planned HIV and AIDS awareness workshop that was to be held at the cathedral.⁹⁹⁷ At the next parish council meeting in June 1999, the members of the church council agreed to have an HIV and AIDS

⁹⁹² E. Tichawangana, same interview. See also T. Nyawera, same interview.

⁹⁹³ Prince, "Salvation and tradition," 79.

⁹⁹⁴ See C. Mauye, same interview. See also T. Nyawera, same interview.

⁹⁹⁵ Information supplied by S. Mabhunu to M. Mbona, Triashill mission, Mutasa, 24 July 2010.

⁹⁹⁶ Cathedral of the Holy Trinity archives, Mutare (HTCM), Minutes of parish council meetings, 1997.

⁹⁹⁷ HTCM, Minutes of parish council meeting, 18 May 1999.

workshop on two separate dates; 16-18 August for adults and 23-25 August for the youth.⁹⁹⁸ Compared to the magnitude of the effects of HIV and AIDS on society, the HIV interventions at the cathedral parish could not correspond with the plight of people infected and affected by the pandemic. HIV appeared to make inroads among the poor blacks as opposed to rich blacks, whites, coloureds and Indians who dominated the membership at the Cathedral of the Holy Trinity.⁹⁹⁹

At St. Paul's Dangamvura, two contradicting versions of the parish's history of responding to HIV and AIDS emerged. On the one hand, the current rector mentioned that the parish council had never carried out any HIV and AIDS interventions until his arrival in 2009.¹⁰⁰⁰ On the other hand, some of the parishioners stated that in the late 1990s the diocesan project discontinued support towards the parish's HIV and AIDS care programme because some members of the church misappropriated the resources that were earmarked for the benefit PLHIV and OVC.¹⁰⁰¹ There might have been lack of coordination between the parish council and the priest. Apparently, the lay members of a parish and the clergy were key players in launching and sustaining any HIV interventions. The willingness of Catholic Christians to assist people infected and affected by HIV and AIDS was an important step in responding to the epidemic. The opposite could also be true. At St. Simon Stock, Rusape, HIV interventions did not feature regularly at the parish council meetings.¹⁰⁰² The blame for this was laid on previous clergy.¹⁰⁰³ This was despite the fact that the lay members of the congregation did not fully utilise the opportunity to integrate HIV interventions in the activities of the parish. However, at Triashill two respondents stated that the regular contribution towards HIV and AIDS awareness by clergy who openly spoke about the epidemic at gatherings such as church services and funerals made a mark on pandemic.¹⁰⁰⁴ The same parish launched AIDS memory books for OVC not only to preserve their family history, but also to reduce chances of incest.¹⁰⁰⁵

⁹⁹⁸ HTCM, Minutes of parish council meeting, 8 June 1999.

⁹⁹⁹ G. Maedze, same interview.

¹⁰⁰⁰ Information supplied by R. Musakwa to M. Mbona, Mutare, 21 July 2010.

¹⁰⁰¹ T. Nyawera, same interview.

¹⁰⁰² SSCPR, See Minutes of parish council meetings: 20 January 1995, 30 March 1995, 14 May 1995, 25 May 1995, 20 October 1995, January 1996, 9 (no specific date stated), 20 June 1996, 23 April 1997, and 16 October 1997.

¹⁰⁰³ R. Chiome, same interview.

¹⁰⁰⁴ E. Tichawangana, same interview.

¹⁰⁰⁵ Information supplied by S. Mabhunu to M. Mbona, Triashill mission, Mutasa, 24 July 2010.

4.3. The Anglican Church's Response to HIV and AIDS

Bishop Masuko's retirement at the end of 1998 and the election of Sebastian Bakare as his successor in April 1999 opened a new era in the response to the HIV pandemic by the Anglican Church in Manicaland. Between 1997 and 1999 the leadership of the Anglican Church, acting under the Zimbabwe Council of Churches opposed the economic policies of President Mugabe's government.¹⁰⁰⁶ The diocesan healthcare centres served members of the public who sought treatment of AIDS-related illness and distributed condoms as a way of preventing sexually transmitted HIV. However, the church's leadership remained generally opposed to the use of condoms as prophylactic. Generally, the Anglican Church in Manicaland took some time before it confronted the pandemic.

This section will show that HIV and AIDS affected the Anglican Church in Manicaland more than what the church did to counter the effects of HIV and AIDS on its followers. Some positive changes were noticeable during episcopacy of Bishop Bakare when a paradigm shift in the institutional policy on the HIV epidemic was witnessed. Bakare's previous appointment as secretary of the Zimbabwe Council of Churches' "Urban and Industrial Mission Department" and as chaplain at the University of Zimbabwe in 1984, made him to appear well informed about social issues including public healthcare.¹⁰⁰⁷ Furthermore, Bakare witnessed HIV and AIDS cases in Germany and California in the US, where it was openly talked about.¹⁰⁰⁸

4.3.1. AIDS-Related Denial and Stigma at the Leadership Level

Within the leadership circles of the Anglican Church in Manicaland, AIDS-related denial and stigma continued to exist. Either the church's leadership was not well informed about HIV and AIDS, lacked interest in responding to the epidemic or that there were other diocesan priorities. According to Nyazika, "the leadership of the diocese lacked interest in obtaining the correct facts and knowledge about HIV and

¹⁰⁰⁶ Dorman, "NGOs and the constitutional debate in Zimbabwe," 848.

¹⁰⁰⁷ Hallencreutz, "Ecumenical challenges in independent Zimbabwe," 295.

¹⁰⁰⁸ S. Bakare, same interview.

AIDS.”¹⁰⁰⁹ Other oral sources from the diocese mentioned the same point.¹⁰¹⁰ Furthermore, another respondent pointed out that between 1995 and 1998, ~~the~~ reluctance to confront HIV and AIDS shown by the diocesan leadership, created an environment that was less supportive of open discussions on the pandemic.”¹⁰¹¹ In 1994 FACT established a church programme that sensitised church leaders on HIV and AIDS.¹⁰¹² The programme was also meant to equip the leadership of different churches including the Anglican Church, with knowledge and skills critical in responding to the AIDS epidemic.¹⁰¹³ While some of the churches leaders embraced this initiative others did not.

In 1996 the bishop hosted a diocesan HIV and AIDS seminar for the clergy at the Cathedral of St. John the Baptist in Mutare.¹⁰¹⁴ The seminar did not provide members of the Anglican Church clergy with further ways of responding to the epidemic. However, some of the clergy gave the impression that the proceedings of the seminar were worthwhile as this was ~~the~~ first time that some priests got detailed facts about the deadly epidemic.”¹⁰¹⁵ Apart from this platform, the diocesan leadership did not do much to educate the church’s clergy on HIV and AIDS. The lack of further opportunities for the church’s clergy to learn about the AIDS epidemic affected their competence in rolling out any HIV interventions at parish levels. According to Arden Strasser and Susan Strasser, generally, the level of indifference shown by church leaders on the epidemic was not helpful and therefore contributed to stigma and discrimination. They observed that the unwillingness by Zimbabwean religious leaders to be tested and disclose their HIV status ~~may~~ impede self-disclosure in general. Role model self-disclosure is important in so far as it reduces society’s denial of AIDS and it serves to reduce stigma.”¹⁰¹⁶ In a paper published in 2009, the

¹⁰⁰⁹ K. Nyazika, same interview.

¹⁰¹⁰ See also J. Chimwaza, same interview. See also E. Mbutsa, same interview. See also M. Nyamwena, same interview.

¹⁰¹¹ M. Mafulela, same interview.

¹⁰¹² —Fait-based approaches,” *AIDS action, The international newsletter on AIDS prevention and care*, 49 (July-September 2000). See also, A. Dube, information supplied to M. Mbona, FACT office, Mutare, 29 July 2010.

¹⁰¹³ See FACTM, L. Muchaneta, FACT church programme report, February 1995. See also, L. Muchaneta, FACT regional community oriented training programme, September 1996.

¹⁰¹⁴ O. Murakwani, same interview.

¹⁰¹⁵ O. Murakwani, same interview. See also M. Mushipe, interview by author at St. Cuthbert’s Denzva, 15 August 2010.

¹⁰¹⁶ A. Strasser and S. Strasser, —Religious affiliation and HIV transmission,” <<http://www.hopeforafrica.ne/NIH.html/>> [Accessed 29 May 2009].

Strassers wrote on HIV and AIDS in Zimbabwe and focused on the relationship between religious affiliation and HIV transmission. None of the Anglican Church clergy in Manicaland had been publicly tested or their HIV status declared.¹⁰¹⁷ This could have promoted an unhealthy culture of silence and denial.

Two important issues marked the closing years of Bishop Masuko's leadership. First, divine healing and witch hunting by Nerwande was discontinued and the bishop dissolved the Community of the Holy Cross on 27 November 1996.¹⁰¹⁸ Nerwande charged exorbitant sums of money for healing services and his fame as a divine healer was phenomenal. The bishops' support of Nerwande's divine healing ministry for almost a decade misled Anglicans in Manicaland to associate AIDS with sin and the work of witchcraft. Apparently, Bishop Masuko stated that HIV and AIDS was a consequence of moral failure.¹⁰¹⁹

Second, Bishop Masuko's last charge to the synod in 1997 contained a statement on HIV and AIDS.¹⁰²⁰ The bishop's charge to the synod sums up well what a bishop considers as the most important issues for the diocese. It was at the diocesan synod session of 1997 that Masuko put across his mind on HIV and AIDS:

It should be understood that it [AIDS] is an economic, social, health and moral problem. The question is how are we going to invest in our children when these problems are destroying them? The church must teach total abstinence before marriage which is Christian and recognised by our cultural values, faithfulness to one's legal partner for life, and that condoms have not been successful and that they promote promiscuity. The church and many people tend to shrug their shoulders and sit on the fence and say that they can do nothing. But it is a fact that when natural disaster comes, it knows no bound. But what the church needs also to know is to put its house in order first before it condemns others.¹⁰²¹

¹⁰¹⁷ O. Murakwani, same interview. See also K. Nyazika, same interview. See also M. Mafulela, same interview.

¹⁰¹⁸ HNM, the Rt Revd Elijah Musekiwa Masuko, Bishop of Manicaland to the Members and supporters of the Community of the Holy Cross Re Dissolution of the Community of the Holy Cross, 27 November 1996. Letter was sent to all parishes and institution of the diocese and to all bishops of the Church of the Province of Central Africa. See also See HNM, Church of the Province of Central Africa, Standing Committee's report to synod, Diocese of Manicaland synod 1997, Agenda and reports, 5-6 December 1997, 15.

¹⁰¹⁹ See HNM, Bishop's charge to the eighth synod: "Unity in the Body of Christ," 5 December 1997.

¹⁰²⁰ HNM, Bishop's charge to the eighth synod, "Unity in the body of Christ."

¹⁰²¹ HNM, Bishop's charge to the eighth synod, "Unity in the body of Christ."

Apart from socio-economic, health and moral realities that fertilised the pandemic, Masuko identified immorality as the main cause of HIV. The lack of well-organised diocesan instituted and coordinated HIV interventions left some people already infected and affected by AIDS in despair. These included members of the Anglican Church in Manicaland.

Bishop Masuko's message on HIV and AIDS appeared to have come late because the bishop was just about to retire in 1998 and –ould not therefore initiate new developments including the launching of HIV interventions at the diocesan level.”¹⁰²² Thus, Bishop Masuko's response to the epidemic was perceived as ambiguous at a time when –many Anglican Church families lost loved ones due to AIDS.”¹⁰²³ Elsewhere in the Anglican Communion in Africa, the Anglican Church of Uganda was ahead of the Anglican Church in Manicaland in responding to HIV and AIDS. For example, in 1995 the Church Human Services AIDS Programme under the Anglican Church of Uganda hosted a conference on HIV and AIDS awareness at Bishop Tucker Theological College in Mukono.¹⁰²⁴ The participants were comprised of 120 Anglican churchwomen from all walks of life including teachers, priests, mothers, wives, lawyers, physicians and grandmothers. At the conference, –the participants shared problems they faced as wives of men who lead –reckless' lives. They were all agreed on the use of condoms in marriage not only for purposes of birth control but for protection against AIDS.”¹⁰²⁵

The fact that the Anglican Church of Uganda ordained women since the 1970s could have been a contributing factor towards women's openness about the HIV and AIDS. The women clergy could have been more sensitive to the ways in which HIV affected women than their male counterparts. The predominantly male leadership in the Anglican Church in Manicaland lacked sensitivity to matters that affected women. The government through the MOHCW encouraged the use of condoms as a practical step in preventing HIV and the church believed and taught that Christian morality was the sole solution.¹⁰²⁶

¹⁰²² M. Nyamwena, same interview.

¹⁰²³ K. Nyazika, same interview.

¹⁰²⁴ Editor, –Fighting AIDS in Uganda,” *Anglican World* 78 (Pentecost, 1995), 18.

¹⁰²⁵ Editor, –Fighting AIDS in Uganda.”

¹⁰²⁶ G. Mukaratirwa, same interview, M. Nyakani, same interview.

According to the rules of diocesan synods in the Anglican Church in Manicaland, an item does not receive any official attention unless it appears in the synod agenda, reports or is moved as a motion from the floor.¹⁰²⁷ Whereas HIV and AIDS appeared under the reports from healthcare institutions, no resolution was then drawn up. Notices of motions constitute the synod's agenda and the clergy and laity were expected to move motions for debate.¹⁰²⁸ The diocesan bishop and members of the clergy and the laity shared in the responsibility of raising issues for the synod agenda. Given the fact that little attention was given to the HIV pandemic by the leadership of the diocese, the church could have missed the opportunity to respond positively to the needs of PLHIV and OVC. Without publicly known diocesan HIV interventions, the PLHIV and OVC from the Anglican Church in Manicaland and others had to seek care and support from elsewhere.¹⁰²⁹ While there was evidence to indicate that the diocese received donations from unnamed international partners, as noted in the audited accounts for 1997, there were no records of incurred costs towards HIV interventions.¹⁰³⁰ This meant that either HIV interventions such as AIDS-related care were non-existent or could have existed but without being reflected in such reports which was quite unlikely.

Within the Anglican Church in Manicaland, responses to the AIDS epidemic at the leadership level remained peripheral. If some HIV interventions existed at the diocesan level, it was always incumbent upon the church leadership to reflect on the work and this would feature in diocesan meetings and circulars. For example, the minutes of a meeting of the diocesan standing committee held in January 1998 did not make any reference to the epidemic,¹⁰³¹ and neither did the diocesan secretary's circular of same year,¹⁰³² and also the minutes of the diocesan standing committee meeting held in October 1998.¹⁰³³ Furthermore, beyond Manicaland, the HIV and AIDS epidemic did not receive much attention at the Lambeth Conference in

¹⁰²⁷ MM, *Diocese of Manicaland standing rules of the diocesan synod*, 1982.

¹⁰²⁸ MM, Diocese of Manicaland, *Diocese of Manicaland standing rules of the diocesan synod*, 1982. See also HNM, Diocese of Manicaland synod, agenda and reports. 7-10.

¹⁰²⁹ M. Nyamwena, same interview. O. Murakwani, same interview. See also M. Mushipe, same interview.

¹⁰³⁰ HNM, Diocese of Manicaland, "Income and expenditure statements," Diocese of Manicaland synod, agenda and reports, 5-6 December 1997, 23-44.

¹⁰³¹ See HNM, Minutes of the Anglican Diocese of Manicaland standing committee meeting, 28 January 1998. See also O. Murakwani, same interview.

¹⁰³² HNM, Acting diocesan secretary/treasurer's circular 3, 1998, 21 August 1998.

¹⁰³³ HNM, Minutes of the Anglican Diocese of Manicaland standing committee meeting, 30 October 1998.

1998.¹⁰³⁴ This did not mean that some Anglican dioceses and provinces in Africa did nothing to combat HIV as noted in the case of Uganda. Within the Anglican Church in Manicaland, responses to HIV at the leadership level existed in the form of moral rhetoric and without practical interventions.¹⁰³⁵ Apparently, the reports of the diocesan synod sessions held in 1982, 1984, 1986, 1988, 1990, 1992, and 1994,¹⁰³⁶ hardly mentioned anything about the AIDS epidemic. Perhaps other priorities took precedence over HIV and AIDS interventions including the welfare of the clergy welfare, evangelism and the construction of the human resource centre.¹⁰³⁷

4.3.2. Engagement with AIDS by the Church Leadership (1999)

The election of Bakare as the second diocesan bishop in 1999 opened a new era in the response to HIV and AIDS by the leadership of the Anglican Church in Manicaland. Unlike his predecessor, Bakare had exposure to the distress that people infected and affected by HIV and AIDS experienced. Bishop Bakare's postgraduate studies in California (1980-1991),¹⁰³⁸ one of the areas hard hit by the pandemic in the early 1980s,¹⁰³⁹ could have shaped Bakare's understanding of pandemic. The first step was that Bakare capitalised on the existing infrastructure at Kubatana under St. Augustine's clinic to initiate further HIV and AIDS interventions in the diocese. The appointment of Lin Parsons as the director of the diocesan healthcare services in 1999 was made with the intention of scaling up HIV and AIDS interventions throughout the diocese.¹⁰⁴⁰ The *Kubatana* initiative managed to achieve positive results through the collaborative effort of healthcare personnel, members of the community and FACT. The nurse at St. Augustine's clinic joined the members of staff from FACT in

¹⁰³⁴ See Lambeth Conference resolution 1.10, Human sexuality of 1998. See also Lambeth Conference 1988 resolution 29 as noted in chapter three.

¹⁰³⁵ M. Mafulela, same interview. See also R. Mlambo, interview conducted by M. Mbona, Anglican Diocesan office, Mutare, 16 August 2010.

¹⁰³⁶ MM, Diocese of Manicaland, —*Acts of the Diocese of Manicaland.*” See also O. Murakwani, same interview. See also K. Nyazika, same interview.

¹⁰³⁷ O. Murakwani, same interview. See also K. Nyazika, same interview. See also J. Chimwaza, same interview.

¹⁰³⁸ S. Bakare, same interview.

¹⁰³⁹ Bayer and Oppenheimer, *AIDS doctors*, 18.

¹⁰⁴⁰ S. Bakare, same interview.

carrying out home visits. Several healthcare workers in the Muchena area joined the AIDS-related care programme.¹⁰⁴¹

Faced with a growing epidemic, some members the Anglican Church in Manicaland were in a state of despondence. Bishop Bakare's commitment to responding to the HIV and AIDS pandemic made Bakare to be seen as –the right person for the moment.”¹⁰⁴² In a circular addressed to the clergy, parishioners and heads of diocesan institutions Bishop Bakare broke out:

Zimbabwe as a nation is daily confronted by the devastating effects of the HIV and AIDS pandemic. The death figures are frightfully high, ranging between 1,500 and 2,000 per week. We do not know the exact number of new cases but it should be terribly high. Such a national disaster creates a context in which the church has to think of a new method to proclaim the gospel. Indeed our clergy spend most of their time at cemeteries, taking funeral services.¹⁰⁴³

This message contained the bishop's concern on the devastating effects of HIV and AIDS on Zimbabweans of which the members of the Anglican Church in Manicaland were part. Unlike his predecessor, Bakare appears to have shown a strong moral will and the courage to address the plight of people infected and affected by the epidemic. Apparently, at the University of Zimbabwe, where he had served as a senior chaplain,¹⁰⁴⁴ Bakare gained deep insights into the effects of HIV and AIDS in the lives of students, staff and various State officials.

In subsequent years, Bishop Bakare launched HIV and AIDS interventions under the Anglican Church in Manicaland. The first step taken was the proposal to use the church's mission sites in the training of voluntary caregivers under the supervision of Parsons:

The Anglican Diocese of Manicaland is now engaged in a programme that seeks to help combat the spread of the disease by establishing AIDS/Health Centres in our rural mission districts. We believe that this

¹⁰⁴¹ FACT Rusape archives, (FACTR), T. Nyaruwa, –Home based-care report,” FACT staff meeting, 28 March 1995.

¹⁰⁴² K. Nyazika, same interview. See also O. Murakwani, same interview; R. Mlambo, same interview.

¹⁰⁴³ St. Matthews Anglican parish, archives, Rusape (SMAR), Churchwarden's file, The Rt. Reverend. Dr. S. Bakare to my brothers and sisters: HIV and AIDS in Zimbabwe, 15 October 1999.

¹⁰⁴⁴ S. Bakare. Same interview.

is one of the ways that the church can respond to this human tragedy in our country.¹⁰⁴⁵

Whereas the strategy appeared to be well meaning, it was met with resistance from some members of the clergy. They opposed the bishop's plan to invest scarce diocesan financial resources towards HIV interventions. One of the main reasons for the clergy's resistance to the move was that ~~this~~ took away the bishop's attention from the welfare of clergy to other pertinent needs."¹⁰⁴⁶ Despite the resistance, Bakare proceeded with the plan of launching diocesan AIDS-related care interventions at selected rural mission sites. Bakare opted to prioritise on the establishment of the programme because the rural folk in Manicaland increasingly carried the burden of AIDS-related care.¹⁰⁴⁷ Whereas the care of the PLHIV and OVC were planned for, the position of the diocese on HIV prevention was not clearly articulated.¹⁰⁴⁸

Bishop Bakare's proposal to launch HIV interventions was set to complement the AIDS-related work by the Roman Catholic and United Methodist churches and FACT in the rural parts of Manicaland. FACT had spread its tentacles across the province with new branches in Rusape, Nyanga and Mutasa.¹⁰⁴⁹ However, the programmes were not directly aligned to particular churches. The directors ~~deliberately~~ avoided being owned and controlled by church leaders and this gave the FBO the flexibility to carry out programming as per community needs."¹⁰⁵⁰ Previously, the uptake of this initiative by the clergy of the Anglican Church in Manicaland was slow. However, Bakare's episcopacy created new opportunities for strong collaboration between FACT and the Anglican Church.¹⁰⁵¹ According to Foster, the healthy working relationship with the churches remained strategic for rural training, orphan care support, sex education, and home care programmes.¹⁰⁵² Some members of the clergy

¹⁰⁴⁵ SMAR, Churchwardens file, The Rt. Reverend. Dr. S. Bakare to my brothers and sisters: HIV and AIDS in Zimbabwe, 15 October 1999.

¹⁰⁴⁶ Nyazika, same interview.

¹⁰⁴⁷ S. Bakare, same interview.

¹⁰⁴⁸ SMAR, Churchwardens file, The Rt. Reverend Dr. S. Bakare to my brothers and sisters: HIV and AIDS in Zimbabwe.

¹⁰⁴⁹ Madava, *The FACT story*, 8-12.

¹⁰⁵⁰ G. Foster, same interview.

¹⁰⁵¹ O. Murakwani, same interview.

¹⁰⁵² FACTR, G. Foster, Guidelines for the establishment of FACT branches, August 1993.

from the Anglican Church in Manicaland expressed regret at having missed the opportunity to participate in the HIV and AIDS programmes launched by FACT.¹⁰⁵³

The establishment of diocesan programmes for the care of PLHIV and OVC programmes at St. Werburgh's Chigodora, Nedziwa in the Mutungagore area and St. Mary Magdalene's Nyanga received approval from local communities.¹⁰⁵⁴ However, politically, the new AIDS-care related projects were held in question. Bishop Bakare's statement on the strategy to outsource funding thus explained:

We are therefore appealing to concerned Christians outside Zimbabwe to assist us as a diocese to establish AIDS healthcare centres. ...By establishing these centres, the diocese hopes not only to share the pain with the people but to give them the support and encouragement they so much need.¹⁰⁵⁵

Understandably, it was the State's responsibility to initiate programmes such as HIV prevention and AIDS mitigation but the State alone could not accomplish this enormous task. At the same time, the involvement of the churches in outsourcing funding for HIV interventions generated controversy from within political circles in Zimbabwe. HIV and AIDS interventions were perceived as ~~undermining~~ undermining the State.¹⁰⁵⁶ According to Chitando, in the late 1990s, ~~as~~ it dawned on the masses that political independence had not been translated into the economic miracle that many had anticipated, discordant voices became more pronounced.¹⁰⁵⁷ The ZCBC reminded the government to deliver decent healthcare services to ordinary people including HIV interventions.¹⁰⁵⁸ Along the same vein, Bakare patently pointed out that ~~dishonesty~~ dishonesty and selfishness on the part of the government and some political leaders left ordinary people in despair.¹⁰⁵⁹ Some church leaders including Bakare invoked the Anglican Church's long history of involvement in public healthcare in Zimbabwe to justify the establishment of HIV and AIDS interventions.

¹⁰⁵³ O. Murakwani, same interview.

¹⁰⁵⁴ SMAR, Churchwardens' file, The Rt. Reverend Dr. S. Bakare to my brothers and sisters: HIV and AIDS in Zimbabwe.

¹⁰⁵⁵ SMAR, Churchwardens' file, The Rt. Reverend Dr. S. Bakare to my brothers and sisters: HIV and AIDS in Zimbabwe.

¹⁰⁵⁶ S. Bakare, same interview.

¹⁰⁵⁷ E. Chitando, ~~Down with the devil, Forward with Christ! A study of the interface between religious and political discourses in Zimbabwe,~~ *African Sociological Review* 6, 1, (2002), 3.

¹⁰⁵⁸ For this see section on the ZCBC in this chapter

¹⁰⁵⁹ S. Bakare, same interview.

4.3.3. Church Healthcare and Treatment of AIDS-Related Illness

The effects of reduced spending on public healthcare by the State resulted in the migration of qualified medical personnel to find greener pastures elsewhere. This affected the delivery of services at most healthcare centres throughout Zimbabwe including Manicaland. The capacity of church healthcare services to assist the sick including PLHIV was also compromised. For example, in 1997, St. David's Bonda hospital only had fifty-five nurses instead of 105.¹⁰⁶⁰ The lack of adequate numbers of qualified medical staff was an impediment on service delivery. HIV and AIDS affected the hospital because it increased workloads for the remaining staff. Dr Matthew McNally, reported that the capacity of the hospital to offer medical services was undermined by lack of qualified medical personnel:

It is the government which allocates nurses posts to us, but in the present economic climate it is unlikely that we get any more posts. Despite these difficulties, our nurses are often praised for the work they do, and I would like to add my own thanks to them for keeping up the hospital's good name.¹⁰⁶¹

The report made no reference to HIV and AIDS as a major health issue facing the St David's Bonda hospital. This could have suggested that the hospital carried out low key HIV and AIDS interventions.

St. David's Bonda hospital, being one of the largest Anglican Church-related healthcare centres in rural Manicaland, was then designated as the district referral hospital for Mutasa. The HIV and AIDS epidemic overwhelmed the services at the hospital as mentioned by Magna Chikukwa, a senior nursing officer at institution since 1980. Chikukwa has recalled: "The pandemic besieged the medical fraternity to the point that some members of staff deserted the hospital for other areas where the situation was not as deplorable."¹⁰⁶² Similarly, St. the report for Peter's Mandeya

¹⁰⁶⁰ See HNM, M. McNally, "St. David's Bonda hospital report," Diocese of Manicaland synod, agenda and reports, 5-6 December 1997, 73-74. Dr Matthew McNally was the medical superintendent of the hospital.

¹⁰⁶¹ HNM, M. McNally, "St. David's Bonda hospital report."

¹⁰⁶² M. Chikukwa, same interview.

clinic's presented at the synod maintained silence on HIV and AIDS.¹⁰⁶³ This was despite of the fact that the clinic served the rural population of Mandeya, Muparutsa, Zindi and Chisuko. It is also close to the Katiyo and Eastern Highlands Tea Estates. These areas attracted migrant workers who were therefore prone to HIV. It is quite likely that these healthcare centres either had other priorities or that they failed to seize the opportunity to highlight the impact of HIV and AIDS on their operations. It appears that the report did not do justice to the conditions at hand.

The lack of mention of HIV and AIDS in the synod reports from St. David's Bonda hospital and St. Peter's Mandeya clinic could have led the synod delegates to underestimate the effects of the pandemic. However, perhaps the relationship between the diocesan hierarchy and heads of diocesan healthcare could have accounted for the situation. In this regard, "the demand by the diocese to control funding and operational activities at diocesan institutions acted as barriers in accessing foreign aid to support the diocesan healthcare services."¹⁰⁶⁴ In this regard the attitude of the diocesan leadership was seen as having undermined the work of its healthcare institutions and therefore HIV interventions might have been affected.

At the diocesan synod session of 1997 the report on St. Augustine's clinic mentioned how the mission had launched HIV interventions since 1995.¹⁰⁶⁵ Part of the report presented at the synod by Sarah Hinton, then sister-in-charge, observed:

Over the past three years we formed from the [St. Augustine's] clinic Kubatana which has twenty volunteers in home based care and orphan care. This is now run by a full-time supervisor, but coordinated by the sister in charge of the clinic. Home based care has seen 120 clients at this time, 70 of which have died; the orphan care helped by FOCUS (FACT-related) in Mutare is at present caring for 201 needy children in the surrounding community. Spiritual care is placed high within these projects and we have worked closely with the priest in charge, CDC Brothers and CZR Sisters. The volunteers also

¹⁰⁶³ HNM, M. Kamhunga, Acting sister-in-charge, "St. Peter's Mandeya clinic report," Diocese of Manicaland synod, agenda and reports, 5-6 December 1997, 5-76.

¹⁰⁶⁴ See HNM, McNally, "StDavid's Bonda hospital report." See also HNM, Kamhunga, "StPeter's Mandeya clinic report." See also, M. Chikukwa, same interview.

¹⁰⁶⁵ HNM, Diocese of Manicaland synod, agenda and reports, 5-6 December 1997.

are involved in drama to local places on AIDS prevention, soap making and nutrition garden for orphan families.¹⁰⁶⁶

The close proximity of St. Augustine's clinic to the mining and timber plantation areas, that attracted migrant labour and local workers, could have contributed towards high cases of HIV and AIDS-related illness. This clinic, located less than thirty kilometres from Mutare establish some HIV and AIDS interventions in response to the acute needs in that area.

The work of the same HIV and AIDS project was highlighted in the report submitted by the priest-in-charge of St. Augustine's mission. The priest-in-charge, Brother Benedict, stated:

The mission runs several projects set up to help the needy and poor people who live in the area. This social programme is very impressive. Most of the projects operate from the clinic here—home-based care, caring for orphans in the villages, AIDS awareness scheme and funds for sponsoring primary school children's fees.¹⁰⁶⁷

The AIDS-related care project at St Augustine's clinic was funded through a partnership between external donors and FACT. The project did not receive funding from the diocesan office.¹⁰⁶⁸ Furthermore, examples of conflict involving the diocesan office, rectors of parishes, heads of schools and leaders of healthcare institutions could have discouraged potential donors from supporting the Anglican Church in Manicaland. This affected diocesan social development projects including HIV interventions.¹⁰⁶⁹ For example, while Benedict and Hinton sourced funding and other forms of support for AIDS care programmes, the perceived unsupportive stance shown by the diocesan leadership, undermined the rapport with prospective donors and the community."¹⁰⁷⁰

¹⁰⁶⁶ HNM, S. Hinton, Sister-in-charge, —StAugustine's clinic report," Diocese of Manicaland synod, agenda and reports, 77.

¹⁰⁶⁷ See HNM, Benedict SSF, —St. George's and St. Michael's report," Diocese of Manicaland synod 1997, agenda and reports, 78.

¹⁰⁶⁸ HNM, Benedict SSF, —St. George's and St. Michael's report."

¹⁰⁶⁹ Between 1990 and 2000 the author served as an educationist at St. Peter's Mandeya mission and was on the development committee of St. Peter's Mandeya clinic until December 2000.

¹⁰⁷⁰ See HNM, Benedict SSF, Priest-in-charge, —St.Augustine's, St. George's and St. Michael's report," Diocese of Manicaland synod, agenda and reports. See also HNM, S. Hinton, —StAugustine's clinic report," Diocese of Manicaland ninth session of synod, Mutare 5-7 May 2000, 42.

The rather unhealthy working relationship between the diocesan leadership and the church's healthcare institutions contributed negatively to the setting up of HIV and AIDS interventions under the Anglican Church. It appears that the failure by the diocesan leadership to work closely with medical personnel stationed at the church's healthcare institutions affected the capacity of the Anglican Church to respond meaningfully to the pandemic. However, the church leadership allowed its healthcare centres to collaborate with the State in the areas of HIV and AIDS awareness, prevention and treatment. While such collaboration was of value to PLHIV, generally, it appears that the Anglican Church had the potential to intensify and broaden its response to HIV and AIDS. This took some time before being initiated. The work of a small diocesan healthcare centre, St. Augustine's clinic, placed the Anglican Church in Manicaland on the map of organisations responding positively to the needs of PLHIV and OVC. However, it has to be noted that the staff and community at St Augustine's mission initiated this.

4.3.3. AIDS-Related Denial and Stigma Unabated at the Grassroots Level

Within the Anglican Church in Manicaland, in the years between 1995 and 1999, AIDS-related denial and stigma was still manifest at the local parish level. The general picture showed that many of the parishes remained seemingly unmoved by the plight of the PLHIV and OVC.¹⁰⁷¹ For example, at St. Matthew's in Rusape, HIV interventions were not integrated in the parish and –the care of people living with HIV and orphans was done unsystematically.”¹⁰⁷² The sporadic efforts by the members of MU at the same parish to assist some of the vulnerable members of the church fell short of meeting the needs of PLHIV and OVC.¹⁰⁷³ The denial of AIDS and the stigmatisation of PLHIV at the parish level affected the church's ability to provide sustainable AIDS-related care and support interventions. This probed the question of whether or not Anglicans at St. Matthew's parish shared the pain and sorrows of PLHIV who were part of the body of Christ. In answering this question, Neville Richardson has observed that: –Those who belong to the Christian community would

¹⁰⁷¹ K. Nyazika, same interview. See also O. Murakwani, same interview.

¹⁰⁷² N. Mushawa, same interview. See also J. Mavhima same interview. See also C. Matenga, same interview.

¹⁰⁷³ J. Mavhima, same interview.

claim that Jesus offered the kind of care that addresses disease and its accompanying fear and sorrow.”¹⁰⁷⁴ The care of PLHIV and OVC was something that Christians at St. Matthew’s parish were still yet to be collectively involved in.

The apparent denial of AIDS at St. Matthew’s parish was noted from the lack of planned strategies on the prevention of HIV. The parish’s inability to launch HIV awareness and prevention programmes affected young people by robbing the future generation of vital information that could have saved them from succumbing to the epidemic.”¹⁰⁷⁵ Until the end of 1999, the Anglican Youth Fellowship at St. Matthew’s parish lacked exposure to youth friendly HIV prevention education programmes. According to another source from the same parish, the church leaders were in the practice of giving moral warnings about HIV without discussing in pragmatic ways other methods of preventing the spread of HIV.”¹⁰⁷⁶ This could have exacerbated the effects of the pandemic on some members of the congregation. An informant, Peter Dhlomo, expressed the view that parishioners were benefited more from HIV awareness and prevention programmes on national television such as the “Mai Chisamba Show” than from the church.¹⁰⁷⁷ The situation at St. Matthew’s was widespread within the Anglican Church in Manicaland and this was fuelled by cultural practices that treated matters of human sexuality as taboo. This affected the contribution of the parishes to HIV prevention.¹⁰⁷⁸

A limited number of documents indicated the apparent lack of mention of HIV and AIDS interventions at St. Matthew’s parish. These included the churchwardens’ report of August 1999,¹⁰⁷⁹ the archdeacon’s report of September 1999,¹⁰⁸⁰ and churchwardens’ annual report of 1999.¹⁰⁸¹ This was despite the fact that some lay people stated that a large proportion of church members at the parish succumbed to

¹⁰⁷⁴ N. Richardson, “A call for care: HIV/AIDS challenges the church,” *Journal of Theology for Southern Africa* 125 (July 2006), 43.

¹⁰⁷⁵ Information supplied by P. Z. Dhlomo to M. Mbona, Rusape, 28 September 2010.

¹⁰⁷⁶ J. Mavhima, same interview. See also C. Matenga, same interview.

¹⁰⁷⁷ Information supplied by P. Z. Dhlomo to M. Mbona, Rusape, 28 September 2010.

¹⁰⁷⁸ J. Mavhima, same interview. See also O. Murakwani, same interview. See also J Chimwaza, same interview. See also Haddad, “We pray but we cannot heal,” 84.

¹⁰⁷⁹ SMAR, Report of the west archdeaconry, January to August 1999.

¹⁰⁸⁰ SMAR, Onious Chikandiwa, Archdeacon’s report, September 1999.

¹⁰⁸¹ SMAR, St. Matthew’s parish end of year report, 1999, 19 March 2000.

AIDS.¹⁰⁸² The geographical position of Rusape, being on the main road junction linking Nyanga, Hwedza, and Murambinda to the Harare, Mutare and Beira highway attracted long distance truck drivers. Furthermore, migrant labour serving at commercial farms and the copper mine at Inyati had the potential of increasing cases of HIV in Rusape. The military base at Tsanzaguru also made the town to be fertile breeding ground for HIV and sex work proliferated.¹⁰⁸³

Given this context, the churches in Rusape had a high probability of having members who were either infected or affected by HIV and AIDS. When the new diocesan bishop issued a circular on HIV and AIDS in October 1999, the church leadership at St. Matthews did not do much in enlightening the congregants on this matter.¹⁰⁸⁴ The parish council took long before realising the urgency with which the diocesan bishop sought to address the effects of HIV and AIDS on Anglicans and the community. Such action on the part of the church's leadership translated into a form of conspiracy of silence.

At Holy Name parish in Sakubva, between 1995 and 1999 the church's income and expenditure statements and the minutes of parish council meetings showed that responses to HIV and AIDS were not a central part of church's activities.¹⁰⁸⁵ This was also confirmed by views expressed by two parishioners from Holy Name.¹⁰⁸⁶ The parish was preoccupied with other issues that could have prevented it from being involved in carrying out HIV and AIDS interventions. On the contrary, at Hilltop circuit belonging to the United Methodist Church and at St. Joseph's Sakubva, a Roman Catholic Church establishment, HIV and AIDS interventions were thriving.

¹⁰⁸² J. Mavhima, same interview. See also C. Matenga, same interview. See also N. Mushawa, same interview.

¹⁰⁸³ N. Mushawa, same interview. See also O. Kanyere, same interview.

¹⁰⁸⁴ J. Mavhima, same interview. See also C. Matenga, same interview. See also N. Mushawa, same interview.

¹⁰⁸⁵ See HNM, Minutes of parish council meeting, December 1995, Minutes of parish council meeting, 11 February 1996, J. Janjawa, Presentation of financial report to congregation, 25 February 1996, Minutes of parish council meeting, 14 July 1996, Income and expenditure statement July 1996-March 1997, Minutes of parish council meeting, 15 March 1998, Analysis of income and expenditure for the year ended 31 December 1998, Minutes of parish council meeting, 24 January 1999, Minutes of parish council meeting, 1 July 1999, HNM, Minutes of parish council meeting, 11 July 1999, Minutes of parish council meeting, 1 August 1999, Minutes of parish council meeting, 29 September 1999, Minutes of parish council meeting, 5 November 1999, Minutes of parish council meeting, 6 November 1999, Minutes of finance committee meeting, 28 December 1999, Income and expenditure analysis for year ended 31 December 1999.

¹⁰⁸⁶ E. Mbutsa, same interview. See also J. Chimwaza, same interview.

Holy Name, Hilltop, St. Joseph's Mutare were among the oldest and largest parishes or circuits located in Sakubva high-density suburb. Generally, the lack of ecumenical collaboration on HIV interventions at the parish level weakened the effect of churches on the pandemic.

The negative effect of HIV and AIDS on members of the Mothers' Union was one of the major factors that led the guild to be involved in HIV awareness education campaigns starting from 1995 onwards.¹⁰⁸⁷ HIV and AIDS awareness education became a topical issue at the guild's district and diocesan conferences and sessions were led by speakers from the nursing fraternity including Patricia Nyazika, Nyasha Madziro and Magna Chikukwa among others.¹⁰⁸⁸ The presentations focused on HIV and AIDS awareness and care only. HIV prevention was one of the critical areas that were not addressed by members of the guild.

One of the reasons for skirting the subject of prevention of HIV appeared to centre on local Anglican churchwomen's discomfort and reluctance to explore the use of condoms in the prevention of HIV.¹⁰⁸⁹ Elsewhere in the Anglican Church of Uganda, in 1995 churchwomen showed enthusiasm and willingness to discuss the use of condoms in the prevention of HIV:

Participants decided that more had to be learned about the condom and how it is used as a prevention measure. They were all agreed on the use of condoms in marriage not only for purposes of birth control but for protection against AIDS.¹⁰⁹⁰

Within the Mothers' Union guild in Manicaland, the negative attitude shown by the members towards the inclusion of HIV prevention education undermined any efforts at stemming the epidemic.

¹⁰⁸⁷ J. Chimwaza, same interview. See also M. Nyamwena, same interview. See also J. Mavhima, same interview. See also R. Munakamwe, same interview. See also B. Makoni, same interview. See also G. Mukaratirwa, same interview. See also M. Nyakani, same interview. See also K. Nyazika, same interview. See also M. Mushipe, same interview. See also O. Murakwani, same interview.

¹⁰⁸⁸ M. Chikukwa, same interview. See also G. Mukaratirwa, same interview. See also M. Nyamwena, same interview.

¹⁰⁸⁹ See chapter 3 section 3.4 of the present thesis. See also M. Nyamwena, same interview. See also B. Makoni, same interview.

¹⁰⁹⁰ Editor, "Fighting AIDS in Uganda."

Ednah Masuko, wife to Bishop Masuko, launched a programme in which the guild members were encouraged to maintain smartness on the pretext that their husbands –abandoned wives who were not smart and sexually appealing.”¹⁰⁹¹ Lessons on personal hygiene were given at the diocesan conferences held between 1995 and 1998. Furthermore, fashion parades and beauty contests at the guild’s gatherings were introduced. Married Anglican churchwomen were sensitized on the importance of sexual attractiveness and Masuko encouraged her fellow sisters to use special herbs that were inserted in the vagina to tighten up the muscles so that their spouses could “enjoy sex.” This approach to sexuality and HIV prevention made most of the Anglican married churchwomen to “continue being infected and affected by the epidemic.”¹⁰⁹² The general lack of openness about a person’s HIV status among members of the guild enhanced AIDS-related denial and the fear of being stigmatised.¹⁰⁹³ Generally, the Manyika women were known to be culturally shy on personal and intimate matters such as sex and therefore HIV might have remained an “untouchable” area.

Between 1995 and 1998, there were very rare cases of members of the MU guild who tested for HIV. As Murakwani has shown, within the Anglican Church in Manicaland –both men and women were unwilling to get tested for HIV and chose to suffer and die in silence.”¹⁰⁹⁴ Furthermore, Murakwani has also indicated that HIV positive women from the Zimbabwe Council of Churches Women’s Desk who presented talks on HIV and AIDS at the diocesan Mothers’ Union guild’s gatherings were reluctant to be identified with any particular church. The tendency not to disclose their church affiliation was due to the fact that –AIDS was still associated with promiscuity.”¹⁰⁹⁵ This attitude gave the impression that AIDS was something outside of the Christian community. Fear and shame associated with AIDS discouraged people from obtaining knowledge about their HIV status. This became a hindrance to any attempts aimed at reducing the denial, stigma and discrimination of PLHIV.

¹⁰⁹¹ M. Nyamwena, same interview. For a further analysis of this see also Haddad, “Choosing to remain silent,” 151-152.

¹⁰⁹² M. Nyamwena, same interview.

¹⁰⁹³ O. Murakwani, same interview.

¹⁰⁹⁴ O. Murakwani, same interview.

¹⁰⁹⁵ O. Murakwani, same interview.

Generally, within some parishes of the Anglican Church in Manicaland, HIV interventions at the grassroots level were affected by lack of resources. This affected AIDS mitigation in areas that included St. Cuthbert's Denzva in Makoni,¹⁰⁹⁶ Honde Valley,¹⁰⁹⁷ and Rusape,¹⁰⁹⁸ among others. However, the situation in some Anglican parishes in Mutare was different. Between 1995 and 1998 the Anglican churchwomen groups at St. Agnes' Chikanga, St. John the Baptist Cathedral, and Mufudziwakanaka parishes had access to limited resources from the diocesan Mothers' Union office. The networks established by some of the Anglican churchwomen in Mutare were instrumental in setting up the stage for care and support towards PLHIV and OVC later in 2000.¹⁰⁹⁹

Some of the respondents from the Anglican Church in Manicaland stated that secrecy and alleged corruption on the part of the guild's leadership at diocesan hindered the fair distribution of items donated towards AIDS-related care. It was stated that ~~the~~ MU [Mothers' Union] committee at the diocesan level received donations in the form of clothes for PLHIV from the UK but the distribution was not transparent."¹¹⁰⁰ The incidents of misusing humanitarian aid material for self-enrichment by people involved in the care of others were prevalent in Zimbabwe. In 1995 Jane Hatendi, wife of the then Bishop Peter Hatendi of the Diocese of Harare in an address to churchwomen leaders at an ~~Interdenominational~~ HIV and AIDS Conference" in Kadoma stated:

Church and NGOs leaders are suspected of giving one donation to the poor and the needy and two donations to themselves thereby forming a company of liars. ...It is alleged that church and NGO leaders are enriching themselves at the expense of beneficiaries. Great women fear and love God in all their actions.¹¹⁰¹

Some members of the guild in Manicaland mentioned that in some areas, goods intended to be given to PLHIV and OVC were converted into personal possessions.¹¹⁰² The perceived lack of transparency in providing material support to

¹⁰⁹⁶ B. Makoni, same interview.

¹⁰⁹⁷ M. Nyamwena, same interview

¹⁰⁹⁸ J. Mavhima, same interview.

¹⁰⁹⁹ R. Munakamwe, same interview. See also R. Mlambo, same interview.

¹¹⁰⁰ J. Chimwaza, same interview. See also E. Mbutsa, same interview.

PLHIV and OVC probed questions on the credibility of the involvement of church groups in caring for people affected and infected by the epidemic.

4.4. The United Methodist Church's Response to HIV and AIDS

This section will explore the response to HIV and AIDS by the United Methodist Church in the period 1995-1999. Despite the effort shown by the church's leadership at educating the clergy on HIV and AIDS, the church delayed the process of sensitising the grassroots members about the pandemic.¹¹⁰³ This section explores the adoption of positive steps by district superintendents in support of the church's HIV and AIDS interventions. This change came in 1995 and continued in the subsequent years.¹¹⁰⁴ The unwillingness to explore condom use in the prevention of sexually transmitted HIV shown by the church's leadership will be discussed. Finally, this section explores some of the 'new' models of OVC care adopted by the United Methodist Church as well as the responses to HIV and AIDS at the grassroots level.

4.4.1. The Church Leadership's Stance on HIV Prevention

Within the leadership of United Methodist Church in Zimbabwe, HIV awareness and prevention took a moralistic outlook. In 1995, the annual conference's board of lay activities recommended that evangelism be strengthened from circuit level upwards in order to save souls from the AIDS menace and further stated: "...a born-again Christian knows no AIDS."¹¹⁰⁵ This appeared to be an oversimplified statement that was divorced from the realities experienced by church followers. The failure by the leaderships of the United Methodist Church to dispel the myth that the people who

¹¹⁰¹ J. Hatendi, "Great women," in S. A. Farag (ed), *Interdenominational AIDS conference for churchwomen leaders in Zimbabwe, A compilation of selected presentations*, 23-27 January 1995, 14. See also J. Chimhaza, same interview.

¹¹⁰² M. Nyamwena, same interview. See also J. Chimhaza, same interview.

¹¹⁰³ T. Matsika, same interview. See also S. Sign, same interview.

¹¹⁰⁴ AM, "Council on ministries report," *Official Journal of the Zimbabwe Annual Conference of the UMC sixteenth session*, 13-17 December 1995, 153-154.

¹¹⁰⁵ AM, "Board of lay activities report," *Official Journal of the Zimbabwe Annual Conference of the UMC sixteenth session*, 96.

contracted HIV were less faithful Christians¹¹⁰⁶ undermined the church's competence in the effort at HIV prevention. The church's competence in responding positively to HIV and AIDS could only be achieved when people realised and accepted the epidemic as a reality. Consistent with this observation, Parry argued:

To become competent requires first and foremost a change in attitude and a committed desire to make a difference. Frequently there is strong denial of the problem and a resistance to change. This resistance may be individual, social, institutional, cultural or traditional.¹¹⁰⁷

Within the United Methodist Church, the belief that the battle against HIV and AIDS could be won through preaching of the gospel and conversion to Christianity¹¹⁰⁸ was deeply entrenched. In this regard, the HIV prevention messages issued by the leadership of the United Methodist Church contradicted that from the Government and was seen as misleading.

However, the church's leadership appeared to be impressed by the work of the State and NGOs in responding to HIV and AIDS but took exception to messages that encouraged the prophylactic use of condoms. In this regard, the church appreciated the HIV awareness efforts carried out by the State especially the MOHCW and the NGOs as noted in the council on ministries report of 1995, which stated:

AIDS has become one of the greatest killer diseases of our time. The positive action which was taken by government, non-governmental organisations, groups in our church and individuals to make people in our society to be aware of this deadly disease and to alleviate the suffering of those already infected need to be commended. We also commend the work which our five hospitals are doing on AIDS awareness and treating AIDS patients.¹¹⁰⁹

Apparently, the State and other private players were involved in responding to HIV and AIDS and that was public knowledge. However, the church's council on ministries showed reservations on public statements on HIV prevention options

¹¹⁰⁶ E. Kabungaidze, same interview.

¹¹⁰⁷ S. Parry, *Beacons of hope, HIV competent churches: A framework for action*, (Geneva: WCC, 2007), 21.

¹¹⁰⁸ A. Mhondoro, same interview.

¹¹⁰⁹ AM, "Council on ministries report," *Official Journal of the Zimbabwe Annual Conference of the UMC sixteenth session*, 153-154.

including the use of condoms issued by the State. The church's leadership publicly discouraged condom use and preached salvation in Jesus Christ as the only definite method of avoiding HIV infection."¹¹¹⁰ This was despite the church having passed two resolutions recommending the prophylactic use of condoms within marriage as noted in chapter three.

The church's leadership spent large sums of money on HIV and AIDS awareness workshops for the clergy.¹¹¹¹ However, at the grassroots level some of the church members gave the impression that the workshops on HIV and AIDS meant for the church's clergy scored limited achievements. HIV and AIDS awareness was achieved through the State's effort and not through church programmes."¹¹¹² The church's district superintendents appeared to acknowledge that ordinary church members lacked enough information on HIV and AIDS. In December 1995 the district superintendents became open about the devastation caused by AIDS on the church's members.¹¹¹³ For the first time since 1985 the district superintendents suggested that concerted effort was needed to educate the population on the dangers of AIDS and the United Methodist Church could be a major player. They stated: "Bishop, the AIDS epidemic has caused bereavement in almost every community—definitely every district has lost loved ones through this incurable disease, AIDS. Bishop, your conference has suffered."¹¹¹⁴ Certainly, the concerns raised by the district superintendents were a reflection of the realities faced by some people. However, whether or not this notable change was going to translate into further action by the district superintendents was something yet to unfold.

The church's district superintendents appeared to believe that Zimbabweans were immune to HIV because the epidemic was known to be common among minority white gay people.¹¹¹⁵ AIDS was then commonly associated with gay people in the US and the UK but it surprised members of the UMC [United Methodist Church] when

¹¹¹⁰ AM, "Board of lay activities report."

¹¹¹¹ AM, "Council on ministries report," 154.

¹¹¹² T. Matsika, same interview. See also J. Makunike, same interview. See also E. Humure, same interview.

¹¹¹³ AM, "District superintendents' composite report," *Official Journal of the Zimbabwe Annual Conference of the UMC sixteenth session*, 62.

¹¹¹⁴ AM, "District superintendents' composite report."

¹¹¹⁵ E. Kabungaidze, same interview. See also Epprecht, *Heterosexual Africa?*, 2,3.

it turned out to infect heterosexual couples.”¹¹¹⁶ However, the effects of HIV and AIDS forced the leadership of the United Methodist Church to accept the reality that the epidemic affected everyone regardless of sexual orientation. There was noticeable change in the perception of AIDS as a disease for ‘_them’ and not ‘_us’ to one of accepting that the pandemic affected everyone.¹¹¹⁷ For the first time the district superintendents accepted that Zimbabweans were dying of AIDS in large numbers. They used a summary of cumulative AIDS cases from 1987 up to March 1995. Manicaland was on fourth position with 4,433 cases, Harare: 8,797 cases, Masvingo: 4,513 cases, Mashonaland East: 4,345 cases, Bulawayo: 4,142 cases, Mashonaland West: 3,878 cases, Midlands 3,942 cases, and the country total was 34,050 cases.¹¹¹⁸ Other sources reported high figures of estimated number of the PLHIV to be at 1,600,000 in 1995¹¹¹⁹ and AIDS-related deaths in 1995 totalled 70,000.¹¹²⁰

The pandemic affected the theology of the United Methodist Church. The theological language used by the church’s leaders in guiding the church to confront the pandemic showed a mixture of life asserting and life denying sentiments. Part of the message on HIV prevention issued by the district superintendents read as:

Our message as a church to these AIDS and HIV [HIV and AIDS] infected communities is that God welcomes sinners who repent but God does not welcome our sin in the case of those who acquired the disease due to promiscuity. To the innocent victims, the message is The Lord is my shepherd... he restores my soul (Psalm 23). So hang on to Jesus the saviour because those who believe in him, though they shall die, shall live eternally. To the AIDS free people, the message from the Zimbabwe Annual Conference is: Live by the word of God, seek morality and chastity. Above all, choose Christ the Lord of life, and live abundantly.¹¹²¹

The district superintendents’ messages on HIV and AIDS appeared to be embracing and yet at the same time condemning PLHIV. They portrayed the image of the United Methodist Church in Zimbabwe as a church for the ‘_innocent’ and ‘_dean’ and not for the ‘_guilty’ and ‘_infected’. This also showed that the Christian leaders tended to

¹¹¹⁶ E. Kabungaidze, same interview.

¹¹¹⁷ E. Kabungaidze, same interview.

¹¹¹⁸ AM, “District superintendents’ composite report.”

¹¹¹⁹ WHO, *Epidemiological fact sheet on HIV and AIDS*, 4.

¹¹²⁰ WHO, *Epidemiological fact sheet on HIV and AIDS*, 5.

¹¹²¹ AM, “District superintendents’ composite report,” 63.

conceptualise AIDS as a new deadlier kind of leprosy with all its overtones of divine punishment and horror.¹¹²² Consistent with this observation, Tiendrebeogo and Buykx stated that –some religious leaders propagated judgemental attitudes towards PLHIV, religious leaders were slow to take action in much of the region.”¹¹²³

By and large the approach used by the district superintendents in dealing with the prevention of HIV infection among the youth in 1995 took a moral outlook:

We, your fathers, believe that adhering to Christian principles is among the very few methods by which an AIDS free community can develop. To do this, we suggest that all HIV positive youths should not marry or get married. Or if they marry, should opt not to have children. Furthermore, we urge youth only to marry an HIV free partner if they wish to have children. That decision is almost as responsible as choosing Christ. All youth who marry in spite of HIV positive state [status] are committing a form of premeditated murder, which is unchristian and unholy. The church believes that if only all people would uphold moral standards, incidents of AIDS spreading would be reduced to zero. Our position as an annual conference is that we choose morality. Our goal is to work towards an AIDS-free community and society.¹¹²⁴

The claim by the leadership of the United Methodist Church to be the most ideal moral models was not necessarily substantiated by factual proof and was therefore part of moral rhetoric. More than ten years of the pandemic’s presence in Zimbabwe, –the members of the UMC [United Methodist Church] still held the view that sex was taboo.”¹¹²⁵ Within the church, there was a struggle to find the right language and platforms to address issues of sexuality in the context of HIV and AIDS.

The understanding that to be HIV negative was synonymous with being a good Christian and vice-versa as stated by the district superintendents strengthened stigma and discrimination of PLHIV. This was a deeply seated problem and the churches in general struggled to overcome this notion. Chowa has contended: –Our church failed to appreciate that young people and church members in general lived in a world where

¹¹²² Niehaus, –Leprosy of a deadlier kind,” 311.

¹¹²³ Tiendrebeogo and Buykx, *Faith-based organisations and HIV/AIDS prevention*, 15.

¹¹²⁴ AM, –District superintendents’ composite report,” 71.

¹¹²⁵ M. Saungweme, same interview.

the HIV was a daily reality.”¹¹²⁶ Generally, some church members denied that Christians were part of the human community susceptible to moral failure. However, some of the church’s pastors, located in the community, were fully exposed to PLHIV and were thus compassionate. The pastors made a passionate plea for the church’s compassion towards HIV positive people and declared the church to be a sanctuary for people who are infected and affected by AIDS.”¹¹²⁷ Therefore, the level of compassion towards PLHIV and OVC by church leaders was influenced by exposure to and interaction with people infected and affected by the pandemic.

In the years 1995-1999, the belief that the use of condoms promoted sexual unfaithfulness was in existence. For example, the church’s leadership refrained from making public statements that openly encouraged people to use condoms as prophylactics.¹¹²⁸ According to Mhondoro, within the clerical leadership of the church in Zimbabwe, condoms use among married couples was resented. He indeed stated that condoms had no place in the lives of Christian married couples because of their potential to promote unfaithfulness.”¹¹²⁹ This was a perception by an individual and the practice on the ground among married couples could have been quite different. However, other church members who are medical personnel were of the opinion that the use of condoms could prevent the spread of HIV. For example, Chowa stated that she used to encourage people to use condoms in order to prevent the spread of sexually transmitted infections.¹¹³⁰ In the Rukweza area Teresa Matsika stated that some married couples felt that condoms as a ‘better evil’ in cases whereby the male spouse was unfaithful and therefore marriages were saved.¹¹³¹ Another respondent stated that until the late 1990s, the members of the UMC [United Methodist Church] were silent about disclosure of HIV status to a spouse or the pastor because of fear of being excommunicated or disciplined.”¹¹³² Other than calling for behaviour

¹¹²⁶ I. Chowa, same interview.

¹¹²⁷ AM, “Clergy report,” *Official Journal of the Zimbabwe Annual Conference of the UMC sixteenth session*, 94.

¹¹²⁸ M. Saungweme, same interview.

¹¹²⁹ A. Mhondoro, same interview.

¹¹³⁰ I. Chowa, same interview.

¹¹³¹ T. Matsika, same interview.

¹¹³² J. Rukweza, same interview.

change,¹¹³³ the church in general appeared to have limited options that could have provided immediate remedies to halt the spread of the epidemic.

At the national and ecumenical levels, the churches belonging to Zimbabwe Council of Churches and affiliated to the Heads of Christian Denominations remained opposed to the use of condoms. Thus condoms were not seen as being short term measure in the prevention of sexually transmitted HIV. While the church leaders and the State's position on the use condom remained poles apart, this had the effect of undermining prevention of HIV contracted sexually. The Zimbabwe Council of Churches and the national leaders of church denominations jointly attacked the State by alleging: –The failure on those promoting the condoms to disclose the fact that condoms do not fully protect [people] from infection with equal vigour in promoting their effectiveness has led youth to believe that condoms are the answer.”¹¹³⁴ Apparently, the gulf between the church leaders and the State on the prophylactic use of condoms confused members of the public. It appears that the church leaders did not fully appreciate the State's approach where the public was warned to stick to one sexual partner and use condoms constantly and consistently. While some pastors expressed discomfort with condom users, the lay members and medical personnel at the church's healthcare institutions held a different position. At Old Mutare and other healthcare centres under the church, –condoms were distributed to clients and constant, consistent and proper use was encouraged.”¹¹³⁵

4.4.2. Church Healthcare and Treatment of AIDS-Related Illness

The escalation in numbers of PLHIV and the growing number of possible AIDS-related deaths made the church's leaders to seek new ways of using the church's healthcare centres to respond to the pandemic. In 1996 the district superintendents admitted to the reality that the –UMC [United Methodist Church] and other churches [denominations] were generally wrestling with AIDS-related deaths that had shaken

¹¹³³ SM, –Health and welfare report,” *Official Journal of the Zimbabwe Annual Conference of the UMC seventeenth session*, 12-15 December 1996, 188.

¹¹³⁴ AM, A statement on AIDS by the HOCD and the ZCC, 3.

¹¹³⁵ T. Manyeza, same interview. See also P. Mufute, same interview.

many communities especially Christian communities in the light of their beliefs.”¹¹³⁶ The marauding nature of AIDS haunted the district superintendents to a point of opening up the church’s doors to people infected and affected by HIV and AIDS. For the first time the district superintendents declared that the church is “ready to respond to Jesus’ invitation to all who are weary or heavy-laden. Jesus would give them rest (Matthew 11: 28).”¹¹³⁷ This was followed by a recommendation by the district superintendents to offer free services to people who were unable to pay medical bills and a review of medical fees downwards at church’s healthcare centres including Old Mutare and Mutambara hospitals in Manicaland.¹¹³⁸ Thus HIV positive people had increased access to medical facilities at these centres. This move, meant to support poor people to access healthcare, ended up attracting patients from urban areas including Mutare, Rusape and Chipinge. They flooded Old Mutare and Mutambara hospitals.¹¹³⁹ This set a new trend in which the church’s healthcare centres began to steal the limelight from State hospitals.

The initiatives carried out by leaders of the United Methodist Church in the care of PLHIV and OVC were interpreted differently by the State. An ambiguous relationship between the State and Bishop Muzorewa could have hindered the church’s plans to expand its HIV and AIDS interventions.¹¹⁴⁰ The State accused the United Methodist Church’s leaders for planning to use the church’s healthcare services to either revive the defunct United African National Council or to support the emerging National Constitutional Assembly under the banner of the Zimbabwe Council of Churches.¹¹⁴¹ In defence, the district superintendents justified the church’s involvement in carrying out HIV interventions by arguing that such work was part of the church’s long legacy of having pioneered the provision of healthcare services to the nation.¹¹⁴²

¹¹³⁶ SM, “District superintendents’ composite report,” *Official Journal of the Official Journal of the Zimbabwe Annual Conference of the UMC seventeenth session*, 86. See also E. Kabungaidze, same interview.

¹¹³⁷ SM, “District superintendents’ composite report.” 86.

¹¹³⁸ SM, “District superintendents’ composite report.” 86.

¹¹³⁹ T. Manyeza, same interview.

¹¹⁴⁰ I. Chowa, same interview.

¹¹⁴¹ Dorman, “Rocking the boat?” 13-18. See also Dorman, “NGOs and the constitutional debate in Zimbabwe,” 848-849.

¹¹⁴² See SM, “District superintendents’ composite report.” See also Chitando, *Living with hope*, 12.

The church's medical work to the people of the colony, Southern Rhodesia (now Zimbabwe) started in earnest in 1897 when the church was founded at Old Mutare. Medical services to the local people were a hallmark of Methodism since the arrival of Bishop Hartzell in 1897 and the founding of Old Mutare hospital by Dr. Samuel Gurney in 1903.¹¹⁴³ Similarly, Hansjörg Dilger highlighted that the involvement of religious organisations in HIV interventions in Africa had historical connections. As Dilger observed:

Faith-based organisation had a long tradition of contributing to healthcare programmes in southern and eastern Africa—as donors, advocating agencies and implementers of projects—and that they established a significant sphere of influence across all sectors and strata of society.¹¹⁴⁴

Furthermore, the willingness of the church's leadership to provide free medical treatment to people in genuine need including PLHIV,¹¹⁴⁵ testified to the church's commitment to meeting the needs of the disadvantaged members of society. The district superintendents stated that the Government of Zimbabwe had no moral right to interfere with the church's healthcare programme."¹¹⁴⁶ A respondent stated that the church was highly respected especially in rural areas and therefore its contribution to healthcare was seen as worthwhile.¹¹⁴⁷ Free medical services could have lured people to join the United Methodist Church.

One might also speculate that the escalation in the church's membership in Zimbabwe from 18,447 in 1986 to 68,603 followers in 1995,¹¹⁴⁸ could have been linked to people seeking salvation, treatment and care in a time of HIV and AIDS. In Zimbabwe there was a historical reality that missionaries used western medicine to attract local Africans to Christianity. Writing on the medical missions in Zimbabwe, Gelfand stated: "Through the practice of medicine the missionary was able to make friendly contact with Africans, who on the whole were ready to use the white man's

¹¹⁴³ Gelfand, "Medicine and the Christian missions," 116.

¹¹⁴⁴ H. Dilger, "Doing better? Religion, the virtue-ethics of development and the fragmentation of health politics in Tanzania," in Prince, *Africa Today*, 95.

¹¹⁴⁵ SM, "District superintendents' composite report," 95.

¹¹⁴⁶ SM, "District superintendents' composite report," 95.

¹¹⁴⁷ E. Kabungaidze, same interview.

¹¹⁴⁸ AM, "District superintendents' composite report," *Official Journal of the Zimbabwe Annual Conference of the UMC sixteenth session*, 72.

knowledge in this field.”¹¹⁴⁹ Chavhunduka also emphasised the same point by asserting that the mission hospitals were “a means of conversion and of keeping the people in touch with the spiritual life of the church.”¹¹⁵⁰

The calls to overhaul the healthcare delivery system made by the leadership of the United Methodist Church testified to a crisis that was associated with the effects of HIV. In 1997 the conference council on ministries observed:

It is sad to note that the healthcare delivery system leaves a lot to be desired. Today the effects of the AIDS pandemic are ghastly to imagine. Diseases like TB and HIV are threatening the greater part of the young. We call for a concerted effort in providing proper teaching to the nation.¹¹⁵¹

Whereas during the late 1990s the general healthcare system in Zimbabwe declined, “churches remained in a favourable position to continue providing decent services due to access to donor funds.”¹¹⁵² By the end of 1997 the decline in public healthcare peaked and church hospitals were literally besieged by influx of patients. The church’s leaders appeared to believe that human life mattered more than anything else.¹¹⁵³ This drove the lay leaders of the church’s annual conference to call for the prioritisation of basic healthcare: “Effective primary healthcare and preventive medicine, dental care and general healthcare should receive primary consideration.”¹¹⁵⁴ Thus, at the leadership level, it became apparently clear that the church’s healthcare system had a crucial role to play in responding to the needs of HIV positive people and provision of healthcare in general.

¹¹⁴⁹ Gelfand, “Medicine and the Christian missions,” 114.

¹¹⁵⁰ G. Chavhunduka, “Traditional medicine and Christian beliefs,” in M. F. C. Bourdillon, (ed), *Christianity South of the Zambezi*, 2 (Gweru, Mambo Press, 1977)133.

¹¹⁵¹ HCM, “Conference lay leaders’ report,” *The Zimbabwe Annual Conference of the UMC special centennial session annual reports*, 9-11 December 1997, 127.

¹¹⁵² T. Manyeza, same interview.

¹¹⁵³ E. Kabungaidze, same interview.

¹¹⁵⁴ HCM, “Conference lay leaders’ report,”

4.4.3. The Care of PLHIV and OVC

The minimum attention given to PLHIV by the State's healthcare system in the late 1990s made the church's leadership to provide home-based care support to families.¹¹⁵⁵ Within the United Methodist Church, primary home-based care was encouraged since the early 1990s. However, the training of voluntary caregivers came later. In 1997 the community home-based care programme at Old Mutare hospital was yet to be established.¹¹⁵⁶ Much of what was mentioned as home-based care referred to the basic training given to families of AIDS patients as part of equipping them to cope with the needs of PLHIV. Inadequate funding for the training of voluntary caregivers and competing needs such as food for PLHIV were some of the known constraints. One of the voluntary caregivers who trained in the late 1990s under FACT expressed the embarrassment she felt on a visit to an HIV positive client who requested some food.¹¹⁵⁷ The PLHIV and OVC needed resources such as food but that became scarce. The church's worldwide distributive system of funding became a source of hope but could not sufficiently cover the needs of the church's AIDS-related care interventions in Manicaland and Zimbabwe.

Despite the escalation in the numbers of OVC, this was one area in which the United Methodist Church in Zimbabwe excelled. For example, in 1995 the church's Mubvuwi guild intensified support to OVC and widows. Part of a report stated: "Orphans and windows were assisted with clothing and maize meal. A total of Z\$2,616,401 was donated to various situations of need."¹¹⁵⁸ Three quarters of the church's congregations observed "Nherera (Orphans) Sunday," 22 June 1997 that was earmarked for AIDS-related OVC care. Over Z\$30,000 and clothes, blankets and clothes were distributed to needy children. The church's friends in Britain and the US boosted the supplies by making further donations.¹¹⁵⁹

¹¹⁵⁵ E. Kabungaidze, same interview.

¹¹⁵⁶ HCM, "Council on ministries report," *The Zimbabwe Annual Conference of the UMC special centennial session annual reports*, 178.

¹¹⁵⁷ T. Matsika, same interview.

¹¹⁵⁸ AM, "MUMC Report," *Official Journal of the Zimbabwe Annual Conference of the UMC sixteenth session*, 176.

¹¹⁵⁹ HCM, "Council on ministries report," *The Zimbabwe Annual Conference of the UMC special centennial session annual reports*, 148.

Whereas the United Methodist Church capitalised on the support received from the church's sister annual conferences mainly in the West, this was understood as undermining the government.¹¹⁶⁰ Van Donk observed that "from 1997 a declining trend has set in, with the economic growth rate reaching a low of -6.8% in 2000."¹¹⁶¹ Furthermore, the government's Social Dimension Fund established in 1991 to pay tuition fees for financially disadvantaged pupils, was drying up. Consistent with this observation, Rodreck Mupedziswa and Perpetua Gumbo stated that by 1998, "the SDF [Social Dimension Fund] has been reported to be in financial dire straits since the later part of 1995 necessitating more stringent testing."¹¹⁶² This situation created a funding vacuum in the cases of financially needy OVC. One respondent stated that the declining economy exposed OVC and other poor people to untold suffering.¹¹⁶³ Through its various structures the United Methodist Church sought to avert the desperate situation faced by OVC.

The call to action by the church's council on ministries suggested that the plight of OVC had to be treated as a matter of urgency. Part of the council's report stated: "The church [UMC] and indeed the Zimbabwe Annual Conference must face up to these challenges squarely and head on. The task is big but this is the world into which Jesus commissioned us."¹¹⁶⁴ In September 1997, the pastor in charge of Hilltop circuit also emphasised the devastating effects of AIDS on OVC: "*Aherera dzirikuwanda. Kufirwa nekufa kusina zororo*: (The number of orphans OVC is ever increasing. Death has not given people any rest)."¹¹⁶⁵ Similarly, in Makoni-Buhera the district superintendent, the Reverend John Chinyati also acknowledged the impact of the pandemic on the members of the church. Chinyati observed: "AIDS caused bereavement and put many souls into being orphans, widows and widowers."¹¹⁶⁶ The worsening situation faced by OVC forced the church leadership to explore new models of care. The model of institutionalised OVC care at places such as Fairfield at

¹¹⁶⁰ E. Kabungaidze, same interview. See also I. Chowa, same interview.

¹¹⁶¹ Van Donk, "Development planning and HIV/AIDS in sub-Saharan Africa," 132.

¹¹⁶² R. Mupedziswa and P. Gumbo, *Structural adjustment and women informal traders in Harare, Zimbabwe*, (Uppsala: Nordiska Afrikainstitutet, 1998), 69.

¹¹⁶³ I. Chowa, same interview.

¹¹⁶⁴ HCM, "Council on ministries report," 137.

¹¹⁶⁵ HCM, Pastor's charge to the charge conference session, 17 September 1997.

¹¹⁶⁶ HCM, J. Chinyati, District superintendent, "Makoni-Buhera district report," *The Zimbabwe Annual Conference of the UMC special centennial session annual reports*, 38.

Old Mutare mission was affected by the pandemic.¹¹⁶⁷ In addition to occupants at the Fairfield Children's home other orphans were made to live with siblings and received material care support from the institution.

At Hilltop in Sakubva, centralised day care as well as the care of OVC in their homes was launched under the Shalom Zone project in 1998.¹¹⁶⁸ Shalom, a US based charity organisation established the "Ishe Anesu Centre" translated to mean; "God is with us."¹¹⁶⁹ Under this model, OVC live at their homes and come to the centre for meals and education daily including weekends and holidays. Apparently, there were multiple cases of child headed families in Sakubva. The Hilltop centre was also chosen because it was registered as an informal study centre since 1982.¹¹⁷⁰ Shalom Zone funded the costs of three meals per day, primary and secondary education materials, and equipment for practical skills' training. The local church members at Hilltop supported the project by carrying out scheduled tasks on a voluntarily basis.¹¹⁷¹ This project was conceived through a partnership agreement between Bishop Jokomo of Zimbabwe and Bishop Felton E. May of the Baltimore-Washington Conference in the US in 1997.¹¹⁷² Elsewhere in Mashonaland East province, the church became instrumental in the establishment of the Uzumba Orphan Trust in 1995. Pastor Passwell Chitiyo mobilised local members of the United Methodist church who set up teams of volunteers and sourced funding for OVC support.¹¹⁷³ Such donor funded OVC-related care projects were new and therefore increased the visibility of the church.

¹¹⁶⁷ P. Mufute, same interview. See also HCM, "Council on ministries report," 177.

¹¹⁶⁸ S. Sign, same interview. See also I. Chowa, same interview. See also A. Mhondoro, same interview.

D. Synder, <http://www.communitiesofshalom.org/files/news_old/shalom/> [Accessed 8 June 2011].

¹¹⁶⁹ E. Kabungaidze, same interview.

¹¹⁷⁰ E. Kabungaidze, same interview.

¹¹⁷¹ Synder, <http://www.communitiesofshalom.org/files/news_old/shalom/> [Accessed 8 June 2011].

¹¹⁷² Synder, <http://www.communitiesofshalom.org/files/news_old/shalom/>

¹¹⁷³ C. R. House, "The Uzumba Orphan Trust: A new approach to AIDS in Africa," *New World Outlook* (March /April 2001), <<http://gbgm-umc.org/now/01ma/uzumba2.html/>> [Accessed 8 June 2011]. See also "Christ for care: The church's role in home-based care," <<http://healthdev.net/site/post.php?s=1069/>> [Accessed 16 May 2009].

4.4.4. Mixed Reactions to HIV at the Grassroots Level

In 1995¹¹⁷⁴ and 1997¹¹⁷⁵ the conference council on ministries observed that the battle against HIV and AIDS could not be won without properly educating the grassroots church followers who lived among the community. Certainly, this deliberate move had the intention of equipping the church's shepherds with skills vital at responding to the pandemic at circuit and station levels. However, limited resources that were channelled by the church towards empowering grassroots communities or lay members affected this plan. These were the people who were on the receiving end from the effects of the pandemic. This appeared to confirm the statement which alleged that "HIV and AIDS-related funding ended up being used for other church programmes including the welfare of clergy."¹¹⁷⁶ This tendency by AIDS service organisations to redirect funding for HIV interventions towards other priorities was common in Zimbabwe and applied to the State too. In 1995, the church and society committee launched a policy which entailed the decentralisation of HIV and AIDS programmes. This ensured that financial resources were spent on AIDS at the circuit and station levels.¹¹⁷⁷ According to Manyeza, Bishop Jokomo was also in favour of establishing specific HIV interventions that addressed people's needs at the grassroots level.¹¹⁷⁸

Some of the structures of the church's annual conference in Manicaland initiated HIV and AIDS workshops at the local level. In 1995 the leadership of the Rukwadano guild's held workshops on HIV and AIDS awareness at circuit and district levels.¹¹⁷⁹ The guild also used the weekly Thursday meetings as platforms to find coping strategies to counter the effects of AIDS on families.¹¹⁸⁰ However, cultural dynamics were an impediment to the sharing information on HIV prevention. A respondent emphasised that the church's married women were shy to discuss HIV and AIDS in

¹¹⁷⁴ AM, "Concil on ministries report," 153-154.

¹¹⁷⁵ HCM, "Concil on ministries report," 137.

¹¹⁷⁶ L. Kupara, same interview.

¹¹⁷⁷ AM, "Church and society report," *Official Journal of the Zimbabwe Annual Conference of the UMC sixteenth session*, 159.

¹¹⁷⁸ T. Manyeza, same interview.

¹¹⁷⁹ AM, "Rukwadano report," *Official Journal of the Zimbabwe Annual Conference of the UMC sixteenth session*, 177.

¹¹⁸⁰ I. Chowa, same interview.

the home.¹¹⁸¹ Meanwhile, this exacerbated HIV prevalence. Change was yet to be seen after the church's leadership hosted thirty-five workshops at circuit level in 1996. The circuits' health committees gained skills on HIV and AIDS awareness, home-based care and primary healthcare.¹¹⁸²

The HIV and AIDS pandemic affected the daily programmes of the lay and ordained church members. In 1997 a report by the church's Mutare south district stated that AIDS related deaths and funerals "made it difficult for people to follow church calendars."¹¹⁸³ Due to pressure to bury the dead, the clergy and congregations were "forced" to reschedule some of the church's important events. However, while the effects of the pandemic were felt by the district in question, some of the church's members also made a mark on HIV and AIDS. A report written by Mutare south district stated: "Workshops have been held to teach people how to protect themselves against AIDS...and how to care for AIDS patients and orphans."¹¹⁸⁴ This did not translate easily to positive action on the ground. Consistent with this observation, Barbara Schmid has stated that:

Public statements on the importance of AIDS—or any other societal issue for that matter—and the conferences held to discuss its implications have in fact rarely been translated into "done things" and little has changed on the ground.¹¹⁸⁵

Within communities, funerals became a rallying point for church leaders and followers in Zimbabwe to theologise about HIV and AIDS. This United Methodist Church was not an exception to this emerging pattern.¹¹⁸⁶ Chitando has observed that during the late 1990s communities coped with increased AIDS-related deaths through music:

¹¹⁸¹ M. Saungweme, same interview.

¹¹⁸² SM, "Health and welfare report," *Official Journal of the Zimbabwe Annual Conference of the UMC seventeenth session*, 187.

¹¹⁸³ HCM, M. Muchanyirei, "Mutare south report," *The United Methodist Church Zimbabwe Annual Conference special centennial session*, 82.

¹¹⁸⁴ HCM, M. Muchanyirei, "Mutare south report."

¹¹⁸⁵ B. Schmid, "AIDS discourses in the church: What we say and what we do," *Journal of Theology for Southern Africa* 125 (July 2006), 93.

¹¹⁸⁶ E. Kabungaidze, same interview

Due to the high death rate attributable to HIV/AIDS, funeral songs dominated the air waves in Zimbabwe. ...Hymns and choruses that consoled the bereaved and promised to reunite the living with the dead were electronically recorded and became well known in the country.¹¹⁸⁷

The laws of inheritance in Zimbabwe showed the extent to which women's security fell under threat. Married churchwomen were affected by cultural norms that denied women rights to inherit the estate of a deceased husband. The civil courts in Zimbabwe did not adequately protect married women. This exposed women to contracting HIV through customary law practices such as widow inheritance. Sylvia Chirawu noted: "Customary practices and norms view women as perpetual minors. ...Women are literally treated as commodities that can be exchanged among the male folk."¹¹⁸⁸

Some of the members of the United Methodist Church, having been affected by AIDS-related deaths, turned to the church for assistance on inheritance matters. In seeking to educate women on matrimonial rights, the church's leadership organised seminars in some of its districts in 1995.¹¹⁸⁹ For example, in 1997 a report from Mutare South district indicates that the members of the Rukwadzano guild were educated on writing of wills at a seminar in Chimanimani.¹¹⁹⁰ In 1997 in Dorowa, Buhera, some church members assisted communities in addressing the subject of legal rights. According to Chowa, "increased death of married couples due to AIDS exposed pitfalls in Christians who had no wills that could have enabled their children to inherit property."¹¹⁹¹ Thus the presence of HIV and AIDS in the church forced the United Methodist church members to become more enlightened on legal issues than had been the case before.

¹¹⁸⁷ Chitando, "Down with the devil, Forward with Christ!," 8.

¹¹⁸⁸ S. Chirawu, "Sex, rights and the law in a world with AIDS: Gender, HIV/AIDS and the law in Zimbabwe." This paper was presented by the author in Mexico, February 2009, 3. The author of this paper was a national coordinator of Women and Law in Southern Africa Research and Education Trust based in Harare, Zimbabwe.

¹¹⁸⁹ AM, "Ministry to women, children and youth," *Official Journal of the Zimbabwe Annual Conference of the UMC sixteenth session*, 174.

¹¹⁹⁰ HCM, "Council on ministries report," *Official Journal of the Zimbabwe Annual Conference of the UMC sixteenth session*, 19-21 September 1997.

¹¹⁹¹ I. Chowa, same interview.

4.5. Synthesis

There is a possibility that the involvement of the churches in both the constitutional reform project and the carrying out of HIV and AIDS interventions was informed by political agendas. Consistent with this observation, Bornstein's study into Protestant NGOs, morality and economics in Zimbabwe observed: "These specific local tensions, between NGOs and the State, were a product of transitional context funding in which NGOs operate. This context was highly political."¹¹⁹² From 1994 onwards, some church leaders joined NGOs in expressing their unhappiness over the rapid decline in the public sector and called upon the State to be accountable.¹¹⁹³ Historically, the relations between the church and the State tumbled in 1997 after the Zimbabwe Council of Churches and the ZCBC participated in the formation of the National Constitutional Assembly. This led to the defeat of the government in the first post-independence referendum and set a stage for the violent elections of June 2000.¹¹⁹⁴ The Anglican and the United Methodist churches participated in the constitutional reform project under the banner of the Zimbabwe Council of Churches and the ZCBC represented the Roman Catholic Church.

Having noted that the years between 1995 and 1999 witnessed a decline in the State's budgetary support towards public healthcare, this chapter has highlighted the significance of church-related HIV interventions to communities. This chapter also noted that the ZCBC reminded the Government of Zimbabwe to care for all its citizens including the poor and PLHIV and OVC.¹¹⁹⁵ Their actions resonated with Denis' argument that church leaders "contribute in a significant manner to the public discourse on HIV and AIDS."¹¹⁹⁶ The ZCBC appeared to have been conscious of the fact that as church leaders they had an influence on the State's policy towards PLHIV. This chapter has observed that HIV and AIDS forced the new leadership of the Anglican Church to confront the pandemic. The same case prevailed within the United Methodist Church and this illustrates that AIDS affected the churches.

¹¹⁹² Bornstein, *The spirit of development*, 115.

¹¹⁹³ Dorman, "Rocking the boat?" 9. See also Chitando, "Down with the devil, Forward with Christ!," 5. See also ZCBCH, ZCBC, "Responsibility – honesty – solidarity."

¹¹⁹⁴ Dorman, "Rocking the boat?" 1. See also Dorman, "NGOs and the constitutional debate in Zimbabwe," 845.

¹¹⁹⁵ ZCBCH, ZCBC, "Responsibility – honesty – solidarity."

¹¹⁹⁶ Denis, "HIV, AIDS and religion in sub-Saharan Africa," 59.

According to Gregson *et al.*, AIDS-related deaths were on the increase from 1994-5 onwards in Manicaland.¹¹⁹⁷ Similarly Halperin *et al.* stated that “personal exposure to AIDS-related mortality and the resulting fear of contracting the virus,”¹¹⁹⁸ accounted for changes in the people’s attitudes towards the pandemic and also towards PLHIV in general.

This chapter noted that during the period 1995-1999, the leadership of all the three church denominations maintained a common position that Christian morality was the only weapon that could be used to prevent the spread of HIV. In the short-term, the stance taken by church leaders might have enhanced both denial and stigma of PLHIV and thus the position could have fallen short of addressing the realities faced by church members, especially that of married women. The Catholic Bishops appeared to believe that strict morality guaranteed an end to the spread of HIV: “We still maintain the call to spiritual rearmament as the lasting solution. We need God in our life. We need to take seriously the call to love through mutual respect, chastity and fidelity.”¹¹⁹⁹ A pragmatic approach which combines a call for a change of behaviour, and for those who do not change their behaviour, the use of condoms could be an effective tool for the prevention of sexually transmitted HIV. The church leaders had a point in advocating for moral behaviour change to halt the spread of HIV. The church leaders and the State in Zimbabwe appeared to have failed to draw lessons from the collaborative approaches used Uganda since 1986. In Uganda, the decline in HIV was partially achieved when “religious leaders did not support the use of condoms, but were won over to a position where they could not oppose either the government or private sector effort to promote condom use.”¹²⁰⁰

The gradual economic meltdown forced church healthcare centres to carry the burden of providing for the medical needs of the general population without much support from the State. The churches had to fend for their own medical care needs to

¹¹⁹⁷ Gregson, “Recent upturn in mortality in rural Zimbabwe,” 1273.

¹¹⁹⁸ Halperin, “Surprising prevention success,” 3.

¹¹⁹⁹ ZCBCH, ZCBC, “Jesus Christ the same yesterday, today and forever.”

¹²⁰⁰ J. Putzel, “History of state action: The politics of AIDS in Uganda and Senegal,” in Denis and Becker, *The HIV/AIDS epidemic in sub-Saharan Africa*, 178. See also E. Green, “The impact of religious organisations in promoting HIV/AIDS prevention,” Unpublished paper, (May 2001). See also R. Thornton, *Unimagined community: Sex, networks and AIDS in Uganda and South Africa*, Online Edition, (2007).

supplement the little that was received from the State. This was mainly because ~~r~~religious organisations have a tradition, often rooted in their scriptures and sacred texts, of dealing with disease holistically.”¹²⁰¹ The study has also noted that the Roman Catholic Church’s healthcare system immensely benefited from the financial resources donated by CRS and other partners. However, it should not be denied that the acts of charity carried out by the churches in the name of responding to HIV amid political decline in Zimbabwe in the late 1990s might have had other agendas. Consistent with this observation, Bornstein noted that Christian humanitarian aid was often accompanied by ~~t~~he proselytising agenda of Christianity—whether implicit or explicit, about converting souls...Humanitarian aid affects people materially and spiritually, whether they are donors, beneficiaries, desperate and disempowered government officials.”¹²⁰²

This chapter found that the Roman Catholic Church in Manicaland was way ahead of the Anglican and United Methodist churches in the care of PLHIV and OVC. Some of the main factors that accounted for the Roman Catholic Church’s stable AIDS-care interventions are the church’s belief in a Christian ethos of care and the restoration of human dignity,¹²⁰³ the use of the existing facilities work, and the collaborative support from voluntary caregivers many of whom were church members. Comparatively, the Anglican Church had limited operations mainly at St. Augustine’s clinic. Within the Anglican Church, the consecration of the new bishop in 1999 was followed by the initiation of AIDS-related care projects. The fact that the leadership of the United Methodist Church encouraged the church’s members at the grassroots level to be involved in AIDS-related care had the effect of empowering Christians to carry out acts of charity. This chapter has also shown that the three church denominations were not involved in ecumenical collaboration on HIV and AIDS interventions within Manicaland province. Nationally, the church leaders used the meetings organised by the ZACH and the Heads of Christian Denominations as ecumenical forums to forge a common position on HIV prevention and AIDS mitigation.

¹²⁰¹ Oliver and Paterson, —Religion and medicine in the context of HIV and AIDS,” 29.

¹²⁰² Bornstein, *The spirit of development*, 170-171.

¹²⁰³ P. Mutume, same interview.

The engagement with the pandemic at the grassroots level largely depended on people's faith practices as well as their spirituality. Conceptually, as Denis has argued that ordinary parishioners are a critical force in confronting the menace of the pandemic:

A significant factor with regard to religious institutions is the faith and spirituality of its members. It is this that informs their response to the epidemic, either positively by fostering care and compassion, or negatively by encouraging stigma and discrimination.¹²⁰⁴

This was particularly the case within all the three churches where mixed responses to the HIV epidemic were manifest. For example, in the Roman Catholic Church, a notable decline in the denial of HIV and AIDS was manifest after some church members, mainly women, persuaded parish rectors to address the subject of HIV during their regular church services and at other times. Thus these women became a significant force in placing issues of sexuality and HIV in the open. In the Anglican Church, the members of the Mothers' Union guild were among the first to confront denial and stigma. However, the failure to address the issue of HIV prevention might have weakened their response.

Elphick's argument that Christianity made an impact on the socio-political history of a country such as South Africa could be important in interrogating the history of church responses to HIV by the Roman Catholic, Anglican and United Methodist churches in Manicaland, Zimbabwe. This chapter has attempted to establish the contribution made by church leaders and Christians in responding to HIV at a time when the State's support for healthcare was on a declining course. Comparatively, within the Roman Catholic Church's parishes in Manicaland in the period 1995-1999 there were notable but limited changes from silence, denial, stigma and discrimination to that of openness about HIV and AIDS. Sampled parishes, including Triashill mission, St. Thomas Nyahukwe, St. Joseph's Sakubva and Regina Coeli had some form of HIV interventions going on. However, at St. Simon Stock, the Cathedral church of the Holy Trinity and St. Paul's Dangamvura, both primary oral and written sources clearly indicate that HIV interventions were still quite low. Conversely, it

¹²⁰⁴ Denis, "HIV, AIDS and religion in sub-Saharan Africa," 59.

follows that instead of being shelters for PLHIV, some parishes continued unabated they denied the existence of AIDS and stigmatised HIV positive people.

The situation in the Anglican Church was similar to what prevailed within the Roman Catholic and United Methodist churches. While some members belonging to the Mothers' Union guild cared for PLHIV and OVC, denial and stigma prevented some of the Anglican parishes from forming AIDS support groups, and yet others did. St. Joseph's Sakubva (Roman Catholic) and Hilltop (United Methodist) all had parish-led HIV interventions and yet close by at the Anglican parish of Holy Name, Sakubva, the parish was still trying to grasp with ways of responding to AIDS. Within some of the United Methodist circuits in Manicaland, increase in AIDS-related deaths forced church members to change their attitude from denial and stigma towards embracing people infected and affected by the pandemic. The leadership of the United Methodist Church went a step further by educating the church's members on the importance of writing wills and appreciating the laws of inheritance of Zimbabwe.

While some limitations in church responses to HIV existed, at least the Roman Catholic, Anglican and United Methodist churches took some positive steps in AIDS mitigation in Manicaland. Consistent with this observation, Prince has stated that:

In general the mainline churches—Anglican, Methodist, Roman Catholic—involved themselves in piecemeal responses to the pandemic during the 1990s, mostly involving home-based care, counselling work as well as caring for orphans, and it was mainly the Pentecostal churches that refused to engage with HIV/AIDS until the year 2000.¹²⁰⁵

Thus, Gelfand's justification for the involvement of the mainline churches in public health in colonial Zimbabwe,¹²⁰⁶ was linked to the use of church-related healthcare centres in HIV prevention and AIDS mitigation. These churches had infrastructure, human resources as well as international connectedness.

This chapter has indicated that during the period 1995-1999, cultural forces continued to inhibit married churchwomen's ability to negotiate safe sex with their spouses. In

¹²⁰⁵ Prince, "Engaging Christianities," ix.

¹²⁰⁶ For this see section on conceptual and theoretical frameworks in this present study.

Zimbabwe, religion and culture worked hand-in-hand and therefore exerted influence on human behaviour patterns. In general, Zimbabwe might share commonalities with other traditional African societies where married women's power to negotiate safe sex with their spouses is limited. The main reason for this might be that in Zimbabwe, generally, women are socialised to acquire those qualities, which fit them into a relationship of dependency on men. These qualities include gentleness, passivity, submission and striving to please men always."¹²⁰⁷ Similarly, Ben Wodi has observed that in African societies, including Zimbabwe, women in traditional societies lack the power to deny sex to their spouses even when they can prove examples of marital infidelity in their relationship".¹²⁰⁸ Churchwomen from the Roman Catholic, Anglican and United Methodist churches in Manicaland shared similar experiences.

Finally, this chapter has sought to show that in all the three churches, women were culturally seen as subordinates and not as equal partners in marriage and that this attitude was favourable to the rapid spread of HIV. Madipoane Maseya has argued that married churchwomen were trapped between two canons," namely the Bible and African culture and like in many patriarchal cultures, a husband determines a married woman's identity. The latter is expected to take control not only of the newly founded household, but also of his wife's body."¹²⁰⁹ Males also dominated as preachers and teachers at church services and tended to use the Christian Scriptures and culture to suppress women's voices. Consistent with this observation, Piet Kuijper has stated: Thus, African Christian women have become vulnerable to HIV/AIDS due to African culture and Christian preaching."¹²¹⁰ Similarly, Messer also observed: Since women in many cultures suffer discrimination because of their gender and often have little or no control over their sexual lives, they are doubly discriminated against."¹²¹¹

¹²⁰⁷ Kambarami, "Femininity, sexuality and culture," 2.

¹²⁰⁸ B. E. Wodi, "Gender issues in HIV and AIDS epidemiology in sub-Saharan Africa," *Wagadu* 2, (Summer 2005), 3. See also Björn Lindgren, "Men rule but blood speaks: Gender, identity, and kinship at the installation of a female chief in Matabeleland, Zimbabwe," in R. Morrell (ed), *Changing Men in Southern Africa*, 188.

¹²⁰⁹ M. Masenya, "Trapped between two canons: African-South African women in the HIV/AIDS era," I. Phiri, B. Haddad, and M. Masenya, (eds), *African women, HIV/AIDS and faith communities*, (Pietermaritzburg: Cluster Publications, 2003), 116.

¹²¹⁰ P. Kuijper, "Religion and HIV and AIDS: defining issue of our time," *Compilation of findings of three case studies and literature for the Knowledge Forum on Religion and Development Policy*, (circa 2006), 8.

¹²¹¹ Messer, *Breaking the conspiracy of silence*, 68.

CHAPTER FIVE

THE LATER YEARS (2000-2007)

5.1. Introduction

This chapter will explore the period when the HIV and AIDS pandemic in Zimbabwe reached crisis levels amid socio-economic and political turmoil witnessed in Zimbabwe between the years 2000 and 2007. This chapter will indicate that within the same period, the Roman Catholic, Anglican and United Methodist churches in Manicaland carried out HIV and AIDS interventions with minimum material support from the State. The way the three churches responded to HIV and AIDS will be discussed following the same order as in chapters three and four of the study.

5.2. The Roman Catholic Church's Response to HIV and AIDS

This section will explore how the ZCBC and the Catholic Diocese of Mutare responded to HIV and AIDS interventions within a -polarised political context in Zimbabwe in general and Manicaland in particular. The interventions under the Catholic Diocese of Mutare were at times perceived by the State as a means of seeking political expedience. This section will further indicate that generally the measures undertaken by the Catholic Diocese of Mutare in assisting people infected and affected by HIV and AIDS had a positive effect on some beneficiaries. The statements on HIV and AIDS made by the ZCBC at national level will be discussed first, followed by the church's HIV and AIDS interventions under a diocesan FBO. This will also include a discussion on the moral behaviour change programme and responses to HIV at the grassroots level in Manicaland.

5.2.1. The ZCBC's Statements on HIV and AIDS at National Level

Between 2000 and 2007 the ZCBC issued public statements that showed further concern on the State's shortcomings with a special focus on the declining socio-economic situation in Zimbabwe. In marking the beginning of the new millennium, the Roman Catholic bishops' thus stated: "We are aware of the difficult socio-economic conditions our nation is going through. ...There is a spirit of apathy and resignation among our people with an underlying healthy tension that is longing for change in our social system."¹²¹² Certainly, the lives of ordinary people continued to be affected by the socio-economic situation and that was further exacerbated by a tense political climate. The members of the ZCBC were disappointed that the birth of the new nation of Zimbabwe, understood to be a blessing from God, turned out to be a curse.¹²¹³ At Easter time in 2000 the ZCBC reminded the State of the horrors of political violence and called on the government to join hands with the church in confronting the challenges facing the country.¹²¹⁴ The ZCBC observed that the political violence witnessed during the referendum for a new constitution held in February 2000, had created a hostile environment in Zimbabwe.¹²¹⁵ This affected the lives of ordinary citizens including PLHIV and OVC.

From 2000 onwards the visibility of the ZCBC as part of civic organisations including the Zimbabwe Council of Churches and the Evangelical Fellowship of Zimbabwe became apparent. Their relationship of these organisations with the State grew tense because they were interested in areas such as constitutional reform and national reconciliation."¹²¹⁶ The ZCBC statements on HIV and AIDS were part of the critical stance taken by civic organisations against the State in the ensuing period. According

¹²¹² ZCBCH, ZCBC, "Jesus Christ the same yesterday, today and forever (Hebrew 13: 8)," A pastoral letter for the new millennium 2000 A.D, December 1999.

¹²¹³ ZCBCH, ZCBC, "Jesus Christ the same yesterday, today and forever."

¹²¹⁴ ZCBCH, ZCBC, "Easter message," 17 April 2000. See also ZCBCH, ZCBC, "Working for peace during elections," 2000.

¹²¹⁵ ZCBCH, ZCBC, "Easter message." See also ZCBCH, "A call to conscience: Zimbabwe silver jubilee, 1980-2005," Joint pastoral letter of the ZCBC, ZCC, EFZ and HOCD, April 2005.

¹²¹⁶ *The state of civics in Zimbabwe: A report prepared for the Zimbabwe Institute*, (September 2008). 26. The source was accessed as pdf. See also E. Sisulu, P. Richard and S. Kibble, "National unity or national exclusion? Where to for the Zimbabwean churches and civil society?" (2009, 11.

to the ZCBC, there was a strong relationship between political intolerance and the services given by the State to PLHIV and children orphaned by AIDS.¹²¹⁷

The government appeared to have taken a partisan approach when selecting to support people in need and the same could be said of the attitude of the opposition party, the Movement for Democratic Change. According to Mpofu, “Parents of school children, pregnant mothers and people infected with HIV and AIDS [PLHIV] were threatened with denial and denied food assistance if they were suspected of belonging to a certain political party.”¹²¹⁸ Thus, PLHIV and orphans and other children made vulnerable by AIDS and the caregivers were victimised if they did not support the political party in charge of food distribution. In response to these unfortunate developments, the ZCBC at one point had this to say: “Nobody shall ever have to suffer reprisals for honestly expressing and living up to their convictions, be they intellectual, religious or political.”¹²¹⁹

Furthermore, the ZCBC expressed disquiet on the politicisation of aid to PLHIV and OVC and encouraged ordinary people to be free to express their democratic rights:

Make your choice in the freedom of your conscience. Do not be afraid. Act as a free citizen. Whatever choice you make, remember to vote for the people who are God-fearing, who will respect human rights and dignity, who will foster the oneness of the Creator, our common Father.¹²²⁰

President Mugabe is a known lay Roman Catholic but relations between him and the ZCBC took a new twist since the late 1980s and throughout the 1990s. Despite this, members of the ZCBC became critical of the policies pursued by Mugabe and his

¹²¹⁷ ZCBCH, ZCBC, “Use your vote, it is your right,” 7 June 2000. See also ZCBCH, ZCBC, “Working for peace during [after] elections,” 2000. See also a similar message from the ZCBC to the nation before the presidential elections March 2002, ZCBCH, ZCBC, “A call to work for unity, peace and harmony,” A pastoral letter, February 2002.

¹²¹⁸ S. Mpofu, “An investigation into the challenges impeding non-governmental organisations in carrying out supplementary feeding programmes: The case of Care International and Plan International in Zimbabwe,” Unpublished Masters in Development Studies thesis, Nelson Mandela Metropolitan University, (April 2011), 70.

¹²¹⁹ ZCBCH, ZCBC, “Use your vote, it is your right.”

¹²²⁰ ZCBCH, ZCBC, “Use your vote, it is your right.” See also ZCBCH, ZCBC, “Tolerance and hope,” May 2001.

Government. In May 2001, the ZCBC urged the State to consider healthcare as a priority:

The poor health delivery system is seriously affecting the majority of our people who are already suffering from the harsh economic environment. Our health[care] institutions cannot even procure some essential drugs. We therefore urge our government to make enough resources available to the health sector.¹²²¹

The sentiment that the State had neglected the public healthcare system became a critical issue for the ZCBC as previously noted in chapter four. Similar pleas were made to the Government in April 1997.¹²²²

Whereas the ZCBC perceived the pandemic to be a social justice issue, the bishops also believed that individual Roman Catholic Christians and others could alter the course of the epidemic through moral behaviour change. In this regard, the ZCBC had this to say:

The reality of the HIV/AIDS is adding to the misery of our families and society as a whole. This reality calls for behaviour change in our attitude towards morality and for Christian principles of abstinence before marriage and faithfulness in marriage to be observed.¹²²³

Within the ZCBC, this position was pronounced in 1987 when the bishops issued their first statement on AIDS. It has to be noted that the statements issued by the bishops were intended for the church's followers and to the nation. However, the bishops' position on moral behaviour had limitations. In reality, the people of Zimbabwe belonged to different faiths and therefore Christian morals could not be seen as universally acceptable in the prevention of sexually transmitted HIV. Furthermore, human sexuality and morality were complex phenomena.

The attempts at preventing the spread of sexually transmitted HIV by the church leaders through the use of moralistic approaches had counterproductive effects because PLHIV –experienced rejection by religious people, congregations or

¹²²¹ ZCBCH, ZCBC, –Tolerance and hope.”

¹²²² See ZCBCH, ZCBC, –Responsibility – honesty – solidarity.”

¹²²³ ZCBCH, ZCBC, –Tolerance and hope.”

institutions.”¹²²⁴ In 2001, similar to the position taken by the ZCBC, the Roman Catholic bishops of Southern Africa declined the use of condoms in the prevention of sexually contracted HIV. The SACBC maintained that condoms eroded human dignity, reduced the beautiful act of love into a selfish search for pleasure, offered no guaranteed protection against HIV infection, encouraged promiscuity, and contributed towards the breaking down of self-control and mutual respect.¹²²⁵ This position failed to address some of the realities of high HIV cases in region.

While the HIV prevention approaches by the ZCBC remained moralistic, the bishops were willing to care for people infected and affected the pandemic. For example, during the severe drought of 2002, the Roman Catholic bishops demanded that the special needs of people infected and affected by the HIV and AIDS crisis and famine be met:

Zimbabwe currently has a large number of orphans because of the scourge of HIV and AIDS. A large number are widows and street kids and the sick are affected by the food shortage more severely than those who have someone to provide for them. We, as your spiritual leaders are seriously concerned with the plight of the people and we cannot continue to preach to people with empty stomachs.¹²²⁶

There is a relationship between the care of HIV positive people and OVC and access to nutritional food. However, the high levels of corruption that had filtered through the grassroots structures affected the fair distribution of food to people infected and affected by the pandemic. Food that was donated to the disadvantaged, including home-based care clients and OVC was clandestinely sold in shops at the peril of the intended beneficiaries.¹²²⁷

In a Lenten pastoral letter for 2003 entitled “A call to metanoia: Listen to the inner voice,”¹²²⁸ the ZCBC castigated some of the people who took advantage of the poor,

¹²²⁴ Campbell, and Rader, *HIV/AIDS, stigma and religious responses*. See also Denis, “The church’s impact on HIV prevention and mitigation,” 75. See also Parker and Birdsall, *HIV and AIDS stigma and faith-based organisations*, 15.

¹²²⁵ Nolan, “Catholics and condoms,” 3.

¹²²⁶ ZCBCH, ZCBC, “Appeal for food in Zimbabwe,” A pastoral letter, August 2002.

¹²²⁷ ZCBCH, ZCBC, “Appeal for food in Zimbabwe.” See also P. Mutume, same interview.

¹²²⁸ ZCBCH, ZCBC, “A call to metanoia: Listen to the inner voice,” Lenten pastoral letter, March 2003.

including the PLHIV and OVC, by seizing food and use it for self-enrichment. Consistent with this observation, in 1995 Jane Hatendi reminded church leaders to be wary of abusing poor people, as she had to state:

Leaders must listen carefully to the criticism from HIV and AIDS patients and PWA [PLHIV] and respond appropriately to their needs. ...The church is the conscience of the larger community, hence the need for a very high level of accountability in all our work.¹²²⁹

The ZCBC stated that the correct thing to do for the Roman Catholics and Christians in Zimbabwe in general was to be the ~~v~~isible sign of Christ today [that] imitate him in showing compassion and concern for the suffering.”¹²³⁰ The ZCBC appeared to strongly believe that the State was responsible for the suffering that Zimbabweans were going through including PLHIV and children orphaned by AIDS. In fulfilment of their calling to fearlessly speak against injustices, the clerics were not afraid of exposing the government’s shortcomings.¹²³¹ Consistent with this observation, Bishop Mutume mentioned: ~~W~~here there is no peace there is no development and HIV and AIDS is a human development issue.”¹²³²

Between 2000 and 2007 there were only a few church leaders in Zimbabwe who openly criticised the government for its ill-conceived policies and the ZCBC was one such an example. The bishops pointed out that the State’s dream of ~~H~~health for all by the year 2000” was non-reachable and the government’s commitment to the reduction of HIV and AIDS by 2015 was a pie in the sky.¹²³³ In 2003, the ZCBC stated:

The situation in hospitals and healthcare centres has deteriorated to shocking levels. Drugs are scarce and if available, the ordinary people are unable to buy them. To make matters worse, the HIV and AIDS pandemic is ravaging in society and Zimbabwe has one of the highest rates of infection in sub-Saharan Africa. We call upon the government, especially the Ministry of health and child welfare, to get priorities right. Caring for the sick is a calling from God of special dignity and

¹²²⁹ Hatendi, ~~G~~reat women,” 14.

¹²³⁰ ZCBCH, ZCBC, ~~A~~call to metanoia.”

¹²³¹ ZCBCH, ZCBC, ~~A~~call to metanoia.” See also ZCBCH, ZCBC, ~~P~~peace in a divided Zimbabwe,” A pastoral statement, Advent 30 November 2003.

¹²³² P. Mutume, same interview.

¹²³³ ZCBCH, ZCBC, ~~A~~call to metanoia.”

importance. It can never be seen as just another job or another way of earning one's living.¹²³⁴

The ZCBC did not focus attention on HIV and AIDS alone but on the national healthcare system as a whole which the bishops believed was under —.a repressive, corrupt and unaccountable government.”¹²³⁵ The fact that the ZCBC maintained that the State should provide affordable healthcare for all citizens was a case to suggest that their voice was important in advocating for the rights of the PLHIV.

Some of the HIV and AIDS interventions carried out by the Roman Catholic Church were closed down by the State under mysterious circumstances. In June 2004, the State ordered the closure of Sibambene AIDS programme by the Roman Catholic Church Archdiocese of Bulawayo. The State justified the action by claiming that the programme was not registered with the Ministry of Labour and Social Welfare despite having served the communities in Matabeleland for ten years. Similarly, the Lutheran Development Services and the Soul's Comfort were also instructed to terminate their AIDS projects in Gwanda district.¹²³⁶ It is important to note that the Sibambene AIDS programme was also funded by CRS similar to church's diocesan AIDS-related project in Manicaland.¹²³⁷

The demand to have NGO programmes to be registered and become accountable to the State as enshrined in the NGO Act of 2004 affected HIV and AIDS interventions carried out by the churches.¹²³⁸ Apparently, the ZCBC was undeterred from meeting the healthcare needs of citizens including continuing with HIV and AIDS interventions. The bishops claimed that this was part of —the option for the poor.”¹²³⁹ While the ZCBC remained committed to supporting the poor, including people infected and affected by the pandemic, the NGO Act further strained the relations between some of the churches and the State in Zimbabwe.

¹²³⁴ ZCBCH, ZCBC, —A call to metanoia.”

¹²³⁵ ZCBCH, ZCBC, —A credible electoral process for a responsible and accountable leadership,” A joint pastoral statement, August 2004. See also ZCBCH, ZCBC, —God hears the cry of the oppressed,” A pastoral letter on the current crisis in Zimbabwe, Holy Thursday, 5 April 2007.

¹²³⁶ Church's AIDS programme closed down, <<http://www.kubatana.net/html/archive/hivaid/040725sokwa.asp?sector=HIVAID&yea/>> [Accessed 22 June 2011]. See also Sibambene Zimbabwe, <<http://www.volensafrika.org/Sibambene.html?lang=en/>> [Accessed 22 June 2011].

¹²³⁷ For this see Banyera, Evaluation of CRS Zimbabwe home-based care programme, 12-17.

¹²³⁸ See chapter 2 of the present thesis.

¹²³⁹ ZCBCH, ZCBC, —The cry of the poor,” A pastoral letter, June 2005.

5.2.2. The Diocese of Mutare's HIV and AIDS Interventions

The decline in the public healthcare system experienced in Zimbabwe led to the intensification of HIV and AIDS interventions carried out by the Diocese of Mutare in Manicaland. In February 2000 the diocesan leadership established a new management committee and appointed a managing director who was to be answerable to Bishop Muchabaiwa and Auxiliary Bishop Mutume.¹²⁴⁰ The need for the diocesan project to respond effectively to the pandemic led to further streamlining of interventions and created additional human resources. The managing director was expected to exercise oversight and management of funds, recruitment of staff, carry out fund raising initiatives and account for donated funds, receive and invest donations, guide the diocesan project in strategic planning, and ensure that the project remained community driven.¹²⁴¹ Sister Michael Nyamutswa, who had served as the diocesan health secretary, was appointed the project's first managing director.¹²⁴² This section will proceed by way of looking at the care of the PLHIV, OVC, prevention of HIV transmission, awareness, treatment and finally discusses the engagement with the pandemic at the parish level.

5.2.2.1. The Expansion of Home-Based Care Interventions

While the State in Zimbabwe stated the importance of AIDS-related home-based care in the national policy on HIV and AIDS in 1999, it was the churches and NGOs that had a track record of providing services in this field. Between 2001 and 2005 the demand for home-based care services in Zimbabwe peaked. This can be linked with low access to ARVs. The increased availability and use of ARVs led clients to move –from being inactive to becoming active members of the community capable of doing household chores or working in the fields.”¹²⁴³ Figures for PLHIV escalated from 600,000 in 1990 to close on 2,000,000 in 2001.¹²⁴⁴ The brain drain or loss of skilled workers in Zimbabwe, coupled with the State's failure to launch home-based

¹²⁴⁰ DOMCCPM, DOMCCP, MCHC project report, March 1999-December 2000, 4, 5.

¹²⁴¹ DOMCCPM, DOMCCP, MCHC project report, 6. See also DOMCCPM, DOMCCP strategic plan 2002-2005, October 2002.

¹²⁴² DOCCPM, DOMCCP report, March to May 2000.

¹²⁴³ Irish Aids, *Looking back, mapping forwards*, 32.

¹²⁴⁴ WHO, *Epidemiological fact sheet on HIV and AIDS in Zimbabwe*, 4.

programmes affected AIDS-related care which thus: —.became increasingly dependent on churches, NGOs and communities with only minimum support from either the government, through the AIDS levy, or the international donor community.”¹²⁴⁵

In 2004, the Government of Zimbabwe launched the “National Community Home-Based Care Standards” followed in 2005 by the “National Home-Based Care Training Manual.”¹²⁴⁶ Prior to these two forms of legislation, home-based care was carried out without a national legislative framework. The gradual massive roll out of ARVs transformed AIDS-related home-based care because this reduced the number of clients. This became possible when the Government of Zimbabwe and ZACH received funding from the Global Fund. Nationally, a few healthcare centres benefited from this. Between April 2004 and by May 2005 a total of 27 public healthcare institutions offered ARV treatment services.¹²⁴⁷ In 2007, ZACH put church healthcare centres on the map of ARV roll out sites. This was carried out at selected church hospitals.

Between March and December 2000, the diocesan project trained an additional 2,000 voluntary caregivers and 2,500 primary caregivers at different stations. The project also supported a further 2,506 PLHIV by giving them clothes, groceries, blankets, sheets, and basic drugs including painkillers and cotrimoxazole.¹²⁴⁸ While such assistance only covered small segments of the people in need, families hard hit by the skyrocketing cost of living appreciated such support. Given that “over 60% of Zimbabweans were unemployed and the majority of the citizens were living on less than a dollar (US\$1) per day,”¹²⁴⁹ this support made a huge difference to PLHIV. In Zimbabwe the bulk of ordinary people hardly had enough money to meet daily needs including the extra burden of caring for the PLHIV. Furthermore, some families who were struggling under severe poverty took advantage of food supplies that were donated towards the sick.¹²⁵⁰ HIV and AIDS-care interventions were also affected by a high degree of politicisation. For example, in 2000 in Manicaland meetings whose

¹²⁴⁵ HDN, *Caring from within*, 20.

¹²⁴⁶ Irish Aid, *Looking back, mapping forwards*, 32.

¹²⁴⁷ HDN, *Caring from within*, 20.

¹²⁴⁸ DOMCCPM, DOMCCP, MCHC project report, 7.

¹²⁴⁹ Irish Aid, *Looking back, mapping forwards*, 31. See also C. Mombe, same interview.

¹²⁵⁰ E. Tichawangana, same interview.

purpose was to campaign for the AIDS levy and the launching of the newly formed National AIDS Council were cancelled because of on-going political sessions in preparation for the parliamentary elections.¹²⁵¹

The AIDS-related home-based care interventions were overstretched by escalation in the demand for such services. In 2002 the diocesan project proposed to support 5,500 PLHIV but ended up assisting 10,208 clients, which was almost double the original figure.¹²⁵² The same report further observed that food shortage, seasonal drought, and the declining economy made the operational environment unpredictable. This was also worsened by unexpected demands for food made by the caregivers.¹²⁵³ In 2002, it became apparent that without the caregivers receiving substantial amounts of food and monetary tokens, the care of the PLHIV by the diocesan project faced collapse. Apart from the care of the PLHIV and OVC, the demands made by voluntary caregivers created additional strains on already limited financial resources.¹²⁵⁴ Priority had to be made between motivating voluntary caregivers by giving them allowances versus the acquisition of standardised home-based care kits. The demand for incentives by voluntary caregivers was necessitated by escalation in poverty levels countrywide. Within some communities, the donor funded HIV and AIDS interventions administered by churches became lifelines for the supply of food and drugs for the sick and the enumeration of OVC opened up prospects of receiving much needed educational assistance.

Home-based care interventions were affected by delayed disbursement of funds. The implications were that the efficacy of service delivery to PLHIV was undermined. For example, in December 2002 a delay in the receiving of funds at St. Therese led to the scaling down of activities.¹²⁵⁵ However, in Chipinge district the *Médecins Du Monde* donated standardised home-based care kits which were a basic need.¹²⁵⁶ The Financial controls imposed by the State's central bank in Zimbabwe delayed disbursement of funds including money that was outsourced for HIV and AIDS interventions. While

¹²⁵¹ DOMCCPM, DOMCCP, MCHC project report for the bridging period, March to May 2000.

¹²⁵² DOMCCPM, C. T. Chibururu, DOMCCP progress report, October 2002.

¹²⁵³ DOMCCPM, Chibururu, DOMCCP progress report.

¹²⁵⁴ DOMCCPM, Chibururu, DOMCCP progress report.

¹²⁵⁵ DOMCCPR, St Therese DOMCCP substations Rusape, Mt Carmel, Gowakowa and Erra Mine quarterly station report, October to December 2002.

¹²⁵⁶ DOMCCPR, Benyera, *Evaluation of CRS Zimbabwe's home-based care*, 20.

some setbacks were encountered, the diocesan project expanded from the previous ten sites to nineteen centres in 2003.¹²⁵⁷ This expansion increased community access to home-based care services when compared to the previous period. Unfortunately, the hyperinflationary environment also limited the number of clients that were supported. In 2003 the total number of PLHIV assisted was at 8 890. This represented a drop from 10,208 clients in 2002.¹²⁵⁸ A notable decline in funds received from donors forced the management of the project to resort to fundraising initiatives at the local level. At St. Therese the World AIDS Day commemorations held on 1 December 2002 became a platform to lobby for donations towards PLHIV. This initiative was well supported by donations from FACT in Rusape, Makoni District AIDS Action Committee, Rusape business community, churches, schools, Makoni Rural District Council, Rusape Town Council, members of the public and the Zimbabwe Republic Police among others.¹²⁵⁹

The need to develop further coping strategies to manage the care of the PLHIV made the leaders of the diocesan project to be innovative. In 2003, another initiative that involved the mobilisation of communities to take care of the sick was launched. This strategy witnessed an increase in the number of active voluntary caregivers from 358 to 4,024.¹²⁶⁰ The calls by the ZCBC to members of the Roman Catholic Church in Zimbabwe to show compassion for each other in the Lenten message of 2003¹²⁶¹ could have resulted in more Roman Catholics registering as voluntary caregivers in their communities. However, declining relations between voluntary caregivers and the project's management affected service delivery. The supporters of political parties who threatened voluntary caregivers worsened the situation. Within the community, voluntary work was understood as a form of employment. In the absence of gainful employment, –serving as a voluntary caregiver in an NGO or similar organisation, enhanced a person's social status.”¹²⁶² While HIV and AIDS impoverished communities, it enriched some people. In 2003, the diocesan project handed over

¹²⁵⁷ DOMCCPM, DOMCCP, DOMCCP annual report, 2003.

¹²⁵⁸ DOMCCPM, DOMCCP, DOMCCP annual report. Information also supplied to M. Mbona by J. Nyamande, DOMCCP head office, Mutare, 10 June 2010.

¹²⁵⁹ DOMCCPR, St Therese DOMCCP substations Rusape, Mt Carmel, Gowakowa and Erra Mine quarterly station report. See also DOMCCPR, St Therese DOMCCP substations Rusape, Mt Carmel, Gowakowa and Erra Mine quarterly station report, January-March 2003.

¹²⁶⁰ DOMCCPM, DOMCCP, DOMCCP annual report.

¹²⁶¹ ZCBCH, ZCBC, —Acall to metanoia.”

¹²⁶² A. Dera, same interview. See also C. Mombe, same interview.

bicycles to 150 long serving voluntary caregivers.¹²⁶³ Besides using the bicycles for home-based care operations, the beneficiaries gained new assets that also became useful to their families. At St. Therese, the budget showed that out of a total of Z\$1 million received, volunteer allowances consumed a fifth of the sum taking Z\$22,113,376 in the first quarter of 2006.¹²⁶⁴

The project was still beset with challenges, which affected its capacity to deliver home-based care services. For example, in 2004 part of a report stated: –Shortages [The] of essential drugs have caused a decline in the health status of clients. The ever-increasing prices of bus fares, groceries, and fuel have hampered the conducting of workshops.”¹²⁶⁵ The CRS had problems in maintaining its funding regime as stated by Evelline Murray, a Roman Catholic nun and DOMCCP managing director:

Although the project is operating within the whole province, programming is mainly concentrated around the mission station at most within a range of 40km radius. The scaling down of the project’s geographical coverage was necessitated by the shortage of resources as the major donor CRS, faced a cash crisis at the beginning of 2004.¹²⁶⁶

According to an official from the National AIDS Council based in Manicaland, the Roman Catholic Church’s AIDS project was one of the few AIDS service organisations that served PLHIV with great fortitude. It was further stated that –the project staff won the hearts of communities and this was attributed to transparency and accountability shown by the leadership.”¹²⁶⁷ While this might have been a valid observation, there were other underlying factors to explain why the staff strived to serve communities diligently. One of such reasons is that the employees also had jobs to protect. AIDS service organisations created rare employment opportunities in Manicaland and countrywide in Zimbabwe.

The care of the PLHIV made the diocesan project to be involved in providing spiritual support to clients. Within Manicaland, between January and March 2006 a

¹²⁶³ DOMCCPR, Benyera, *Evaluation of CRS Zimbabwe’s home-based care*, 20.

¹²⁶⁴ See DOMCCPR, St Therese DOMCCP substations Rusape, Mt Carmel, Gowakowa and Erra Mine quarterly station report, January-March 2003.

¹²⁶⁵ DOMCCPR, St Theresa DOMCCP quarterly work plan, July to September 2004.

¹²⁶⁶ DOMCCPM, E. Murray, DOMCCP director’s activity report, January to March 2006, 3.

¹²⁶⁷ L. Kupara, same interview. See also DOMCCPM, Murray, DOMCCP director’s activity report, 6.

total of 2,600 female and 2,345 male clients living with HIV received spiritual support including prayer, readings from the Bible, and counselling, all as a part of care.¹²⁶⁸ Spiritual leaders and caregivers provided spiritual and psychosocial support to PLHIV. However, at times the clients converted to Christianity, became a member of any church or joined the Roman Catholic flock. The following extract serves as an illustration:

It was noted that terminally ill clients are eager to turn to God...a client (name supplied) of B102 Vengere, Rusape, who received the sacrament of baptism and passed away seven days later. One of our volunteers, Flora Marima, helped this client to receive Christ.¹²⁶⁹

Religion assumed new significance in the lives of clients who were assisted by the Roman Catholic Church. Personnel from the diocesan project went beyond providing for the physical needs of beneficiaries by ensuring that spiritual needs were also met. The church's priests, nuns, caregivers, the laity and the religious carried out pastoral work towards the PLHIV. This was consistent with the catechesis that is based on the "Paschal Mystery" where death is not the end but brings about hope in the resurrection. Records based on Makoni district showed that 366 prayer sessions for HIV positive people were held in 2007 alone,¹²⁷⁰ but many other unrecorded sessions could have been accomplished.

The NGO Act also led AIDS-related service organisations to forge new partnerships. The new partnerships were of benefit to selected communities in Manicaland. In 2004, the diocesan project and Plan International, an NGO that worked with underprivileged children, established the Circle of Hope project and supported home-based care in parts of Mutare and Mutasa.¹²⁷¹ In 2006 the new recruits of voluntary caregivers from Mutare and Mutasa serving under the Circle of Hope project included seventeen members of the Apostolic sect of Johane Marange out of 150 other people. This is one of the few recorded incidence in which members of an Apostolic sect became voluntary caregivers. It is possible that increased cases of HIV forced some of

¹²⁶⁸ C. Mauye, same interview. See also T. Nyawera, same interview.

¹²⁶⁹ DOMCCPM, Murray, DOMCCP director's activity report, 7. See also DOMCCPR, F. Nyatsuro, DOMCCP Makoni district brief annual report to CRS at a core-partners meeting held in Harare, 10-12 December 2007.

¹²⁷⁰ DOMCCPR, Nyatsuro, DOMCCP Makoni district brief annual report to CRS.

¹²⁷¹ DOMCCPM, J. Nyamande, DOMCCP Circle of Hope partnership project with Plan International for Mutare and Mutasa, 4 April 2006.

its members to train and serve as voluntary caregivers. This indicated a shift from findings by Gregson *et al.* whose study in 1999 concluded that HIV was less prevalent among male Apostles and Zionists in Manicaland.¹²⁷² In 2006, new realities in relation to HIV emerged seven or more years later. Within home-based care, more females than males were engaged as voluntary caregivers. For example, in 2007 there were very few male voluntary caregivers serving in Rusape under the diocesan project. The town of Rusape had 18 male and 163 female voluntary caregivers serving 325 male and 708 female clients.¹²⁷³ One of the ways that was used by the diocesan project to motivate male voluntary caregivers was through the provision of regular allowances. In 2007 the Project Support Group, a University of Zimbabwe based NGO working to strengthen organisational capacity of NGOs, assisted the diocesan project in the payment of Z\$6,780,000 as incentives for voluntary caregivers.¹²⁷⁴

In 2007, AIDS-related home-based care faced an uncertain future. The leadership of the diocesan project developed a survival strategy by shifting towards increased use of community resources. Under this model, the community provided much of the needed resources and took a leading role in responding to HIV and AIDS. The streamlining of responsibilities between the diocesan project and the local communities transformed the community's perception of AIDS-related care:

In the past communities used to think that the burden of caring for their sick members was the onus of the donors and government. It has been observed that our communities now appreciate that they themselves are responsible for caring for their sick people. We have also noted that communities now frequently mobilise their humble resources to assist their sick members. Increase in community secondary care givers, capacity building in HBC now taken seriously in order to improve the quality of care they render to their ill members. This led to an increase in the demand for standard HBC kits.¹²⁷⁵

The increased visits to PLHIV made by some members of the community created further opportunities for clients to access critical information on health education.

¹²⁷² See Gregson, —Apostles and Zionists.”

¹²⁷³ DOMCCPR, D. Bakare, C. Gwatidzo, V. Dhliwayo, Makoni district DOMCCP report, May 2007.

¹²⁷⁴ DOMCCPM, E. Murray, DOMCCP and PSG quarterly report, January to April 2007, 3.

¹²⁷⁵ DOMCCPM, F. Nyatsuro, DOMCCP quarterly report, October to December 2007, 5 January 2008, 15.

This included ‘advice’ on the use of herbal or natural medicine, antiretroviral therapy and voluntary counselling and testing.¹²⁷⁶

The positive contribution to AIDS-related home-based care by NGOs and the churches did not receive much recognition from the State in Zimbabwe. In fact this undermined the work of voluntary caregivers as well as PLHIV. In Manicaland voluntary caregivers formed the backbone of AIDS related care. Consistent with this position, a study by the Tearfund concluded that if the goodwill of the volunteers in home-based care were to be exhausted and their contribution withdrawn, the global response to HIV and AIDS would be significantly weakened.¹²⁷⁷ While the operational environment for the FBOs including church-related HIV interventions experienced some challenges, the Roman Catholic Church in Manicaland assisted the State in its legitimate responsibility to care for the sick. Occasionally, the State provided guidelines on home-based care standards and conducted sessions with voluntary caregivers.¹²⁷⁸ In 2007, in Makoni district, ninety caregivers received standardised home-based care kits from the State.¹²⁷⁹ While this is noted, the quantity of home-based care kits was far below required supplies. This situation led AIDS service organisations to use donor funds to procure home-based care kits. The project staff also facilitated collaboration on AIDS-related treatment and care with the New Start Centre and Rusape General Hospital’s opportunistic infections and maternity departments.¹²⁸⁰ This initiative benefited home-base care clients.

5.2.2.2. The Care of OVC Intensifies

The number of orphans and other children made vulnerable by AIDS in Zimbabwe escalated from 345,000 in 1988 to 1,140,000 in 2003.¹²⁸¹ According to Kaseke and Dhemba, the number of children orphaned by AIDS in 2006 was at 1,300,000.¹²⁸² In

¹²⁷⁶ DOMCCPR, Nyatsuro, DOMCCP Makoni district brief annual report to CRS. See also A. Dera, same interview.

¹²⁷⁷ Tearfund, *Faith untapped: Why churches can play a crucial role in tackling HIV and AIDS in Africa*, (2006), 24.

¹²⁷⁸ DOMCCPM, Nyatsuro, DOMCCP quarterly report, 7.

¹²⁷⁹ DOMCCPR, Nyatsuro, DOMCCP Makoni district brief annual report to CRS.

¹²⁸⁰ DOMCCPR, Nyatsuro, DOMCCP Makoni district brief annual report to CRS.

¹²⁸¹ NAC, *The HIV and AIDS epidemic in Zimbabwe*, 43.

¹²⁸² Kaseke and Dhemba, —Zimbabwe country report,” 11.

2001 UNAIDS observed that Zimbabwe had 830,000 AIDS-related orphans and the figure increased to 1,100,000 in 2007.¹²⁸³ In February 2000, the diocesan project supported 3,120 OVC and the figure escalated to 7,700 OVC in December 2000.¹²⁸⁴ In 2002, the initially budget catered for 25,000 OVC but the project ended up caring for 66,704 OVC in Manicaland.¹²⁸⁵ At the end of 2007 the number of OVC supported by the project totalled 69,000. This was against the backdrop of an initial budget of 15,000 OVC inclusive of beneficiaries from Chipinge, Mutare, Nyanga, Mutasa and Makoni.¹²⁸⁶ Within Manicaland, few organisations engaged in diverse strategies all aimed at addressing the plight of OVC. For example, in 2000 Makoni North benefited from a joint initiative between the diocesan project and the Support to Replicable Innovative Village Level Efforts for Vulnerable Children in Zimbabwe (STRIVE) project.¹²⁸⁷ In a 2002 report the project paid school fees to children made vulnerable by AIDS in sixteen primary and four secondary schools located in 129 villages. The total number of beneficiaries was at 2,841 pupils. In addition to school fees, beneficiaries also received nutritional food and psychosocial support.¹²⁸⁸ This joint AIDS-related OVC care project engaged local communities in production of food part of which was used to feed children orphaned by AIDS.

While the Government of Zimbabwe's Basic Education Assistance Module supported financially disadvantaged primary and secondary school pupils, generally, the initiative was overwhelmed by high demand. As observed by the Basic Education Assistance Module programme, expenses were only covered for very limited needs: –Its main support is in the form of payment of tuition fees, examination fees, building fund and school levies.”¹²⁸⁹ Whereas the programme rarely covered needs such as building fund, levies, stationery, uniforms and food, the joint project provided full educational assistance. The funding model also equipped OVC with practical skills and that appeared to be quite unique. In 2002, the old school buildings at St. Therese were renovated and converted into a skills training centre for OVC. Similarly, at Dora

¹²⁸³ WHO, *Epidemiological fact sheet on HIV and AIDS in Zimbabwe*, 4.

¹²⁸⁴ DOMCCPM, DOMCCP, MCHC project report, 8.

¹²⁸⁵ DOMCCPM, Mabururu, DOMCCP progress report.

¹²⁸⁶ DOMCCPR, Benyera, *Evaluation of CRS Zimbabwe's home-based care*, 18.

¹²⁸⁷ Kaseke and Dhembu, —Zimbabwe country report,” 11. See also DOMCCM, DOMCCP, Gowakowa pilot project, July 2002.

¹²⁸⁸ DOMCCPM, DOMCCP, Gowakowa pilot project.

¹²⁸⁹ N. Marongwe, —Observatory case studies: The basic education assistance module (BEAM) in Zimbabwe,” (May 2007), 16. This was accessed as pdf.

under St. Joseph's Sakubva, a carpentry project was set up and at Gowakowa dressmaking and carpentry were introduced. These income generation projects for OVC were established with the support of CARE Zimbabwe.¹²⁹⁰

In 2003, at St. Therese in Chiduku, out-of-school youth were financially and technically supported to establish projects such as piggery units, vegetable gardens, poultry, candle making, pottery and hawker services.¹²⁹¹ This was done out of a realisation that high levels of poverty further undermined the personal dignity of OVC. They hardly had any family resources for relief as stated:

Not only have they suffered grief at the death of their parent/s but they have also been seriously affected by the disease for many years as dwindling household resources are consumed in pursuit of alleviating medications and an elusive cure.¹²⁹²

The displacement of families and people living on farms under the fast-track land reform programme also affected OVC. The diocesan project was one of the few FBOs that unlocked the full capacity of communities in responding to the needs of the OVC at a time Zimbabweans in general were faced with social-economic constraints.

Apparently, assistance became a necessity at a time when –ommunities including Christians were struggling to eke out a living.¹²⁹³ In this regard between 2004 and 2007 the Circle of Hope project already mentioned above also became a lifeline for OVC in five wards of Mutasa district and ten wards in Mutare urban. A combination of challenges justified the project's involvement in the care of OVC and PLHIV as stated by Nyamande: –The high incidence of HIV and AIDS, recurrent drought and the worsening economic conditions have in a big way worsened the socio-economic status of the communities.¹²⁹⁴ OVC care and support came in a variety of ways including the supply of fertilizers, maize seed, block grants in fees for 222 male and

¹²⁹⁰ DOMCCPM, DOMCCP, report on the partnership meeting between the DOMCCP and CARE Zimbabwe, 22 August 2002.

¹²⁹¹ DOMCCPR, St. Therese DOMCCP substations Rusape, Mt. Carmel, Gowakowa and Erra Mine quarterly station report, January-March 2003.

¹²⁹² WCC, *Ecumenical HIV/AIDS Initiative in Africa (EHAIA): Zimbabwe*, (2004), 36, <<http://www.wcc-coe.org/wcc/what/mission/ehaia-html/sa-zimbabwe-e.html>> [Accessed 4 August 2011].

¹²⁹³ P. Mutume, same interview.

¹²⁹⁴ DOMCCPM, Nyamande, DOMCCP Circle of Hope partnership project.

263 female students and direct fees payment for another 500 OVC.¹²⁹⁵ This also served to motivate members of the community to increase their involvement in OVC care interventions. In the Gowakowa area, wards 3, 7, 8, 9, 10 and 35 established food security projects for the OVC under the *zunde ramambo* scheme.¹²⁹⁶

The material assistance towards orphans and other children made vulnerable by AIDS was also extended to relatives and members of the extended family. This was done in order to harmonise the relationship between OVC and members of the extended family. The latter insisted that it was their right to inherit the deceased's assets as a precondition to caring for surviving children.¹²⁹⁷ In 2006 the project staff intensified civic education on the legal rights and the abuse of the OVC by guardians.¹²⁹⁸ Thus, the care of the OVC extended into other spheres of human life including equipping beneficiaries with knowledge on civil rights. Apparently, civic education became a new subject of interest introduced to curtail abuse of property rights for already disadvantaged children by family members.

In 2007, some of the OVC supported by the Roman Catholic Church through its project in Manicaland were also evangelised. There was noticeable interest in the influence of humanitarian aid on OVC and religion appeared to be significant as was noted: —Most orphans who attended our spiritual support sessions have changed their behaviour. They are now regularly attending church services and joining youth groups in churches.”¹²⁹⁹ This incident is similar to the case of the evangelisation of PLHIV under home-based care discussed above. Both cases resonated well with an observation made by Bornstein in relation to the organisation Charitable Choice in the US: —Underlying the discourse of choice, responsibility, and liberty are narratives of conversion. That individuals can be transformed and reformed—converted, born again.”¹³⁰⁰ Therefore, aid donated to the OVC in Manicaland by the diocesan project could have contributed to the proselytising of some of the beneficiaries.

¹²⁹⁵ DOMCCPM, Nyamande, DOMCCP Circle of Hope partnership project.

¹²⁹⁶ DOMCCPM, S. Mabhunu, DOMCCP STRIVE quarterly report, July to September 2007.

¹²⁹⁷ M. Mudzimiri, same interview.

¹²⁹⁸ DOMCCPM, DOMCCP-PSG activity report, January-March 2006, 5. See also DOMCCPM, F. Nyatsuro, DOMCCP quarterly report, October to December 2007, 5 January 2008, 5, 12.

¹²⁹⁹ DOMCCPM, Murray, DOMCCP and PSG quarterly report, 4.

¹³⁰⁰ E. Bornstein, —Fait, liberty and the individual in humanitarian assistance,” in M. Feher, G. Krikorian and Y. McKee (eds), *Nongovernmental politics* (New York: Zone Books, 2007), 664.

Gender balance became one of the major strengths of the diocesan project's OVC care programme whereby at least 60% of school fees grants beneficiaries were females.¹³⁰¹ Zimbabwe is one of the countries in Africa where the girl child is generally disadvantaged. A number of girls and young women were empowered through gender sensitive OVC intervention. The project's workers also organised counselling services for children orphaned by AIDS. For example, in 2003 Ashbel Vudzijena, serving as the project's social welfare officer, organised a psychosocial support workshop in Mutare with clients from Triashill, St. Peter's, Avila, Regina Coeli, St. Joseph's Sakubva, Mt. Mellery, St. Therese, St. James and Gowakowa.¹³⁰² Counselling became a crucial topic in training sessions for caregivers and community leaders. The project recognised the close relationship between psychosocial support and the provision of basic human needs. In this regard, poverty and loss of parents due to HIV forced young boys to venture into fruit vending at public markets and they also transported baggage by using wheelbarrows. The young male school drop outs in Mutare, Rusape and Nyanga received school fees assistance from the OVC programme under the diocesan project.¹³⁰³

5.2.2.3. The Moral Behaviour Change Approach to HIV Prevention

Between 2000 and 2007 HIV prevention under the Roman Catholic Church adopted the "moral behaviour change" approach.¹³⁰⁴ This was done in a bid to reduce the spread of sexually transmitted HIV. In 2000, the project's staff held workshops that focused on the "behaviour change process." The initiative was launched at St. Joseph's Mutare and thereafter expanded to the other parts of the diocese.¹³⁰⁵ Briefly, the basis for this was that all people have the capability to review their values, attitudes and then change behaviour:

¹³⁰¹ DOMCCPM, Nyatsuro, DOMCCP quarterly report. See also DOMCCPR, Nyatsuro, DOMCCP Makoni district brief annual report to CRS.

¹³⁰² DOMCCPM, A. Vudzijena, Orphan psychosocial workshop report, 1-5 September 2003.

¹³⁰³ DOMCCPM, F. Nyatsuro, DOMCCP-PGS activity report, January-December 2007, 7.

¹³⁰⁴ This concept was based on training in moral principles that influenced human sexual behaviour and were meant to prevent people from contracting HIV as opposed to using condoms.

¹³⁰⁵ DOMCCPM, DOMCCP, MCHC project report for the bridging period March to May 2000.

The education for life behaviour change process motivates individuals to act positively with accurate knowledge of HIV/AIDS so that they change values. The process acts on the auspice that individuals can only change to sustainable positive behaviour to avoid contraction of HIV and AIDS if the project addresses the root causes. The root causes in this case are wrong values that people hold which lead to false attitudes and then risk behaviour when people are pursuing/protecting those values.¹³⁰⁶

This initiative was well supported by Franciscan sisters working within the diocese.¹³⁰⁷ The programme also grew popular with the State's district health executive personnel in Mutare, Mutasa and Makoni districts. They adopted the church's moral behaviour change model and used it in training of State medical personnel.¹³⁰⁸ It has to be noted however that the church's moral behaviour change programme in Manicaland was intolerant to the use of condoms in prevention of sexually transmitted HIV. In 2006 the Government of Zimbabwe launched a behaviour change programme in which the promotion of consistent male and female condom use will remain a key priority."¹³⁰⁹

In 2002 the moral behaviour change strategy formed the main part of HIV prevention among the youth in the diocese. At St. Therese, the moral behaviour change programme targeted at in-school and out-of-school youth. There were separate sessions for people involved in sex work, widows and single mothers.¹³¹⁰ Similarly, in the same year, workshops on behaviour change and they targeted male and females involved in sex work in the Headlands and Rusape. Few males and more female participants attended the sessions.¹³¹¹ While the level of attendance appeared small, the strategy seems to have paid dividends. For example, in October 2002 the school dropout rate among girls due to unplanned pregnancies in Manicaland fell by 60%.¹³¹² Few FBOs and churches in Manicaland engaged with women involved in sex work in order to assist them reduce the spread of HIV. This was at a time when society, including Christians, blamed such women for fuelling the spread of HIV. Some steps

¹³⁰⁶ DOMCCPM, DOMCCP, MCHC project report for the bridging period.

¹³⁰⁷ A. Vinyu, information supplied to M. Mbona, Cathedral of the Holy Trinity, Mutare, 10 June 2010.

¹³⁰⁸ DOMCCPM, DOMCCP, MCHC project report for the bridging period.

¹³⁰⁹ NAC, *National behavioural change strategy*.

¹³¹⁰ DOMCCPR, St Therese DOMCCP substations Rusape, Mt. Carmel, Gowakowa and Erra Mine quarterly station report, July 2002.

¹³¹¹ DOMCCPR, St Therese DOMCCP substations Rusape, Mt. Carmel, Gowakowa and Erra Mine quarterly station report, July 2002.

¹³¹² DOMCCPM, Mabururu, DOMCCP progress report.

were taken in order to assist people involved in sex work to establish self-help income generation projects. While some Roman Catholic Christians were not keen to support this initiative,¹³¹³ the intervention transformed the livelihoods of some of the women formerly involved in sex work in Rusape town. This model of HIV prevention became a tool to achieve community empowerment and improvement of livelihoods. Similarly, in 2006 FACT officers in Rusape used that strategy. Some women previously engaged in sex work were assisted to start small businesses as ways of discouraging them from risking their lives from HIV.¹³¹⁴ Such projects, established as part of HIV prevention, had the intended effects of creating favourable micro economic conditions that led beneficiaries to quit sex work.

The moral behaviour change approach led to the formation of 140 HIV prevention clubs in schools in Manicaland. The “AIDS clubs” as they were often called aimed at sensitising in-school youth about the dangers of contracting HIV. This approach proved attractive and workable in schools because the intention was to encourage pupils to hold discussions on HIV and AIDS within a relaxed environment such as during volleyball, basketball and tennis games.¹³¹⁵ In April 2007 the project was supporting 140 AIDS prevention clubs in schools and conducted moral behaviour change awareness sessions for 3,500 in-school youth in that year. One of the limitations of this strategy was its failure to reach out to children from remote parts of the diocese.¹³¹⁶ However, this was resolved through the holding of camps that targeted in-school youth. In 2007 the in-school youth from Chiome, Tsikada, Bingaguru, Dehwe and Gowakowa were beneficiaries of a behaviour change and life skills training camp.¹³¹⁷ Furthermore, the same communities also held camp sessions and workshops on child rights, child abuse and protectors in the community. The participants included community leaders, caregivers, councillors, village heads, religious leaders, child protection committees, guardians, teachers, school heads and the children. Thus, in a bid to meet the needs of OVC, the project also took over the responsibility of socialising and the upbringing of children, a role that was previously held by parents, the extended family, the school, the church and the community.

¹³¹³ C. Mauye, same interview.

¹³¹⁴ O. Kanyere, same interview.

¹³¹⁵ DOMCCPM, DOMCCP, DOMCCP-PSG activity report, January-March 2006, 9.

¹³¹⁶ DOMCCPM, Murray, DOMCCP-PSG quarterly report, 4. See also DOMCCPM, Nyatsuro, DOMCCP-PGS activity report, 6.

¹³¹⁷ DOMCCPM, S. Mabhunu, DOMCCP-STRIVE quarterly report, July to September 2007, 10, 11.

The church's healthcare centres in Manicaland also became important in rolling out PMTCT services. The first PMTCT project at a rural church healthcare centre in Zimbabwe was established at Murambinda hospital in Manicaland under the Roman Catholic Archdiocese of Harare in 2001.¹³¹⁸ From 2002 onwards, PMTCT services were launched at diocesan healthcare centres including Avila, Regina Coeli, Mt. Mellery, St. Therese, Triashill, St. Babra's and St. Andrew's. The rollout of PMTCT services at church healthcare institutions became possible through the initiative of ZACH and Centre for Disease Control.¹³¹⁹ Given that the church's healthcare centres were scattered in rural parts of Manicaland, the rollout of PMTCT led to improved access to HIV prevention interventions for people in those rural areas. Previously, the PMTCT services were only offered at large Government hospitals in towns and cities. They were of limited benefit to people living in rural areas. The diocesan project also assisted healthcare centres in capacity building through the provision of requisite support services for PMTCT. In Manicaland province more than 50% of the church healthcare institutions were under the Roman Catholic Church.¹³²⁰ Thus, the launching of the PMTCT services could have bolstered the image of the Roman Catholic Church as a caring church. In the 1990s the ZCBC actively opposed the abortion of HIV positive foetus and the launch of the PMTCT services in Zimbabwe became a positive step in saving the lives of many babies.

In 2002, the Roman Catholic diocesan project became one of the few faith-based AIDS service organisations that facilitated the establishment of VCT at the church's healthcare. This was achieved through the support of ZACH. Increased access to VCT services by communities made it possible for more people to be HIV tested than was the case. Consistent with this observation, the launch of the VCT services at Triashill hospital in 2002 made it possible to have HIV tests done locally.¹³²¹ When people became aware of their HIV status they were also likely to take informed decisions on safe sex and therefore reduced the spread of HIV. However, another perception was

¹³¹⁸ F. Perez *et al.*, "Implementing a rural programme of prevention of mother to child transmission of HIV in Zimbabwe: first 18 months of experience," *Tropical medicine and international health* 9, 7 (July 2004), 774-783.

¹³¹⁹ See map showing ZACH hospitals and AIDS activities in chapter one of the thesis. See also V. Chitimbire, same interview.

¹³²⁰ V. Chitimbire, same interview.

¹³²¹ M. Mbona is indebted to E. Mupotsa, a primary healthcare counsellor, for supplying this information, Triashill hospital, September 2010. This was also confirmed by Cosam Matsekwa of DOMCCP centre, Mutare, in a telephone conversation with M. Mbona, 30 September 2011.

that ~~knowing~~ one's HIV status was a scaring thing because if found HIV positive people took it as a death sentence.¹³²²

Between January and March 2006 the project staff coordinated VCT outreach programmes in Mutasa Chimanimani, Chipinge, Makoni, Nyanga and Mutare. The purpose of the initiative was to allay people's fears of knowing their HIV status. This programme led to a numerical improvement in men's participation in VCT, a reduction in new cases of HIV, and increased openness about the epidemic.¹³²³ However, this intervention had limitation. For example, Halperin *et al.* writing on factors that could have contributed to a decline of HIV in Zimbabwe including Manicaland observed that ~~voluntary~~ counselling and testing and PMTCT programmes were, however, unlikely to have contributed significantly as they were scaled up only after 2002.¹³²⁴ The number of sites offering VCT services was still outnumbered by demand and therefore led to limited access. This was particularly the case with Government healthcare centres.¹³²⁵

In 2007, people who wanted to have HIV tests overwhelmed VCT facilities under the church's healthcare centres.¹³²⁶ This new pattern was obviously linked to increased availability of ARVs in 2007. The fact that there were increased chances of obtaining HIV test results immediately, and thereafter obtain affordable treatment for HIV, motivated people to seek VCT services. In November 2007, VCT generated statistics from Makoni district became critical in drawing up specific prevention strategies. The statistics revealed that the 25-49 years cohort had HIV prevalence of 64% while that of the 15-24 years was at 14%. The results enabled the diocesan project to intensify HIV prevention targeting the 25-49 years cohort.¹³²⁷ Project officers also worked closely with heads of schools and encouraged them to be pro-active on the prevention of HIV among teachers and pupils.¹³²⁸ It should be noted that the project staff advocated for the moral behaviour change approach and not the use of condoms.

¹³²² A. Dera, same interview.

¹³²³ DOMCCPR, D. Bakare, C. Gwatidzo, V. Dhliwayo, Makoni district DOMCCP report, May 2007.

¹³²⁴ Halperin, —Surprising prevention success,” 3-4.

¹³²⁵ *HIV and AIDS in Zimbabwe*, <<http://www.avert.org/aids-zimbabwe.htm>> [Accessed 30 September 2011].

¹³²⁶ DOMCCPM, Nyatsuro, DOMCCP quarterly report, 8.

¹³²⁷ DOMCCPM, Nyatsuro, DOMCCP quarterly report, 9.

¹³²⁸ DOMCCPM, Nyatsuro, DOMCCP quarterly report, 6.

While this approach could have had some limitations, Chiome mentioned that at St. Joseph's secondary school in Rusape teachers and students generally held HIV prevention messages in high regard.¹³²⁹

5.2.2.4. The Treatment of AIDS-Related Illness

The Roman Catholic diocesan project established convenient and cost effective ways of treating AIDS-related illness through the use of natural medicine. In 2003, one of the first herbal gardens for the propagation of medicinal herbs to treat AIDS-related illnesses was established at Regina Coeli hospital in Nyanga, Manicaland.¹³³⁰ Bori Hounnou, a Swiss medical doctor whose husband was serving at the church's hospital initiated the project. Subsequently, this spread to the other stations in Manicaland as stated: "They have established a large medicinal garden, and have a solar drier for preparing herbal teas and drying herbs for use in ointments. Now each station is developing a garden of medicinal plants."¹³³¹

The herbal therapy project became a necessity at a time when the majority of the PLHIV could not access antiretroviral treatment (ART) because it was quite expensive. In 2003 the results of using herbs such as *gundamiti* showed that 62 clients out of 1 816 PLHIV at St. Therese responded well to the herb: "The drug is in fact very effective as some of the PLHIV who were bed bound are back on their feet and there is improvement on their health status. This clearly means there is need to increase the purchase of the drug."¹³³² Herbal therapies were developed because some herbs boosted the body's immune system. A study by Irish Aid indicated that herbal therapies "had a positive effect on people living with HIV and gave them the hope to live longer."¹³³³ Within Manicaland, some members of the public were already exposed to herbal therapies for the treatment of AIDS-related illness. In 1996 Marlou

¹³²⁹ R. Chiome, same interview.

¹³³⁰ Information supplied to M. Mbona by J. Nyamande, DOMCCP head office, Mutare, 10 June 2010.

¹³³¹ DOMCCPM, K. Lindsey, Seminars on natural medicine in Zimbabwe, September to October 2006.

¹³³² DOMCCPR, St Therese DOMCCP substations Rusape, Mt Carmel, Gowakowa and Erra Mine quarterly station report, January to March 2003.

¹³³³ Irish Aid, *Looking back, mapping forwards*, 31.

Bijlsma, a Dutch national who worked with the Mutare City Health launched an herbal treatment project for PLHIV.¹³³⁴

In 2004 the herbal garden project situated at St. Joseph's Sakubva in Mutare started to distribute medicinal herbs. Some of the herbal therapies included the use of artemisia annua powder to boost the immune system as well as moringa, and aloe vera among others.¹³³⁵ The new initiative also established facilities to manufacture capsules from herbs and followed recommended pharmacological practice. In October 2006, communities were trained in the use of natural medicines by "Action for Natural Medicine of Germany." This witnessed the certification of fifty caregivers and traditional health practitioners. Auxiliary Bishop Mutume and the provincial governor of Manicaland, Tinaye Chigudu officiating at the certification ceremony held at Regina Coeli in Nyanga.¹³³⁶ The medicinal herbal project gained popularity within communities and its products were also declared as suitable for use with AIDS-related clients in Government hospitals. Herbal therapies became a source of relief at a time when the State's healthcare service struggled to supply many important pharmaceuticals.¹³³⁷ In Mutare, the clients taking sweet wormwood, moringa, chiororo and using azad skin ointment showed improvement in health as evidenced by gaining weight and disappearance of skin rashes. Further step in ensuring the monitoring of the viral load for patients using herbal therapies at St. Joseph's, Sakubva were taken. This was achieved after the installation of a specialised CD4 count machine in March 2006,¹³³⁸ being the only one of its kind in Zimbabwe.¹³³⁹

Within Manicaland, the popularity of herbal therapies in the treatment of AIDS-related illness witnessed a proliferation of herbal gardens. At least the initiative gave the community an opportunity to participate in the treatment of AIDS-related diseases through the growing of herbs. However, in some areas the efficacy of project was affected by shortage of equipment and other ingredients used to manufacture herbal

¹³³⁴ M. Bijlsma, *Living positively: nutrition guide for people with HIV/AIDS*, (Mutare: Mutare city health department, 1996).

¹³³⁵ C. Mombe, same interview.

¹³³⁶ DOMCCPM, Lindsey, Seminars on natural medicine in Zimbabwe.

¹³³⁷ DOMCCPM, DOMCCP, DOMCCP-PSG activity report, 8.

¹³³⁸ DOMCCPM, DOMCCP, DOMCCP-PSG activity report, 8.

¹³³⁹ C. Mombe, same interview. See also information supplied to M. Mbona by J. Nyamande, DOMCCP head office, Mutare, 10 June 2010.

products.¹³⁴⁰ Despite these challenges, herbal medicines complimented conventional drugs as stated:

To date, the project has developed 20 herbal products, which are complimenting conventional drugs in the treatment of mild to complicated conditions like common cold, headache, diarrhoea, asthma, bronchitis, fever, herpes, sexually transmitted diseases, and stubborn wounds and suppressed immune system. We have clients from various parts, towns and cities of Zimbabwe coming to seek herbal therapy from our project. The herbal therapies are promoting the clients' longevity. Bed-ridden clients are becoming productive again which is a positive development in the project.¹³⁴¹

The use of herbal therapies in the treatment of AIDS-related diseases 'replaced' the therapies used by traditional health practitioners. The present research has observed that while herbal therapies were useful, they did not appear to be a cure for HIV. What people needed at that time were ARVs and thus the uptake of herbal therapies was limited. However, the herbal therapies under the diocesan project in Manicaland made a contribution to the treatment of AIDS-related illness though no absolute cure is still available.

Initially, in 2004 a limited number of HIV positive people could access ARV treatment from the State's national referral healthcare centres in Harare and Bulawayo. While this was expanded to reach provincial hospitals including the Mutare General hospital in Manicaland, the intervention still fell short of reaching a majority of PLHIV. Generally in Zimbabwe, availability, affordability, and accessibility of ARVs were identified as important gaps in HIV programming in the country.¹³⁴² The number of beneficiaries receiving ARVs was quite low and rural folks could hardly access ARVs because the process of screening clients was riddled with red tape and corruption. In 2005, Murambinda hospital became the first rural sites in Manicaland and nationally to distribute of ARVs. This initiative was attractive to PLHIV from other parts of the country including Harare, Bulawayo, Gweru, Rusape, Mutare and Nyanga. The cost of the drugs was low and no clients were

¹³⁴⁰ DOMCCPM, Mabhunu, DOMCCP STRIVE quarterly report, 9.

¹³⁴¹ DOMCCPM, DOMCCP, DOMCCP-PSG activity report, 8.

¹³⁴² See HDN, *Caring from within*, 20.

turned away.¹³⁴³ At the end of 2007 church healthcare centres in Manicaland namely St. David's Bonda, Mt. Selinda and Mutambara hospitals benefited from the ARV roll out programme under the Global AIDS Fund, Round One.¹³⁴⁴ From 2008 onwards Triashill, St. Babra's, Regina Coeli, St. Therese and St. Joseph's hospitals, among the others, were designated as ARV access sites.¹³⁴⁵ The roll out of ART at the diocesan healthcare centres improved access to the 'life-giving' service and thus placed the Roman Catholic Church in Manicaland in the limelight.

The diocesan project also provided financial assistance to some HIV positive people who could not afford to pay for treatment. Between January and March 2006 Project Support Group and CRS donated Z\$165 500 540 for the procurement of conventional medicinal drugs and sanitary supplies not available at the public clinics and hospitals. The assistance benefited 1 306 PLHIV,¹³⁴⁶ and the trend continued into 2007. Between January and March 2007 the project provided medical supplies to PLHIV that included cotrimoxazole, amoxen, betadine, metronidazole, fansidar, clotrimazole, jik, antibacterial soap, protective materials, doxycilin, paracetamol and skin rash lotions.¹³⁴⁷ Comparatively, the numbers of people assisted were relatively low compared to those in need. Having stated thus, the diocesan project made a positive mark on access to AIDS-related treatment services to rural council and state clinics.¹³⁴⁸ For example, under the project, healthcare centres belonging to rural councils and government in Mutasa and Mutare witnessed the sharing of scarce medical resources and HIV clients were freely served at different hospitals and clinics.

The rollout of ARVs brought relief to bed-bound clients but inadequate supplies of food affected their full recovery.¹³⁴⁹ The Roman Catholic diocesan project was one of the few AIDS service organisations in Manicaland that linked the provision of ART

¹³⁴³ T. Matsika, same interview.

¹³⁴⁴ See map of ZACH: HIV and AIDS activities in chapter one of the thesis. See also ZACH, summary report on the Global Fund to Fight AIDS, Tuberculosis and Malaria Round One, Phase Two Grant managed by the ZACH as the principal recipient.

¹³⁴⁵ C. Mukazi, same interview. Although the information falls out of the scope of the present focus it points out at some critical processes in the treatment of AIDS.

¹³⁴⁶ DOMCCPM, DOMCCP, DOMCCP-PSG activity report, 8.

¹³⁴⁷ DOMCCPM, Murray, DOMCCP-PSG quarterly report, 4.

¹³⁴⁸ DOMCCPM, J. Nyamande, Summative progress report of the Circle of Hope project, 4 April 2006, 9.

¹³⁴⁹ DOMCCPM, Nyatsuro, DOMCCP quarterly report, 9.

with the availability of adequate food resources for clients. However, in 2006, the scheme to provide supplementary food to PLHIV was affected by a decline in funding. Consistent with this observation, Murray reported: “Our impact in this regard has been minimal since the organisation had no adequate funds to procure food hand-outs for the critically ill patients. ...There is also a critical shortage of drugs in the health centres.”¹³⁵⁰ Apparently, the project was also affected by the scarcity of food commodities experienced in Zimbabwe during that period. Due to this situation, PLHIV supported by diocesan project failed to receive their regular food hampers.¹³⁵¹ While the project made efforts at treating AIDS-related illness it appears that the Roman Catholic Church did not do enough advocacy work towards increased access to ART. The Episcopal leadership of the Roman Catholic Church appeared not to have used its voice effectively in ensuring that the government considered the treatment of AIDS as a top priority. The massive roll out of ARVs only came at the end of 2007. However, given the challenges associated with the socio-economic environment in Zimbabwe, there were limits to which the churches could advocate increased access to ART.

5.2.3. HIV and AIDS Interventions at the Grassroots Level

Between 2000 and 2007 there were limited changes in the way some of the Roman Catholic Church’s parishes in Manicaland responded to HIV and AIDS. At the Cathedral of the Holy Trinity the epidemic might have remained ‘peripheral.’ For example, minutes of parish council meetings held on 24 April 2001,¹³⁵² August 2001,¹³⁵³ 2005 and 2006¹³⁵⁴ did not mention anything about HIV and AIDS. The items discussed as reflected in the minutes include electricity bills, church building repairs, choir, catechist classes and garden upkeep. Given the limited number of primary written sources, it might be unfair for the researcher to base the response of

¹³⁵⁰ DOMCCPM, Murray, DOMCCP director’s activity report, 7.

¹³⁵¹ DOMCCPM, Nyatsuro, DOMCCP-PGS activity report, 9.

¹³⁵² HTCM, Minutes of parish council meeting, 24 April 2001.

¹³⁵³ HTCM, Minutes of parish council meeting, 21 August 2001.

¹³⁵⁴ See HTCM, Minutes of parish council meetings, 15 March 2005, 17 May 2005, 21 June 2005, 28 June 2005, 23 August 2005, 20 September 2005, 27 September 2005, 18 October 2005, 13 December 2005, 17 January 2006, 17 February 2006, 21 February 2006, 25 April 2006, 16 May 2006 and 4 July 2006.

the cathedral parish to HIV from such sources. However, a general profile emanating from the present research study indicates that parish response to HIV showed that there were limited HIV interventions. The parish is also known to home to professionals from different trades including medical doctors and nurses, educationist as well as business people among others.¹³⁵⁵ It could be improper to speculate that most of the cathedral parishioners were not well enlightened on HIV and AIDS. The literacy levels in that parish were a reason to think that the church members could have been in a good position to understand the effects of HIV and AIDS on society. The Cathedral of the Holy Trinity appeared to have taken little initiative in responding to HIV and AIDS at the parish. The pandemic could have been perceived as a condition experienced by other people living elsewhere as well as the poor.¹³⁵⁶

The involvement of parishes in responding to HIV and AIDS also depended upon the enthusiasm shown by the laity and the clergy. At Kriste Mambo, Father Jimmy Nyangadi mentioned that from 2006 onwards an HIV and AIDS programme was initiated in which –seminars on HIV and AIDS were done under the auspices of family life teachings.”¹³⁵⁷ While this initiative was helpful to the members of the congregation, the denial of HIV and AIDS led some members of the Roman Catholic Church to leave the church. Former Catholics joined the Pentecostal and apostolic churches that claimed to heal AIDS. However, contrary to this development, the HIV pandemic did not dissuade some Roman Catholic married churchwomen from –faithfully keeping to their faith in Christ especially members of women’s guilds.”¹³⁵⁸ Some Roman Catholic married churchwomen resolved to discuss options for safe sex in cases whereby male spouses were suspected of being unfaithful. Between 2005 and 2007, some Roman Catholic married churchwomen persuaded their spouses to visit VCT sites.¹³⁵⁹ If the results from HIV tests were positive the couples visited the priest or at times decided on measures to be taken including the use of ARVs. Two respondents at St. Thomas’ Church, Nyahukwe mentioned that some married men

¹³⁵⁵ Information supplied to M. Mbona by A. Vinyu, Cathedral of the Holy Trinity, Mutare, 20 June 2010. See also G. Maedze, same interview.

¹³⁵⁶ G. Maedze, same interview.

¹³⁵⁷ J. Nyangadi, same interview.

¹³⁵⁸ C. Mauye, same interview. See also M. Mudzimiri, same interview.

¹³⁵⁹ T. Nyawera, same interview.

later realised the value of VCT, and the increased access to ART from 2007 onwards made that PLHIV to live longer than was the case in earlier years.¹³⁶⁰

In 2005, St. Paul's parish, incorporating St. Barnabas' church located in Dangamvura Area 13, witnessed the integration of HIV interventions in the parish's activities. HIV and AIDS became a regular topic for discussion in small group meetings and gatherings for different Roman Catholic guilds. The groups were designed according to age, sex and marital status of participants. This strategy was necessitated by the realisation that the pandemic's –sharp teeth claimed the lives of prominent parishioners.”¹³⁶¹ At the end of 2007 the parish established a committee known as –St. Paul's Home Health Education Service Programme” which became part of the formal parish structures in 2008.¹³⁶² A theological statement underpinned the committee's activities: –The body of Christ is sick physically, mentally and spiritually. If the church does not take care of AIDS, AIDS will take care of the church.”¹³⁶³ The programme of action had to bring together different skills, talents, knowledge and –caring hands' for use in responding to the healthcare needs of parishioners and the community at large. Despite the previous record of a collapsed HIV intervention initiative under the diocesan run AIDS care project, the clergy and the parishioners appeared enthusiastic to assist people infected and affected by the pandemic. Programmes such as HIV prevention through moral behaviour change, AIDS awareness, home-based care, nutrition, herbal treatment, VCT with support from the New Start Centre were functional.¹³⁶⁴ Locally identified experts including Cecilia Mukazi, a Roman Catholic nun and matron of S. Joseph's hospital¹³⁶⁵ facilitated at some the parish's HIV and AIDS seminars.

5.3. The Anglican Church's Response to HIV and AIDS

This section will explore the HIV and AIDS interventions carried out by the Anglican Church under the leadership of Bishop Bakare. The momentum set by Bishop Bakare

¹³⁶⁰ V. Chitabamoto, same interview and M. Mudzimiri, same interview.

¹³⁶¹ T. Nyawera, same interview.

¹³⁶² Information given by R. Musakwa to M. Mbona, St Paul's Dangamvura, 21 July 2010.

¹³⁶³ See St Paul's Dangamvura home health education service programme notebook kept at the parish.

¹³⁶⁴ T. Nyawera, same interview.

¹³⁶⁵ C. Mukasi, same interview.

in 1999 led to further significant input towards HIV and AIDS interventions at diocesan level between 2000 and 2007. This section will also indicate that medical personnel serving at the Anglican Church's healthcare institutions supported the Government's position on use of condoms in the prevention of sexually transmitted HIV. In this section, the researcher has demonstrated that the leadership of the Anglican Church in Manicaland expanded the number of its healthcare centres due to a need to respond to HIV and AIDS. The response to HIV and AIDS by the Anglican Church during this period will be discussed in the following order: the bishop and the diocesan synod, the Lay Training, Relief and Information Centre, prevention, treatment, home-based and OVC care, the Mothers' Union and the parishes.

5.3.1. Diocesan Leadership's Engages with HIV and AIDS

The HIV and AIDS interventions in the Anglican Church in Manicaland under Bishop Bakare came ahead of the initiative undertaken by the Council of Anglican Provinces in Africa CAPA in 2001.¹³⁶⁶ Ecclesiastically, the diocese is part of the Church of the Province of Central Africa, which is affiliated to the Council of Anglican Provinces in Africa. Within the Council of Anglican Provinces in Africa one of the first steps towards responding to the pandemic witnessed when the "All Africa Anglican Conference on HIV and AIDS" was held at Boksburg, South Africa in August 2001. That was followed by the establishment of the HIV and AIDS commission in December 2001 under the leadership of Archbishop Njongonkulu Ndungane of the Anglican Church of Southern Africa.¹³⁶⁷ The major outcome of the conference was that the Anglican Church in Africa undertook to carry out HIV and AIDS interventions that include: HIV prevention, pastoral care, counselling, home-based and OVC care, offer leadership in responding to the epidemic, and prepare people for death and dying.¹³⁶⁸ Whereas the commission endeavoured to be of assistance to the Anglican Church in Africa, dioceses operated as autonomous entities and thus carried out HIV and AIDS interventions independently. Some of the Anglican dioceses and church provinces in Africa including those from Zambia, Kenya and Uganda were

¹³⁶⁶ Anglican United Nations office, *Working together*, 5.

¹³⁶⁷ Anglican United Nations office, *Working together*, 5.

¹³⁶⁸ Anglican United Nations office, *Working together*, 13.

already ahead in responding to HIV and AIDS since the late 1980s. The HIV and AIDS interventions in the Anglican Church in Manicaland were initiated earlier than the programme started by the Council of Anglican Provinces in Africa.

A newly crafted mission statement for the diocese emphasised the social mission of the church. It was implicitly implied that the church's leadership has to respond to the needs of society by seeking to address HIV and AIDS, poverty and injustice.¹³⁶⁹ In line with tenets of the diocesan mission statement, the subject of HIV and AIDS occupied a central part of Bishop Bakare's first charge to synod of 5-7 May 2000 as was to be stated:

Unless it is involved in social and diaconal services, the church exists for itself and serves no purpose. One major concern is that of health. The body of Christ is afflicted with AIDS and its members are dying every day in great numbers. AIDS is here to stay unless we change our behaviour. We see this as part of our challenge and as a diocese [we] are responding by planning to increase the number of health centres already in operation. These centres will augment the work of Bonda Hospital and our clinics at St. Augustine's and St. Peter's Mandeya.¹³⁷⁰

The fact that at least HIV and AIDS was identified as a life and death issue showed the level of seriousness with which the diocesan leadership undertook to address the effects of the pandemic. This was to be followed by the channelling of diocesan resources towards HIV and AIDS interventions in a systematic way. Bakare also held the belief that ~~the~~ education of the clergy and the laity on the pandemic could lead to a transformation of people's attitudes.¹³⁷¹

The bishop's charge to synod served as a blueprint whose purpose included steering discussion towards the empowerment of local communities at Anglican parishes to launch HIV interventions:

These committees will help oversee the centre's work, which include dissemination of information, improvement in peer education,

¹³⁶⁹ HNM, Bishop S. Bakare's reflections on the mission of the church, circa 2000).

¹³⁷⁰ HNM, Bishop's charge to synod, Diocese of Manicaland ninth session of synod, Mutare 5-7 May 2000. See also SMAR, Rusape, The Rt Revd Dr S Bakare to my brothers and sisters Re HIV and AIDS in Zimbabwe, 15 October 1999.

¹³⁷¹ HNM, Bishop's charge to synod, Diocese of Manicaland ninth session of synod, See also K. Nyazika, same interview. See also Chimwaza, same interview.

counselling and referral. The major objectives of this effort are: to prevent initial infection of HIV/AIDS disease, to help alleviate the suffering of those infected by HIV/AIDS disease, and to foster the self-sufficiency of children orphaned by this disease through mentoring and provision of skills training.¹³⁷²

Within the Anglican Church in Manicaland, the first resolution on HIV and AIDS was passed at that synod of May 2000. This was close to two decades after AIDS became a worldwide pandemic and a severe threat to Zimbabwe. The highlights of the resolution stated that delegates at the diocesan synod agreed to recognise HIV and AIDS as a biomedical reality, that AIDS was the major cause of surges in recent deaths, that 25% of adults were living with the epidemic and that the diocese supports the work of the National AIDS Council.¹³⁷³ Bishop Bakare was appointed as one of the board members of this newly established council.¹³⁷⁴ Perhaps this was in recognition of Bakare's commitment to responding to the pandemic in Manicaland

While the resolution appeared progressive, it had some contradictions. On the one hand, the resolution undertook to respect the local cultural traditions and policies of the state in Zimbabwe. On the other hand, the same resolution called upon male members of the church to stop fuelling the epidemic through culturally justified concurrent sexual partnerships.¹³⁷⁵ Some of the Anglican married men hid behind culture to justify extramarital sexual relationships that often led to contracting of HIV. The same resolution also added that it was important for the Anglicans in Manicaland in general and men in particular to respect the rights of women including their choice of safe sex.¹³⁷⁶ The church's synod collectively declared its intention to reduce the spread of HIV by emphasising faithfulness and abstinence only. This strategy fell short of assisting married couples by not openly encouraging the prophylactic use of condom in case where one of the partners was HIV positive. Furthermore, the resolution proposed the formation of healthcare committees in all ecclesiastical division, the establishment of home-based care programmes and the care of widows

¹³⁷² HNM, Bishop's charge to synod, Diocese of Manicaland ninth session of synod.

¹³⁷³ SMAR, The Rt. Revd Dr. S. Bakare to my brothers and sisters Re Resolution of the Diocese of Manicaland on HIV and AIDS prevention, 26 September 2000.

¹³⁷⁴ SMAR, The Rt. Revd Dr. S. Bakare to my brothers and sisters Re Resolution.

¹³⁷⁵ SMAR, The Rt. Revd Dr. S. Bakare to my brothers and sisters Re Resolution.

¹³⁷⁶ SMAR, The Rt. Revd Dr. S. Bakare to my brothers and sisters Re Resolution.

and OVC by the church.¹³⁷⁷ In 2001, the leadership of the diocese engaged the services Chinouya, Musoro and O'Keefe from the Human Rights and Research Institute of London University to carry out a needs assessment study in relation to HIV and AIDS.¹³⁷⁸ The diocesan leadership used the findings of the said study as a basis to launch appeals for international donor funding towards the church's HIV and AIDS interventions.¹³⁷⁹

Some of the church's clergy held reservations about the bishop having to prioritise HIV and AIDS interventions ahead of other pressing needs. Consequently, this led to low-key HIV interventions at the parish level. This was despite the reality that HIV and AIDS affected Anglicans, other Christians and non-Christians too. For example, the fact that clergy spent long hours visiting the sick and burying the dead was a sign indicating that AIDS affected communities. It was out of this realisation that the leadership of the diocese took practical steps in empowering the clergy to confront denial, stigma and discrimination of the PLHIV. In this regard, regular workshops for the clergy were organised. At one of the workshops held at St. Augustine's mission in December 2001, the presentations drew similarities between people infected and affected by the pandemic with lepers in Jesus's time. This sensitised the clergy to the need for a ministry of compassion.¹³⁸⁰

A process of transforming the clergy's perception of the PLHIV and paving a way to the building up of positive attitudes towards AIDS-related care among Anglican Christians ensued. Some members of the church's clergy perceived HIV as being deadlier than leprosy and therefore they stigmatised the PLHIV. This perception was not new. Consistent with this observation, Niehaus referring to AIDS in South Africa, states that historically, the Christian missionaries in Africa evoked the biblical images of leprosy and helped to establish it as a maximal and very contagious illness in the minds of their African converts and this representation of leprosy still resonates today."¹³⁸¹ In September 2003 the clergy from the diocese and their wives also attended a retreat at which the participants were urged, to be proactive and not

¹³⁷⁷ SMAR, The Rt. Revd Dr. S. Bakare to my brothers and sisters Re Resolution.

¹³⁷⁸ Chinouya, *The Anglican Diocese of Manicaland*.

¹³⁷⁹ S. Bakare, same interview.

¹³⁸⁰ MM, P. Mvenge, "Pastoral care: A church's mission to the sick and underprivileged," Unpublished paper presented at a clergy workshop, (2000).

¹³⁸¹ Niehaus, "Leprosy of a deadlier kind," 318.

retroactive in responding to the HIV and AIDS pandemic in their respective parishes.”¹³⁸²

Bishop Bakare’s fortitude in responding to the pandemic in Manicaland was evident from his second “Charge to synod” delivered on 3 May 2002. Bakare reminded the delegates of what appeared to be obvious and yet not much had been done to date: “There may be some people who choose to ignore the cries of our people ... Fellow citizens are crying because they feel at a loss when HIV/AIDS claims the life of a beloved member of the family.”¹³⁸³ The fact that the bishop mentioned the harmful effects of HIV and AIDS served to express Bakare’s empathetic feelings that were accompanied by a show of pragmatism:

Works of mercy are therefore not optional but imperative. Thus the diocese has used its resources for the construction of three new health centres in order to combat the HIV/AIDS pandemic. When they become functional, they will serve as training centres for home-based care programmes as well as centres for dissemination of information and health education to complement on what our hospital at Bonda is doing.¹³⁸⁴

For example, in March 2000, St. David’s Bonda hospital was assisted by the diocese to launch a home-based care initiative called “Mukai” translated in English as “Wake Up or Awaken”¹³⁸⁵ This will be further discussed below (see sections 3.4 and 3.5 of the present chapter).

In February 2004, Bishop Bakare implored the members of the Anglican Church in Manicaland to be compassionate to people infected and affected by the HIV and AIDS pandemic.¹³⁸⁶ Similarly, in the *Ad-Clerium* issued at the beginning of Lent in 2004, the bishop had this to say: “There is no respect of life, which is demonstrated by those who inflict HIV/AIDS on their unsuspecting wives/husbands or partners, let

¹³⁸² MM, F. G Matongo, “The role of the church in advocacy,” Unpublished paper presented at an ADM priests and wives conference, Nyanga, 12-14 September 2003.

¹³⁸³ MM, Bishop’s charge to synod, Diocese of Manicaland tenth session of synod, 3 May 2002.

¹³⁸⁴ MM, Bishop’s charge synod, Diocese of Manicaland tenth session of synod.

¹³⁸⁵ M. Chikukwa, same interview. G. Mukaratirwa, same interview.

¹³⁸⁶ SMAR, Bishop S. Bakare, To all clergy, headmasters, churchwardens, and evangelists, *Ad-Clerum*, 4 February 2004.

alone defenceless minors.”¹³⁸⁷ Subsequently, Bishop Bakare’s Easter message of 2004 highlighted that it was imperative for the Anglican Church in Manicaland to make life bearable for PLHIV and OVC that were living in a state of endless isolation and misery.¹³⁸⁸ In Bishop Bakare’s third charge to synod held on 11-12 June 2004, the delegates were thus reminded:

The issue of HIV/AIDS remains an enormous challenge to all of us, whether infected or affected. We as a church have largely remained passive and are yet to break the silence that has engulfed this pandemic. We often choose to be judgemental and have thereby added to the stigmatisation of those infected with the virus.¹³⁸⁹

The message could have been underpinned by public perception that those who contracted HIV were promiscuous. Among Anglicans in some parts of Manicaland, AIDS had a history of being understood as punishment from God for the sin of sex.¹³⁹⁰ There was little change to the position that the PLHIV deserved the ordeal because they were sexually and spiritually unfaithful.

The diocesan leadership moved another step forward by mainstreaming HIV and AIDS interventions at the synod. The diocesan synod moved an unopposed motion in which thus reads:

That this synod declares HIV/AIDS as an emergency; and that there be HIV/AIDS mainstreaming in all programmes and activities of the diocese, HIV/AIDS policy formulated, all collections/offerings on the Sunday nearest to 1 December be used for diocesan HIV/AIDS programmes.¹³⁹¹

The resolution of 2004 was different from the previous one of 2000. The previous resolution permitted the diocese to be involved in HIV and AIDS interventions and the one for 2004 obliged the diocesan leadership, church members and institutions to invest time and resources in order to stem the tide of the pandemic. This meant that

¹³⁸⁷ SMAR, Bishop S. Bakare, To all clergy, headmasters, churchwardens and evangelists Re Lent the time of repentance, 17 February 2004.

¹³⁸⁸ MM, Bishop S. Bakare, To all clergy, churchwardens, evangelists and headmasters Re Easter message, 4 April 2004.

¹³⁸⁹ MM, Bishops charge to synod, Diocese of Manicaland eleventh session of synod, 11-12 June 2004.

¹³⁹⁰ M. Mushipe, same interview. See also Nyazika, same interview. See also Murakwani, same interview.

¹³⁹¹ MM, Diocese of Manicaland, Rules, Resolutions and motions of synod.

HIV interventions formed a critical aspect of activities at the church's parishes, schools and healthcare institutions. The new resolution also facilitated the formation of the diocesan HIV and AIDS commission comprised of eight commissioners including two members of the clergy and six lay Anglicans. Furthermore, the leadership of the Anglican Church in Manicaland also commissioned a research project for the purpose of encouraging people to disclose their HIV status. The findings from Chinouya's study published in 2007 indicated that Anglicans and other Christians in Manicaland need to overcome denial and stigma by –supporting families and communities in exercising their right to health and information on matters that affect their health, including the presence of HIV in their midst.”¹³⁹²

5.3.2. Diocesan HIV Interventions Rocked by Controversy

The church's leadership officially tasked the Lay Training, Relief and Information Centre to coordinate and implement the diocesan HIV and AIDS interventions. In 1999 a diocesan lay training centre was established at St. Augustine's mission with the mandate of assisting Anglicans to understand the biblical, doctrinal, liturgical, historical and sacramental aspects of the church. In 2000, the need to sensitise Anglicans in responding positively to HIV and AIDS created additional work for the centre. It became the hub of the diocesan training programmes for HIV and AIDS interventions as the bishop had to state:

Our people need education to help them change behaviours that put them at risk of becoming HIV infected. By offering education and support activities, we are not limiting our work to Anglican Church members only, but will serve communities at large.¹³⁹³

In August 2003, the centre expanded to include the relief and information portfolios and thus changed its name.¹³⁹⁴ One of the major tasks of the centre was to spearhead HIV interventions under relief and training. In compliance with Anglican Church rules, at the synod of June 2004, –The LATRIC [Lay Training, Relief and Information

¹³⁹² Chinouya, *TAURAI! (Communicate!)*, 8.

¹³⁹³ HNM, Bishop's charge to synod, Diocese of Manicaland ninth session of synod.

¹³⁹⁴ MM, Bishop's charge to synod, Diocese of Manicaland eleventh session of synod, Mutare, 11-12 June 2004.

Centre] was formerly accepted as a semi-autonomous service arm of the Diocese of Manicaland.”¹³⁹⁵ The bishop in consultation with the standing committee was responsible for the appointment of the board that comprised of eight members: three clergy and five lay persons at least two of who shall be women.”¹³⁹⁶ Things did not move on smoothly for the centre. The researcher, being the clergy in Manicaland, has been aware of ‘misgivings’ from some of the clergy who felt that the centre’s director and staff had more favourable working conditions than the priests.

The establishment of the centre had the intention of meeting some of the requirements made by the donor community. Some prospective donors were only prepared to provide funding earmarked for HIV interventions through a semi-autonomous organisation for the purposes of monitoring and accountability. Consistent with this observation, Oliver and Paterson had this to say: “It is common for funding streams and policy makers to demand specific information about timelines, scope and so on.”¹³⁹⁷ In April 2004, the centre hosted a series of skills-sharing workshops on HIV and AIDS. At workshops the participants were exposed to the following aspects: local trends in HIV and AIDS in Zimbabwe and abroad, the nature of local church interventions in Manicaland, and suggestions for holistic approaches in responding to the epidemic.¹³⁹⁸ The participants included forty people from different sections of the diocese namely, the Mothers’ Union, Vabvuwi, youth, medical personnel from diocesan healthcare institutions, members of religious communities, archdeacons, heads of school, HIV and AIDS centre managers from Munyaradzi, Mukai, Kubatana, as well as the centre’s staff. This initiative benefited from collaboration between the Lay Training, Relief and Information Centre and AIDS service organisations in Manicaland including FACT (Mutare), the National AIDS Council, Zimbabwe AIDS Network, Simakai and Padare/Men’s Forum on Gender.¹³⁹⁹

The work of the centre was negatively affected by the working relationship between the diocesan secretariat and the Lay Training, Relief and Information Centre’s director. In a report to the diocesan synod in 2004, the director hinted at the declining

¹³⁹⁵ MM, Diocese of Manicaland, LATRIC constitution, 2003.

¹³⁹⁶ MM, Diocese of Manicaland, LATRIC constitution.

¹³⁹⁷ Oliver and Paterson, “Religion and medicine in the context of HIV and AIDS,” 30.

¹³⁹⁸ MM, Anglican Diocese of Manicaland information release, May 2004.

¹³⁹⁹ MM, Anglican Diocese of Manicaland information release, May 2004.

relationship between the centre and other wings of the diocesan structure.¹⁴⁰⁰ A planning meeting held between 6 and 7 February whose purpose was to improve on the ailing relations appeared to have spilled the beans. The diocesan secretary's claim for travel expenses for the workshop in question caused mayhem as expressed by the director of the centre:

It was hoped that the two senior officers at the diocese would have more insight into the centre. Sadly only the diocesan secretary attended some, and not all sessions of the workshop. Two days after the workshop the diocesan secretary demanded that he be paid mileage for having come to the workshop. This was duly done, despite the fact that the rest of the participants were not paid anything.¹⁴⁰¹

Apparently, some of the funds used by the centre were outsourced from the USPG and other church partners in the UK, US and Canada. It seems that the discordant relationship was related to use and control of the newly launched diocesan FBO's funds. The director perceived the said claim as unjustifiable and, therefore, this affected the working relationship.

The operations of centre also came under the spotlight of State intelligence personnel. The situation was further exacerbated by a perception that the programmes initiated by the Lay Training, Relief and Information Centre were a threat to national security as noted:

Sadly, also is the fact that some officials in the Diocese of Manicaland have sent false information to the police and Central Intelligence Office to the effect that the relief centre was working to undermine the government of Zimbabwe. At this point it is important to mention that the staff at the Lay Training, Relief and Information Centre has suffered indifference, contempt and psychological harassment, outright contempt and sabotage from senior officers.¹⁴⁰²

¹⁴⁰⁰ MM, N. Mkaronda, LATRIC report to the Diocese of Manicaland eleventh session of synod, 11-12 June 2004.

¹⁴⁰¹ MM, N. Mkaronda, LATRIC report.

¹⁴⁰² MM, N. Mkaronda, LATRIC report.

The Anglican Church in Manicaland used its relief portfolio to provide care and support to displaced former farm workers notably in the Rusape area.¹⁴⁰³ This was in the form of food and shelter. This drew the interest of State security agencies mainly the police and the central intelligence organisation. The same relief programme catered for the needs of the PLHIV and OVC. This provided enough reasons for the State to be suspicious especially bearing in mind the fact that the churches could have used Christian humanitarian aid for other ulterior agendas.¹⁴⁰⁴ The ‘estranged’ relationship between the employees at the Lay Training, Relief and Information Centre, senior diocesan staff and the clergy undermined HIV and AIDS interventions.

While some challenges existed, the centre successfully assisted with the construction St. Werburgh’s clinic and paid staff salaries for 2004. In 2004 the centre also donated maize to over 2,000 families who were beneficiaries of the AIDS-related home-based care programme at Munyaradzi in Nyanga.¹⁴⁰⁵ Unfortunately, the interventions appeared unsustainable. The centre’s food assistance programme to HIV positive and children orphaned by AIDS was overwhelmed by demand. Lay people and clergy expected to receive funds for relief projects including HIV and AIDS interventions. Unfortunately, the centre’s funds were quite limited. The workshops and training programmes included HIV interventions. For example, between September 2004 and December 2005 workshops focused on basic counselling skills, AIDS and liturgy, support groups, self-reliance and the importance of VCT.¹⁴⁰⁶

The training earmarked to assist people to respond to HIV and AIDS was usually provided to members of the Anglican Church only and in a way that undermined its value to the community. In February 2006 the centre hosted a junior church council workshop at St. Augustine’s mission. Attendees came from St. David’s Bonda, St. Matthias Tsonzo, St. Mary Magdalene Nyanga, St. Anne’s Goto, St. Faith Rusape, and St. Augustine’s high schools.¹⁴⁰⁷ One of the major thrusts of the workshop was

¹⁴⁰³ MM, N. Mkaronda, LATRIC report. See also MM, The LATRIC information desk, *Anglican Diocese of Manicaland newsletter*, (2004), 6.

¹⁴⁰⁴ For a thorough discussion on this see Bornstein, *The spirit of development*.

¹⁴⁰⁵ MM, N. Mkaronda, LATRIC report.

¹⁴⁰⁶ SMAR, V. Mkaronda LATRIC to all clergy and evangelists Re training programmes for 2005, 24 March 2005.

¹⁴⁰⁷ MM, M. N. Mbwando, LATRIC principal tutor to heads of schools and chaplains Re junior church councillors’ workshop, 1 February 2006.

the focus on HIV prevention among the youth. The junior church councillors were to initiate peer educators' programmes in their respective schools.

5.3.3. HIV Prevention Strategy Wrapped in Ambiguity

One of the rare undertakings by the Anglican Bishops of Zimbabwe, including Bishop Bakare, was the issuing of a joint pastoral letter that covered the topic of HIV and AIDS. This was done at the Bernard Mizeki Festival on 16 June 2001.¹⁴⁰⁸ Part of the pastoral letter stated:

Recent predictions indicate that Zimbabwe will achieve zero growth next year because of the HIV/AIDS pandemic. This is causing untold suffering to families, communities and the nation as a whole. Africa now has a total of 23 million orphans and most of these are in the sub-Saharan region. Zimbabwe is one of the leaders in the spread of this pandemic. Besides the human suffering, this pandemic has a disastrous effect on health delivery and economy. The solution is not in the free distribution of condoms or the frantic search for a cure but in teaching of sound Christian behaviour. The moral decay of our society must be harnessed.¹⁴⁰⁹

While the bishops acknowledged the devastation caused by the pandemic, their attitude towards the prophylactic use of condoms was less helpful. In the short term it was a publicly known fact that the consistent, constant and correct use of condoms reduces the spread of sexually transmitted HIV. The same letter also carried an embracing theology towards PLHIV that noted: "HIV/AIDS is not a punishment from God but we must accept that 99% of that is through sin. The church has on numerous occasions been accused of letting the nation down and there is some measure of justification in such a statement."¹⁴¹⁰ This did not automatically translate into the acceptance of the PLHIV by some church members at the grassroots.

¹⁴⁰⁸ Bernard Mizeki was an accomplice of Bishop Knight-Bruce who was martyred by the Mangwende people near Marondera on 18 June 1998. Each year on a Saturday close to 18 June Anglicans mainly from the Church of the Province of Central Africa and Mozambique gather at the shrine to celebrate his life. See also Weller, *Anglican Centenary in Zimbabwe*, 12-13.

¹⁴⁰⁹ SMAR, Anglican bishops in Zimbabwe pastoral letter to the Anglican community in Zimbabwe delivered on the occasion of the Bernard Mizeki festival, 16 June 2001.

¹⁴¹⁰ SMAR, Anglican bishops in Zimbabwe pastoral letter to the Anglican community.

The leadership of the Anglican Church in Manicaland held the position that the only way to stop the spread of the epidemic was through moral behaviour change. In September 2001 Bishop Bakare invited Rosemary Munaki, the Zimbabwe Council of Churches Youth desk officer, to conduct a seminar on moral behaviour change and HIV prevention. Six clergy and ten secondary school teachers from within the diocese attended the seminar. Munaki insisted on moral behaviour change and strongly condemned the use of condoms in preventing sexually transmitted HIV: –Since the onset of the AIDS pandemic condoms are being pushed on by governments, as advertised in the media, and promoted in every walk of life as the answer to prevent the further spread of AIDS.”¹⁴¹¹ Latex condoms commonly accessible to the public in Zimbabwe had some limitations and generally the leaders of churches were reluctant to recommend their use in the prevention of sexually transmitted HIV. The moral behaviour change model advocated for by the Zimbabwe Council of Churches resonated well with the approaches followed by the Roman Catholic and United Methodist Church in Manicaland. However, the limited number of workshops on HIV and AIDS interventions at diocesan level could have affected intended outcomes. At the diocesan level the lack of HIV prevention education programmes for the out-of-school youth exposed young people to risks of contracting HIV.

In-school youth in attendance at diocesan schools took the initiative of raising HIV and AIDS awareness and prevention among peers and the community. AIDS clubs located at St. Faith’s, St. David’s Bonda, St. Mary’s Magdalene and St. Augustine’s and other high schools in Manicaland and nationally used to explore the advantages and disadvantages of using condoms for the prevention of HIV.¹⁴¹² The FACT and National AIDS Council jointly initiated AIDS clubs that held symposiums within Manicaland and nationally.¹⁴¹³ According to the November 2002 publication of *Partners: The Journal of the Transvaal, Zimbabwe and Botswana Association*, the secretary acknowledged the interest in AIDS shown by students at two Anglican

¹⁴¹¹ MM, R. Munaki, ZCC programme officer, —AIDS prevention and the condom,” Unpublished paper presented at the workshop on behaviour change, hosted by the Diocese of Manicaland, (September 2001).

¹⁴¹² S. Bakare, same interview. See also O. M. Kanyere, same interview.

¹⁴¹³ This is based on the experiences of the researcher as a chaplain and teacher at St. Faith’s high school where a thriving FACT club existed and won the national AIDS quiz competition several times between 2001 and 2006.

Church schools including St. David's Bonda Girls high in Manicaland and Bernard Mizeki College (Anglican Diocese of Harare). It was reported:

We hear that young people are setting up HIV/AIDS clubs to inform and educate themselves on the risks and ways to avoid the HIV infection. They feel their parents are not giving them the knowledge, information and help although all families and friends are losing relatives.¹⁴¹⁴

The article was written with the intention of highlighting the need to support HIV and AIDS interventions in Zimbabwe. The AIDS clubs in the church's schools sensitised the students and staff on HIV and AIDS. The researcher served at St. Faith's mission between 2001 and 2007 and is therefore aware of the activities carried out by the school AIDS clubs.

At St. David's Bonda, members of the school AIDS club positively influenced married churchwomen's perception of condoms. In 2005, some married churchwomen gradually started to explore how they could convince their husbands to accept the use of condoms for the prevention of sexually contracted HIV.¹⁴¹⁵ This came after the school AIDS club hosted seminars for the community and explored various ways of preventing HIV. The change became a breakthrough in the response to HIV and AIDS. However, pockets of resistance at the use of male and female condoms among some members of the Mother's Union guild in Manicaland still existed. This was noted in August 2005 at a diocesan Mothers Union conference held at St. Augustine's. A guild member from St. Daniel's Mupotedzi in Honde Valley intercepted a presentation on HIV prevention. She insisted that using condoms disturbed her sexual crave: *-Ini zvekondomu handidi. Ndinofa ndadya.* (I am uncomfortable with the use of condoms. I am not scared to die of AIDS).¹⁴¹⁶ It is important to note that the ambiguity shown by some members of the Mothers' Union on the prophylactic use of condoms undermined any effort at reducing sexually contracted HIV. This shows that there was a dichotomy on which approach could be

¹⁴¹⁴ P. Dutton, "Secretary's notes," *Partners: The Journal of the Transvaal, Zimbabwe and Botswana Association: News of the Anglican Church in Zimbabwe, Botswana and the Transvaal* XVII, 3 (November 2002), 3.

¹⁴¹⁵ G. Mukaratirwa, same interview. See also M. Chikukwa, same interview, M. Nyakani, same interview.

¹⁴¹⁶ C. Mbona, information supplied to M. Mbona, Rusape, 14 June 2010. See also M. Nyamwena, same interview. See also K. Nyazika, same interview.

‘acceptable’ for the prevention of HIV within the Mothers Union guild in Anglican Church in Manicaland.

In 2002, St. David’s Bonda hospital rolled out PMTCT and VCT services. This was achieved mainly through support from ZACH.¹⁴¹⁷ The new services increased workloads for staff serving at the diocesan healthcare centre. In 2003 the staffing situation became worse after the departure of McNally, having served the hospital for twelve years.¹⁴¹⁸ Service delivery was dealt a blow because qualified medical doctors were very scarce in Zimbabwe at that time. In June 2004, a report by Roseline Chasakara, the matron at St. David’s Bonda hospital, stated that the PMTCT and VCT services enhanced holistic clientele satisfaction.¹⁴¹⁹ While this was the case, the additional HIV and AIDS-related facilities exerted pressure on the hospital. The hospital handled referrals from forty-seven clinics in Mutasa District. The situation improved later when PMTCT and VCT were also initiated at some of the clinics in Mutasa. For example, In 2005 St. Augustine’s clinic rolled out PMTCT and VCT services which was achieved through the initiative of ZACH.¹⁴²⁰ Crucial HIV prevention interventions available at the Anglican Church healthcare centres were disposable to members of the public. Thus HIV and AIDS transformed the structures and services that were made available to the community through the church’s healthcare centres.

5.3.4. The Treatment of AIDS-Related Illness

Between 2000 and 2007 the HIV and AIDS pandemic led to the expansion of diocesan healthcare services. The new clinics at St. Werburgh’s and Munyaradzi became functional and offered services to PLHIV. The clinic at Nedziwa was constructed and by 2010 was awaiting electrification.¹⁴²¹ The diocesan leadership

¹⁴¹⁷ MM, R. Chasakara, –St. Davids Bonda hospital report,” Diocese of Manicaland eleventh session of synod reports. See also M. Chikukwa, same interview.

¹⁴¹⁸ Faculty of Health Sciences, *The CATHARTIC*, University of Cape Town, (2007), 15. See also M. Chikukwa, same interview.

¹⁴¹⁹ MM, R. Chasakara, –St. David’s Bonda mission hospital report.”

¹⁴²⁰ MM, –St. Augustine’s clinic report,” Diocese of Manicaland eleventh session of synod reports.

¹⁴²¹ M. Mushipe, same interview. S. Bakare, same interview.

took the initiative to strengthen the church's impact on the pandemic. For the first time at the diocesan synod of 2000, the report on St. David's Bonda hospital stated that HIV and AIDS led the pack of common ailments treated at the healthcare centre.¹⁴²² Cordial relationships between Bishop Bakare and diocesan healthcare centres made HIV interventions easier.¹⁴²³ The establishment of the Mukai home-based care community centre at the hospital in March 2000 placed the hospital in a new position in relation to AIDS mitigation.¹⁴²⁴ In Zimbabwe between 2000 and 2007, the healthcare system in general, including HIV and AIDS prevention services were affected by:

...low donor funding. ...The inflationary pressures arising from the drought, low economic growth, high fuel prices on the international market and high HIV and AIDS disease burden has negatively affected the effective response to HIV and AIDS in Zimbabwe.¹⁴²⁵

This put an additional strain on St. David's Bonda hospital, which at that time also served as the district hospital for Mutasa.¹⁴²⁶ The general shortage of AIDS-related treatment drugs undermined the capacity of the diocesan healthcare centres to respond effectively to the needs of PLHIV.

The general shortage of resources including funding affected the service delivery at St. David's Bonda hospital. However, this situation was common throughout the country. In 2002, Susie Steyn of USPG writing in the publication *Transmission* reported that at St. David's Bonda mission parents and teachers were not speaking enough about HIV prevention and thus local teenagers in the high school took the matter into their own hands...and were speaking openly and honestly, without fear of reprisal."¹⁴²⁷ This publicity was important to USPG's fund-raising activities and in

¹⁴²² HNA, M. McNally, "St. David's Bonda hospital report," Diocese of Manicaland ninth session of synod reports, 43.

¹⁴²³ M. Chikukwa, same interview.

¹⁴²⁴ S. Bakare, same interview. See also M. Chikukwa, same interview.

¹⁴²⁵ WHO, *United Nations General Assembly (UNGASS) report on HIV and AIDS*, 35. Accessed as pdf. See also Madzingira, "The Zimbabwe national AIDS levy trust," 33. See also V. Chitimbire, same interview, See also M. Chikukwa, same interview, See also T. Manyeza, same interview.

¹⁴²⁶ M. Chikukwa, same interview. See also MM, "Diaconal commission report," Diocese of Manicaland eleventh session of synod reports. See also MM, R. Chasakara, "St. David's Bonda mission hospital report."

¹⁴²⁷ S. Steyn, "Students lead bravely where parents fear to tread," *Transmission* (Autumn 2002), 5.

turn benefited St. David's Bonda hospital. Apparently, USPG has been a donor for the hospital for many years.¹⁴²⁸ As Steyn was to state:

You can learn more about HIV/AIDS work in Manicaland by supporting USPG project 262: St. David's hospital, Bonda in Zimbabwe. In 2002, USPG is giving £14,850 to this Anglican mission hospital, where at least a quarter of the patients are HIV positive.¹⁴²⁹

Further financial support to the hospital by USPG was highlighted in a report submitted to the diocesan synod of 2004.¹⁴³⁰ Financial grants that were received by the hospital from USPG and other donor organisations including Plan International were important in ensuring procurement of food for patients, fuel, drugs, and other overheads expenses. The USPG funded HIV interventions in a number of Anglican dioceses in countries across sub-Saharan Africa. For example, between 1992 and 2003 the Anglican Church in Malawi received £40,000 for HIV prevention interventions at four church hospitals.¹⁴³¹ Similarly, in 2003 the Anglican Church of Southern Africa received £65,000 for HIV and AIDS interventions,¹⁴³² and the Anglican Church of Ghana also received £14,000 for its HIV and AIDS-related programmes.¹⁴³³

The delayed roll out of ART at St. David's Bonda hospital weakened its credibility as a healthcare centre of eminence. St. David's Bonda hospital only received approval from the State to be a site for the roll out of ARVs in 2007. This development restored its image as a reputable healthcare centre in Manicaland. The hospital became one of the earliest beneficiaries of the Global Fund to Fight AIDS, Tuberculosis and Malaria Round One for Zimbabwe. This initiative was achieved through ZACH, which was then a principal recipient.¹⁴³⁴ The incurable nature of AIDS and the delayed roll out of ART affected Dr Denys Taylor's legacy at the hospital. Taylor worked at the

¹⁴²⁸ M. Chikukwa, same interview.

¹⁴²⁹ M. Chikukwa, same interview. See also MM, Diaconal Commission, "Diaconal commission report," Diocese of Manicaland eleventh session of synod reports. See also MM, R. Chasakara, "St. Bonda mission hospital report."

¹⁴³⁰ MM, R. Chasakara, "St. David's Bonda hospital report." See also M. Chikukwa, same interview.

¹⁴³¹ J. Treadwell, "Women in Malawi struggle to support their children," *Transmission* (Spring 2003), 6.

¹⁴³² J. Self, "The church is battling with AIDS in South Africa," *Transmission*, 6.

¹⁴³³ J. Okine, "Church needs to discuss AIDS," *Transmission*, 7.

¹⁴³⁴ V. Chitimbire, same interview. See also M. Chikukwa, same interview. See also The Global Fund, *Report on the involvement of faith-based organisations in the Global Fund*, (2008), 32.

hospital between 1937 and the early 1970s. He was an Anglican priest and a trained medical doctor who exuded great prowess in his days at St. David's Bonda hospital. Members of the public were tempted to think that the current medical doctors at Bonda were inferior to the legendary Dr Taylor."¹⁴³⁵ The hospital's former glory has been restored by its programme that provides ARVs to HIV positive people regardless of the ability to pay as well as the place of origin."¹⁴³⁶ Generally, people in Zimbabwe have high regard for church healthcare centres and the roll out of ARVs at these sites was celebrated. Similarly, Chitimbire stated: "The people trusted ZACH and church hospitals because there is transparency unlike state hospitals where corruption led to the swindling of ARVs by staff members because of high demand."¹⁴³⁷ The roll out of ART at St. David's Bonda hospital provided an essential and convenient healthcare service to rural communities who lived far away from Mutare.

5.3.5. Expansion of AIDS-Related Care Interventions

In March 2000, Magna Chikukwa of St. David's Bonda hospital was appointed by Bishop Bakare to manage the Mukai home-based care project.¹⁴³⁸ However, compared to others in the same area, the intervention came eight years later than those under the neighbouring Roman Catholic Church's healthcare system. The centres included Triashill, St. Babra's and Regina Coeli and Mt. Mellery. They initiated home-based care since 1992.¹⁴³⁹ In 2004, at the diocesan synod Chasakara reported that the Mukai home-based care centre received financial and material support from Plan International and the Mutasa district health office: "HBC kits remain a problem to replenish. However, the district tries its best now and again to provide any available logistics such as drugs, HBC kits, soap and Vaseline with the support of Plan International."¹⁴⁴⁰ In 2005 Mukai was faced with a funding crisis. Thus, the AIDS-

¹⁴³⁵ M. Chikukwa, same interview. See also S. V. Humphrie, "Bsh hospital, (The)," *The annals of the royal college of surgeons of England* 49, 6 (December 1971), 356. <<http://www.ncbi.nlm.nih.gov/pmc/articles/pmc2388046/pdf/>> [Accessed 7 October 2011].

¹⁴³⁶ M. Chikukwa, same interview.

¹⁴³⁷ V. Chitimbire, same interview.

¹⁴³⁸ M. Chikukwa, same interview.

¹⁴³⁹ See also DOMCCPM, Evaluation report.

¹⁴⁴⁰ MM, R. Chasakara, "St. David's Bonda hospital report."

related care interventions came under siege. The project's donors appeared to have withdrawn their support. The NGO Act of 2004 led to a deterioration of the situation as mentioned by Chikukwa: "Our donors dropped and we had no supply of home-based care kits. We had no supplementary food to give to people living with HIV and there was no fuel for the hospital ambulances that we used for the outreach activities."¹⁴⁴¹ Local fundraising activities to support people infected and affected by the pandemic were affected by general poverty in Zimbabwe. A countrywide looming economic crisis undermined the home-based care initiative. Without external donor funding AIDS-related care interventions at Mukai had to be closed down.

The communities around Bonda launched a new OVC intervention in June 2005. The Chiedza Community Based Orphan Welfare Organisation emerged as a response to the hardships faced by OVC and received its funding from the Bonda Art and Craft Centre (BACC) formed in 1992.¹⁴⁴² Until 2005 the craft centre focused on economic empowerment of women from the local community some of who were living with HIV. According to Gladys Mukaratirwa, the director craft centre and also the coordinator of the Chiedza orphan care project, 25% of the sales from each member's art and craftwork are donated towards the care of OVC.¹⁴⁴³ Unlike other AIDS-related organisations that entirely depend on external donor support, this intervention benefited from resources generated by local people. This strategy was not affected by the economic decline because the art and craft products were highly marketable in countries such as the US, Canada, UK and Germany."¹⁴⁴⁴ The success of the intervention was seen in the increase in the number of educational beneficiaries from 32 OVC in 2005 to 129 in 2007. Those who received medical and nutritional supplies also increased from 45 OVC in 2005 to 68 in 2007.¹⁴⁴⁵ The project, located in ward twelve of Mutasa district, spread its tentacles to primary and high schools, the orphanage at St. David's Bonda and communities from surrounding areas. These include St. Gabriel Chirarwe, Sadziwa and Musodza. However, given the obvious

¹⁴⁴¹ M. Chikukwa, same interview.

¹⁴⁴² G. Mukaratirwa, same interview.

¹⁴⁴³ G. Mukaratirwa, same interview. See also Bonda Art and Craft Centre archives, Bonda, (BACCB), Chiedza community based orphan welfare, presentation at the XVI International AIDS conference, Toronto Canada, 17 August 2006.

¹⁴⁴⁴ G. Mukaratirwa, same interview. See also M. Nyakani, same interview.

¹⁴⁴⁵ BACCB, Chiedza community based orphan welfare, presentation at the XVI International AIDS conference.

rapid increase of OVC in Manicaland, the intervention only served a small fraction of those in need.

The Kubatana home-based care programme at St. Augustine's clinic was fundamental to the clinic's services. In 2004 George Madziwanyika, sister in charge of the clinic stated:

The clinic trained 24 home-based caregivers in August in 2002 with help from the ZACH. There was an in-service training in October 2003 with the help again from the ZACH. The clinic and the CHBC [Community Home-based Caregivers] are working hand in hand to alleviate the HIV/AIDS pandemic in the communities.¹⁴⁴⁶

St. Augustine's clinic was not spared from the hardships that affected the public healthcare system in Zimbabwe in general. Under these conditions, ZACH became a lifeline for HIV and AIDS interventions at St. Augustine's clinic: "[The] ZACH is really helping us with drugs and medicines for home-based care patients, a gesture we encourage to continue."¹⁴⁴⁷ Between 2000 and 2007, ZACH was instrumental in outsourcing financial and other forms of support in order to bail out the public healthcare system in Zimbabwe in general including HIV interventions in Manicaland. According to Chitimbire, a plan was designed to ensure that at least one healthcare centre belonging to member churches rolled out one HIV and AIDS intervention programme. This became possible through funding from the Centre for Disease Control and the World Bank.¹⁴⁴⁸ It therefore follows that part of the credit for church-led AIDS-related treatment in Manicaland goes to ZACH.

Diocesan efforts at establishing home-based care centres were met with mixed feelings. On the one hand, the projects received limited State support because they were perceived as undermining the Government. The lack of State support for Nedziwa clinic delayed the opening of the new healthcare centre.¹⁴⁴⁹ On the other hand, in 2010 the National AIDS Council's officer for Makoni district applauded Bishop Bakare for the upcoming clinic at Nedziwa. Both the community and the

¹⁴⁴⁶ MM, G, Madziwanyika, "St Augustine's clinic report," Diocese of Manicaland eleventh session of synod reports.

¹⁴⁴⁷ G, Madziwanyika, "St Augustine's clinic report."

¹⁴⁴⁸ V. Chitimbire, same interview.

¹⁴⁴⁹ S. Bakare, same interview.

National AIDS Council found this clinic to be a healthcare asset.¹⁴⁵⁰ An increase in the number of healthcare centres in Manicaland strengthened the province's response to the pandemic. The diocesan initiated home-based care projects could have increased the visibility of the Anglican Church in Manicaland especially in communities where such projects were located. Consistent with this observation, Prince and others have asserted:

While the involvement of religious institutions in welfare, education and health services is not a new phenomenon in Africa, The experience of HIV/AIDS is contributing to the popularity of Christian values in public life: values of love, brotherhood, equality and honesty.¹⁴⁵¹

Anglican Church agencies based overseas used the church's networks to benefit PLHIV. Donations of materials for AIDS-related care benefited the Anglican dioceses of Manicaland and Central Zimbabwe. For example, in 2002 Jill Hetherington from London made an appeal for:

...blankets, buckets, disinfectant rubber gloves and dressings, which are urgently needed by the village home carers in Manicaland and Central Zimbabwe...and TZABA sends this out to the Bishops concerned, together with about £2 000 received in other donations.¹⁴⁵²

5.3.6. Responses to HIV and AIDS at the Grassroots Level

Between 2000 and 2007 some of the Anglican Church's parishes stepped up HIV and AIDS interventions. While initially there had been a slow uptake of HIV and AIDS interventions at the Cathedral of St. John the Baptist in Mutare,¹⁴⁵³ the epidemic brought some parishioners from denial and stigma to a position of meaningful engagement with the pandemic. In 2002, some of the parishioners changed from a position of denial, silence, stigma and discrimination to that of acceptance, disclosure and embracing of PLHIV. The changes were witnessed after the appointment of the

¹⁴⁵⁰ H. T. Muchinako, interview conducted by M. Mbona, Makoni district NAC office, Rusape, 11 January 2011.

¹⁴⁵¹ Prince, "Introduction to special issue," ix.

¹⁴⁵² J. Hetherington, "You CAN help AIDS Patients in Zimbabwe", *Partners*, 24. See also I. Mukuwanda, "Response to Michael Mbona's email: Diocese of Central Zimbabwe, PATHAIDS, 23 February 2011.

¹⁴⁵³ See HNM, Minutes of the Cathedral of St John the Baptist vestry meeting, 26 February 2001.

Reverend Erick Ruwona as the new dean in 2000. Ruwona is one of the few clergypersons from the Anglican Church who together with Bishop Bakare preached and taught the parishioners at the cathedral about the importance of AIDS-care and compassion.”¹⁴⁵⁴

Whereas this change might have been welcome to some members of the parish, others resisted the hanging of the red ribbon at the main entrance of the cathedral. This move became a public sign by the parish to show its solidarity with HIV positive people. Some members of the parish argued that the red ribbon could be misconstrued by passers-by to suggest that the members of the parish were HIV positive.”¹⁴⁵⁵ In January 2005, the Cathedral of St. John the Baptist declared its status as a drop-in-centre for the PLHIV and OVC.¹⁴⁵⁶ This initiative received funding from the International Migration Organisation, local donations and some members of the parish volunteered to participate in the programme.¹⁴⁵⁷ Apparently, clergy’s attitude towards HIV and AIDS had a bearing on parishioners’ reaction to the pandemic.

At Holy Name, Sakubva positive and negative responses to the pandemic at the parish level were found. According to the copies of the minutes of the parish council meetings,¹⁴⁵⁸ and financial statements¹⁴⁵⁹ for the period 2000-2005, HIV and AIDS was not discussed at that level. However, in 2001 Lovemore Magwere’s friends living in the UK assisted the parish with a donation towards fees for OVC.¹⁴⁶⁰ Magwere was a parishioner at Holy Name who could have been sympathetic to OVC from Sakubva. Similarly, in June 2002 Holy Name parish received an amount of £280 from the Reverend Martin Preston and Friends of Holy Name in England.” This money

¹⁴⁵⁴ M. Mafulela, same interview. See also S. Bakare, same interview.

¹⁴⁵⁵ M. Mafulela same interview.

¹⁴⁵⁶ SMAR, H. Simbi and M. Mafulela to the Revd Matyatya Re St John Cathedral HIV/AIDS and friendly drop-in-centre launch, 3 January 2005.

¹⁴⁵⁷ S. Sebastian, same interview. See also M. Mafulela, same interview.

¹⁴⁵⁸ HNM, Holy Name, Sakubva, Minutes of parish council meetings, 20 August 2000, 10 September 2000, 14 October 2000, 1 November 2000, 21 January 2001, 25 February 2001, 11 March 2001, 5 May 2001, 18 November 2001, 17 February 2002, 4 March 2002, Minutes of vestry meeting, 2000, Minutes of parish council meeting, 22 March 2004, 8 May 2004, 25 July 2004, 19 September 2004, 24 October 2004, 16 January 2005, 12 June 2005 and 10 July 2005.

¹⁴⁵⁹ See HNM, Holy Name Sakubva, Income and expenditure for January 2000, Income and expenditure for May 2000, and Proposed budget statement for 2001.

¹⁴⁶⁰ HNM, Holy Name, Minutes of parish council meeting, 15 July 2001.

targeted needy children.¹⁴⁶¹ The parish's expenditure records indicate that in July 2002 school fees for OVC were paid to Elise Gladhill, Mutare Boys, Dangamvura, Mutare Girls, Hilltop Study Centre, Sakubva 1, Sakubva 2, Nyakuipa, Nyamajura, Theydon high schools and Zamba, Mutanda, Dangare, Gombakomba and Chisamba primary schools all in Manicaland.¹⁴⁶² In 2003, a total of Z\$122,925 was paid as second term fees at the same schools and a list of beneficiaries appeared.¹⁴⁶³ The noble initiative faced threats of sustainability because most of the parishioners at Holy Name were economically impoverished. HIV and AIDS interventions largely remained at the periphery of the parish council activities.

At St. Matthew's Vengere, Rusape, HIV and AIDS interventions remained at a low key. Minutes of parish council meetings, reports by church office bearers and other related documentation painted a grim picture.¹⁴⁶⁴ The parish's lay leadership appeared to have maintained a low profile in responding to the pandemic. However, this was not to suggest the parishioners were not either infected or affected by AIDS. In 2003, the parish's lay leadership expressed their concerns at declining financial resources as families struggled to give towards the parish. Part of the churchwarden's report read: –Many families have single parents and some are child-headed families due to the high death rates year after year. The pinch is felt when advocating for healthy church giving.”¹⁴⁶⁵ The churchwarden's noted that parishioners were dying in large numbers and used the platform to highlight concerns over the church's declining revenue. This gave the impression that the financial needs of the parish were more important than the welfare of parishioners who could have been infected and affected by the HIV and AIDS pandemic.

¹⁴⁶¹ HNM, Holy Name, Minutes of parish council meeting, 9 June 2002. See also HNA, Obert J. Murakwani and Grey J. Mwale to Revd Martin Preston Re acknowledgement of gift, 2 June 2002.

¹⁴⁶² HNM, Holy Name, Statement of expenses for July 2002.

¹⁴⁶³ HNM, School fees payment vouchers and receipts from receiving schools, number 69/03- 85/03, all dated 7 May 2003.

¹⁴⁶⁴ See SMAR, O. Chikandiwa, Archdeacon's letter to all churchwardens and priests, 21 March 2000, 11 April 2000, 17 May 2000. See also E. Hwata, Annual report for 2001. See also Youth chairperson's report for March 2001 to January 2002, Minutes of parish council meeting, 6 February 2002, Minutes of the vestry meetings, 27 January 2002, 19 January 2003, 25 March 2004, Churchwarden's report 2000, Receipts and payments, January-December 2002, Minutes of parish council meeting, 11 December 2005, 29 April 2007, 23 August 2007, 28 October 2007, 16 December 2007.

¹⁴⁶⁵ SMAR, B. L. Dipura, St Matthew's Vengere, Churchwarden's report to the parish, 2003.

However, it appears that the appointment in 2000 of the Reverend Elinos Hwata as rector of St. Matthews introduced new ways of responding to the pandemic. Hwata was one of the few church leaders in Rusape who collaborated with AIDS service organisations including FACT (Rusape).¹⁴⁶⁶ In 2003, Hwata took the initiative of embracing single mothers some of who were HIV positive.¹⁴⁶⁷ A parish welfare committee existed at St. Matthews but they did little to openly assist people infected and affected by epidemic. One of the reasons for this was that members of the parish were generally in a state of denial about their HIV status and that AIDS was never mentioned as the cause of death.¹⁴⁶⁸ This could have affected the level of assistance given to PLHIV and OVC by the congregation and the priest.

Between 2000 and 2006 Ruth Bakare served as president of the Mothers' Union of the Anglican Church in Manicaland. Ruth Bakare mentioned that the church, including the Mothers' Union guild and the clergy, could have done more work in educating the members of the guild in particular and the Anglicans in general about the pandemic.¹⁴⁶⁹ In 2001, the diocesan Mothers' Union guild focused on African cultural and traditional beliefs and practices that undermined the status of women and in turn were responsible for fanning HIV. In her message as Bakare called upon the members of the Mothers' Union to show solidarity with widows many of who were infected and affected by HIV and AIDS.¹⁴⁷⁰ Young widows were stigmatised by society because they were suspected of having killed their husbands. Within the Anglican Church, this perception was not new. Some of the members of the Anglican Church in Manicaland thought of Christian widows as having killed their husbands and were victims of the killer disease *shuramatongo* or AIDS.¹⁴⁷¹ An escalation in the number of young widows made the leadership to review the rules of full membership. In 2001 the age at which formerly married Anglican widows could be admitted into full membership was reduced from sixty to forty years.¹⁴⁷² In addition to that, the

¹⁴⁶⁶ M. Temberere, interview conducted by M. Mbona, FACT, Rusape centre, 20 August 2010.

¹⁴⁶⁷ SMAR, E. Hwata, Annual report for 2003.

¹⁴⁶⁸ J. Mavhima, same interview.

¹⁴⁶⁹ R. Bakare, interview conducted by M. Mbona, Murambi East, Mutare, 16 August 2010.

¹⁴⁷⁰ MM, R. Bakare, Speech on Mary's Day 2001: Theme: Your story is our Story, MM. See also a similar message in 2002, MM, R. Bakare, MU diocesan president's speech on Mary's Day, 25 March 2002.

¹⁴⁷¹ M. Nyamwena, same interview. See also J. Chimwaza, same interview.

¹⁴⁷² SMAR, R. Bakare, Message from the MU president, Manicaland, August 2000. See also R. Munakamwe, same interview. See also C. Mbona, information supplied to M. Mbona, Rusape in 2010.

pandemic led the leadership to consider educating Anglican churchwomen on their legal rights. For example, in 2001 at St. Anne's Goto, Anglican churchwomen were exposed to education on legal rights of women in Zimbabwe.¹⁴⁷³

In 2001, practical steps were taken in order to ensure that some widows and orphans were cared for. The diocesan Mothers' Union office received foreign donations worth Z\$146,709 and paid out Z\$46,415 as school fees towards orphans.¹⁴⁷⁴ Ruth Bakare's encouraged her fellow sisters to start OVC care interventions at local parish level. Support groups were thus established at Chikanga, Mufudziwakanaka, St. John's Cathedral and St. James' Zongoro.¹⁴⁷⁵ In 2002, the diocesan committee received a donation from the Mothers' Union guild worldwide office in London. This was earmarked for support of grandparents caring for children whose parents died from AIDS-related diseases and as well as child-headed households.¹⁴⁷⁶ Unfortunately, the humanitarian aid was politicised and this affected the plan to procure and distribute maize to 1,200 starving selected heads of families in Manicaland.¹⁴⁷⁷ This was perceived as undermining the state and thus failed to reach out to some of the intended beneficiaries. Given the wider socio-political context in Zimbabwe, as well as the potential effect of humanitarian aid administered by churches, this should not have come as a surprise.

Anglican churchwomen moved a further step by addressing theologies that undermined the position of women in marriage and in society in general. The effects of the epidemic on Anglican women led Ruth Bakare to advocate new ways of reading the Bible that do not justify male domination.¹⁴⁷⁸ The stance taken by Bakare was pragmatic:

There is a need to care for those who are infected and affected by HVI/AIDS by encouraging HIV testing and openness about HIV status, promoting the use of condoms within marriage where one

¹⁴⁷³ See HNM, Ruth Bakare, MU to all churches in the diocese, September 2001.

¹⁴⁷⁴ MM, Treasurer, "Diocese of Manicaland MU income and expenditure statement," August 2001.

¹⁴⁷⁵ R. Munakamwe, same interview. See also MM, R. Bakare, MU diocesan president's speech on Mary's Day, (25 March 2002).

¹⁴⁷⁶ R. Bakare, same interview.

¹⁴⁷⁷ Bishop S. Bakare "The Diocese of Manicaland," in *Partners*, 5-6.

¹⁴⁷⁸ MM, R. Bakare, "Violence between couples," unpublished paper presented at a Diocese of Manicaland MU conference, (circa 2002).

partner is promiscuous or already infected, offer pastoral care and support groups for the HIV infected and affected as well as discouraging stigmatisation.¹⁴⁷⁹

Under the leadership of Ruth Bakare, the guild advocated a gendered approach to the pandemic.¹⁴⁸⁰ Apparently, the lack of sensitisation of male Anglicans in Manicaland on HIV issues exposed married women to HIV and therefore undermined prevention efforts. A respondent had this to say: –Not enough was done to educate men on matters of sexuality. The church has not been involved enough in educating mothers and fathers together on the prevention of sexually contracted HIV.”¹⁴⁸¹

Whereas the Mothers’ Union guild at the diocesan level carried out HIV and AIDS interventions, the pandemic affected the guild’s constitution. In 2004 the guild’s leadership made the diocesan synod aware of an earlier rule to enrol any Anglican women communicants of reasonable standing into the membership of the guild without due consideration of marital status.¹⁴⁸² While the move was welcome to young widows and single mothers, a segment of the membership had reservations. One of the issues of discontent was that the new rules on lower age limit for the admission of widows and the enrolment of single mothers undermined the sanctity of holy matrimony.¹⁴⁸³ AIDS-related deaths affected young couples and that accounted for why the diocesan president embraced young women. Under the leadership of Ruth Bakare, the Mothers’ Union diocesan office rendered support to Anglican churchwomen infected and affected by HIV. This was noted from an increase in the number of support groups which provided for –emotional, moral, financial and other material needs.”¹⁴⁸⁴ Financial support was also obtained from other parts of the Anglican Communion. For example, in May 2003 Portia Magada who accompanied Bishop Bakare on a visit to the Diocese of Nova Scotia and Prince Edward Island

¹⁴⁷⁹ MM, Bakare, –Violence between couples.”

¹⁴⁸⁰ MM, Bakare, –Violence between couples.”

¹⁴⁸¹ R. Munakamwe, same interview. See also J. Mavhima, same interview. See also J. Chimwaza, same interview.

¹⁴⁸² MM, Diocese of Manicaland, Agenda and reports, Anglican Diocese of Manicaland eleventh session of synod.

¹⁴⁸³ M. Nyamwena, same interview.

¹⁴⁸⁴ R. Mlambo, same interview. See also R. Munakamwe, same interview.

received donations towards care and support of PLHIV, young widows and orphans in Manicaland.¹⁴⁸⁵

The effects of HIV and AIDS on Anglican churchwomen in Africa attracted international attention from the Mothers' Union guild worldwide office at Mary Sumner House in London. In 2004 Kisten Ryley writing in the *Home and Family* observed that in the wake of reviewing the balance of power in sexual relationships that often exposed women to HIV:

The MU is addressing these issues in local communities by raising awareness of HIV/AIDS, educating people in ways of preventing its spread, and also by looking at the emotional and spiritual needs of those living with or affected by the virus.¹⁴⁸⁶

Members of the guild from different parts of Africa were involved in HIV and AIDS mitigation. A few examples included the Katanga Diocese (Democratic Republic of the Congo), the Southern Highlands Diocese of Tanzania (Tanzania), the Diocese of Swaziland (Swaziland),¹⁴⁸⁷ the Anglican Church of Rwanda, the Anglican Church of Uganda,¹⁴⁸⁸ the Diocese of Upper Shire (Malawi) and the Diocese of Kirinyaga (Kenya).¹⁴⁸⁹ While the Mothers' Union guild's worldwide office recognised the damage caused by HIV to Anglican churchwomen and their families, each diocesan guild chose suitable HIV intervention strategies for its people. HIV and AIDS opened up a new channel for the Mothers' Union worldwide office to support African women. This was done by addressing some of the greatest barriers to controlling the spread of the virus—lack of awareness, stigma and discrimination."¹⁴⁹⁰ The HIV and AIDS interventions carried out by members the guild in Manicaland had to be viewed in line with work carried out by other Anglican Church Mothers' Union guilds from the African continent.

¹⁴⁸⁵ MM, P. Magada, "Visit to the Diocese of Nova Scotia and Prince Edward Islands," report to eleventh session of synod.

¹⁴⁸⁶ K. Ryley, "Positive action: The MU has become a powerful force in the fight against HIV/AIDS", *Home and Family*, (Summer 2004), 20.

¹⁴⁸⁷ Ryley, "Positive action," 21.

¹⁴⁸⁸ M. Duggan (ed), "Friendship in Uganda," *Home and Family*, 21

¹⁴⁸⁹ N. Lawrence, "Transforming communities: MU Workers are making a difference to families around the world," *Home and Family*, 26.

¹⁴⁸⁹ Lawrence, "Transforming communities," 27.

¹⁴⁹⁰ Ryley, "Positive action," 20.

The guild's leadership also linked HIV and AIDS interventions with the Millennium Development Goals. For instance, at the guild's retreat held on 14-16 October 2005 a presentation on what role the guild could play in reversing the spread of the pandemic was made. Delegates undertook to reduce HIV prevalence in the youth and in women of childbearing age.¹⁴⁹¹ The presentation was meant to sensitise delegates to the importance of goal number six, which is on halting the spread of HIV and AIDS by the year 2015. Apparently, the leadership of the guild used to encourage the members to go for HIV test and pledged support for those who tested positive.¹⁴⁹² In 2005, one of the first known cases of public disclosure of HIV status occurred at the guild's conference held at St. Augustine's. An informant stated that ~~thereafter~~, a large proportion of the members of the guild began to talk openly about HIV."¹⁴⁹³ They also took the initiative to assist people infected and affected by the epidemic including at Chikanga, Cathedral of St. John the Baptist, St. Mary's Magdalene, St. James Zongoro, St. David's Bonda, St. Cuthbert's Denzva and St. Augustine's. Thus, members of the guild in the Anglican Church in Manicaland ~~brought forth~~ their being human (*ubuntu*), promoting communal responsibilities against the HIV/AIDS threats."¹⁴⁹⁴ However, some women appeared less eager to continue hearing about HIV and AIDS: ~~At the MU [Mothers' Union] conferences some women announced that they had heard enough of AIDS talks. They said that they had left behind their homes and problems so that they could enjoy themselves through singing, dance and listening to the gospel.~~"¹⁴⁹⁵

5.4. The United Methodist Church's Response to HIV and AIDS.

This section will explore the response to HIV and AIDS by the United Methodist Church between 2000 and 2007. While the church leadership, took bold steps towards intensifying HIV and AIDS interventions, the HIV prevention strategy remained moralistic. In August 2000 the church's Africa Central Conference session held in

¹⁴⁹¹ MM, T, Jera, ~~Millennium Development Goals~~," Unpublished paper presentation at the Diocese of Manicaland MU leadership retreat, 14-16 October 2005.

¹⁴⁹² R. Mlambo, same interview.

¹⁴⁹³ A. Waziweyi, interview conducted by M. Mbona, Catholic Commission for Peace and Justice office, Mutare on 2 September 2010. R. Bakare, same interview. R. Mlambo, same interview.

¹⁴⁹⁴ Chinouya, ~~Ubuntu and the helping hands for AIDS~~," 104.

¹⁴⁹⁵ R. Bakare, same interview. See also M. Nyamwena, same interview.

Maputo approved a resolution to have two church annual conferences in Zimbabwe.¹⁴⁹⁶ Subsequently, HIV and AIDS interventions in Manicaland were mainly an initiative of the Zimbabwe East Annual Conference. Within the church in Africa, there was also considerable interest in the pandemic. In August 2000 Bishop Joao S. Machado of Mozambique who served as president of Africa Central conference reminded his fellow bishops to take clear actions on HIV interventions on the African continent. Machado suggested: “Let us renew our efforts hand by hand so that our voice is heard and respected. Union makes the force.”¹⁴⁹⁷ The year 2004 witnessed changes in the leadership of Zimbabwe Episcopal Area when Bishop Jokomo retired due to ill health and Bishop Eben Nhiwatiwa was elected as the successor. HIV and AIDS responses by the Zimbabwe East Annual Conference will be discussed in the following order: actions by the church’s leadership, treatment of AIDS-related illness, care of PLHIV and OVC, and grassroots HIV interventions at parish level.

5.4.1. The Church Leadership Reacts to HIV and AIDS

The birth of the new millennium witnessed intensified responses to HIV and AIDS by the church’s structures in Manicaland and Zimbabwe. First, in January 2000 the church’s leadership convened the “Consultation for HIV/AIDS Education, Awareness, and Prevention Training” workshop in Kadoma. The workshop attended by 136 participants from the clergy, the laity and the church’s youth resolved “to return home and begin implementing an agreed action plan.”¹⁴⁹⁸ This workshop was co-sponsored by the health and welfare department of the church’s General Board of Global Ministries with the intention of empowering the United Methodist Church in Zimbabwe to confront the challenges of HIV and AIDS in the new millennium.¹⁴⁹⁹

¹⁴⁹⁶ UMCAUM, Official minutes of the ninth session of the Africa Central conferences of the UMC held in Maputo, 16-20 August 2000.

¹⁴⁹⁷ UMCAUM, J. S. Machado, “Episcopal message to the Africa Central conferences,” Official minutes of the ninth session of the Africa Central conferences, 30.

¹⁴⁹⁸ United Methodist News Service, “Zimbabwe United Methodists confront AIDS crisis,” 9 February 2000, <<http://gbgm-umc.org/programs/aids/aidszimbabwe1.stm/>>, [Accessed 29 May 2009].

¹⁴⁹⁹ B. Gittens, “AIDS in Zimbabwe: Disrupting the community’s social fabric,” <<http://gbgm-umc.org/programs/aidsafrica/aidszimbabwe2.stm/>> [Accessed 29 May 2009]. See also SM, “Council on ministries report,” Zimbabwe Annual Conference of the UMC twenty-first session, 13-17 December 2000, 26.

The agreed plan of action entailed that the church focuses on the promotion of AIDS education and awareness campaigns, the encouragement of responsible behaviour, the provision of counselling services to PLHIV and their families, the care of OVC and the home-based care programme for the sick and dying.¹⁵⁰⁰ The global leadership also took Zimbabwe's socio-economic decline as a good opportunity to support local United Methodist Church to respond to HIV and AIDS effectively:

The church must continue to play the leading role in HIV/AIDS education, prevention and care. Our brothers and sisters in Africa, now more than ever, will continue to need our spiritual and financial commitment to deal effectively with this devastating health crisis.¹⁵⁰¹

The United Methodist Church in Zimbabwe in general including Manicaland took advantage of such support. The links between the local church and its sister annual conferences in the US became important channels of obtaining critical resources.

In August 2000 the "HIV and AIDS: Youth's Challenge in the New Millennium," workshop was another platform of interaction for the church's youth, church leadership, state health experts and delegates from the church's global leadership. In an address by the key speaker, Randolph Nugent, the general secretary of the General Board of Global Ministries, the church's young people in Zimbabwe were praised for being:

...the first group within United Methodism to recognise the danger of the HIV virus and the likelihood of AIDS. In the face of such conditions, you have not become paralysed but have moved rapidly to action. You are to be commended for your action.¹⁵⁰²

The conference focused on abstinence and fidelity as the only method of HIV prevention. Participants also explored other topics including peer pressure and decision making, campaigns against child abuse, community home-based care, how to relate to PLHIV, and handling bereavement and grief.¹⁵⁰³ Delegates from the United Methodist Church in Manicaland were part of the participants at that conference.

¹⁵⁰⁰ Gittens, "AIDS in Zimbabwe: Disrupting the community's social fabric."

¹⁵⁰¹ Gittens, "AIDS in Zimbabwe: Disrupting the community's social fabric."

¹⁵⁰² Wilkinson, "General secretary of the GBGM praises Zimbabwe youth."

¹⁵⁰³ Wilkinson, "HIV/AIDS Conference for the United Methodist youth in Zimbabwe."

However, the church's lack of corresponding efforts in establishing HIV interventions targeting the youth at the grassroots level undermined this national effort.¹⁵⁰⁴

In December 2000, the church's district superintendents in Zimbabwe admitted that HIV and AIDS was a grim reality and thus stated that ~~the~~ epidemic devastated the nation.¹⁵⁰⁵ There was need for further action in responding to HIV and AIDS and thus the district superintendents called upon the delegates to act decisively:

We urge our conference to facilitate the formation of support groups, home-based care units, where the patients will be encouraged to go on good nutrition and exercise, remain on medical monitoring and for those who are HIV positive and not yet having AIDS, be encouraged to go for viral load testing periodically and advocate for behaviour change as a preventive measure.¹⁵⁰⁶

The pandemic in Zimbabwe appeared to force the district superintendents to show care towards people infected and affected by HIV and AIDS. Thus, the church's senior pastors sought to become agents of change by advocating for the expansion of the church's HIV interventions.

The socio-economic hardships in Zimbabwe made it ~~a~~ difficult for [the] PLHIV to access treatment and have a good diet and therefore died early leaving behind a trail of orphans.¹⁵⁰⁷ The church's district superintendents also noted that combination of escalating poverty levels and the effects of HIV and AIDS on the population were among the possible reasons why it became quite complex for the State to achieve the set goal of ~~H~~Health for all by 2000.¹⁵⁰⁸ Any attempts at responding to the needs of PLHIV and OVC could only yield positive results if poverty alleviation was addressed. AIDS service organisations faced difficulties in launching AIDS-related care. At the church's annual conference session in December 2000 lay leaders were convinced that the spread of HIV could be reversed through marital faithfulness and

¹⁵⁰⁴ I. Chowa, same interview.

¹⁵⁰⁵ SM, ~~D~~istrict superintendents' composite report," Zimbabwe Annual Conference of the UMC twenty-first session, 2.

¹⁵⁰⁶ SM, ~~D~~istrict superintendents composite report," 3.

¹⁵⁰⁷ E. Kabungaidze, same interview.

¹⁵⁰⁸ SM, ~~D~~istrict superintendents composite report," 4.

honesty alone.¹⁵⁰⁹ Members of the council on ministries committee also suggested that other than relying on biomedicine for the treatment of AIDS-related illness, church members could simply invoke the healing power of Jesus Christ. They quoted the words of hymn 108 entitled *Murapi ari pano*, (The great Physician).¹⁵¹⁰ Faith was perceived as being central to the healing of the PLHIV and this appeared to be quite common among the church's followers as stated: "Even though HIV/AIDS is continuing to kill our people and to leave hundreds of children in our society, but we have hope in the healing power of our Lord Jesus Christ."¹⁵¹¹

In December 2002 the church's annual conference session in Manicaland was forced to give further attention to HIV and AIDS because the clergy and parishioners spent a great amount of time in caring for the sick and burying the dead. Part of a report read: "Bishop, the AIDS pandemic continues to cause havoc unabated. This continues to occupy the pastors' time officiating at funerals and visiting the sick. The number of orphans grows daily."¹⁵¹² At the same session the council on ministries reported that church members who were infected or affected by HIV and AIDS were now in the habit of seeking the healing services of "Tsikamutanda", a prominent traditional health practitioner and magician. The traditional healer-cum prophet claimed to have power to destroy witchcraft and evil forces that caused ill health, including HIV.¹⁵¹³

Apparently, some church members could have consulted *Tsikamutanda* whose fame was spreading as noted: "Of late the whole country was taken by storm by *Tsikamutanda*'s activities which caused havoc in many communities living behind trails of hatred, frustrations, accusations, and in some cases closed churches."¹⁵¹⁴ Within the United Methodist Church in Manicaland, there was a perception that church followers visited *Tsikamutanda* because they lacked courage to resist the

¹⁵⁰⁹ SM, "Conference lay leaders report," Zimbabwe Annual Conference of the UMC twenty-first session, 12. See also Hilltop circuit (HCM) archives, Mutare, "Council on ministries report," *Official Journal of the Zimbabwe East Annual Conference of the UMC forth session*, 9-12 December 2004, 125.

¹⁵¹⁰ Conference Board of Publications (The), *Ngoma dzeUnited Methodist Church YeZimbabwe*, 2002 edition (Harare: United Methodist Press, 1964), 115.

¹⁵¹¹ SM, "Council on ministries report," 26. See also Burchardt, *Faith Matters*, 30-33.

¹⁵¹² SM, "Conference committee on episcopacy report," Zimbabwe East Annual Conference of the UMC second session, 12-15 December 2002, 16.

¹⁵¹³ See also Ashforth, "AIDS, witchcraft and the problem of power,"

¹⁵¹⁴ SM, "Council on ministries report," Zimbabwe East Annual Conference of the UMC second session, 22.

temptation' posed by the HIV. The council on ministries maintained that faith in Jesus Christ was a source of strength amid the HIV and AIDS crisis by invoking the words of a song: "My hope is built on nothing less than Jesus' blood and righteousness; I dare not trust the sweetest fame, but wholly lean on Jesus' name."¹⁵¹⁵ Given the knowledge that ARVs were not affordable and inaccessible to the majority of poor Zimbabweans, AIDS made some Christians to seek healing from different sources.

In 2004, the election of Bishop Nhiwatiwa to the episcopacy brought further input to the church's HIV and AIDS interventions. Under Bishop Nhiwatiwa's leadership, the United Methodist Church established volunteer groups that received training in basic skills of care giving and counselling to the sick and bereaved."¹⁵¹⁶ It had taken the church's annual conference in Zimbabwe four years to launch this intervention since the church's district superintendents made a proposal in 2000. While some HIV interventions were immediately undertaken, others like the formation of support groups lagged behind. Perhaps there was also little awareness of the fact that support groups created safe space for HIV disclosure and care."¹⁵¹⁷ Meanwhile, an influx of AIDS patients at big hospitals in Harare, and Mutare led Bishop Nhiwatiwa to appoint full time hospital chaplains. The new appointees were to assist the church's pastors-in-charge who appeared overstretched by ever increasing demand for pastoral services due to HIV and AIDS.¹⁵¹⁸ The appointment of full time hospital chaplains increased the visibility of the United Methodist Church in some of the state's hospitals. This was also likely to cast the image of a caring church and there could have won new converts.

In 2004, the United Methodist Global AIDS Fund was launched in the US with the purpose of representing the commitment of the denomination to eradicate HIV and AIDS in the world."¹⁵¹⁹ A special appeal made to members of the church

¹⁵¹⁵ SM, "Council on ministries report," 22. The song was taken from the Wm. B. Bradbury, Seventh Day Adventist Hymn 39: Dombo rine simba (My hope is built in Jesus the Rock) in *Kristu Mundwiyo* (Bulawayo: Zambesi Union Publishing House, nd), 46.

¹⁵¹⁶ HCM, Bishop E. Nhiwatiwa, "Episcopal address," *Official Journal of the Zimbabwe East Annual Conference of the UMC fourth session*, 9-12 December 2004, 27.

¹⁵¹⁷ M. Sungweme, same interview. See also T. Matsika, same interview.

¹⁵¹⁸ HCM, Bishop E. Nhiwatiwa, "Episcopal address."

¹⁵¹⁹ J. Winker, *Response of the United Methodist Church to the global AIDS pandemic: A 2008 survey of annual conferences*, (2008), 2.

denomination in the US to support this fund suggested: –The \$8 million goal represents a \$1 commitment of every member of the United Methodist Church in the USA [US]. Funds support education, prevention, treatment, and care programmes for [the] PLHIV.”¹⁵²⁰ The United Methodist Church in Zimbabwe benefited from the fund through the links with the annual conferences of: Baltimore Washington, Wyoming, Oklahoma Indian missionary, Tennessee, Switzerland-France and Memphis.¹⁵²¹ Generally, the churches in Zimbabwe could not directly access the Global Fund to Fight AIDS, Tuberculosis and Malaria because of its stringent requirements.¹⁵²² Within the political volatile environment in Zimbabwe, the Government of Zimbabwe held the United Methodist Church in suspicion over the Global AIDS Fund.¹⁵²³ This did not deter the church’s leadership from carrying out HIV and AIDS interventions. In 2008, Jim Winkler, the general secretary of the general board of church and society, stated that the church’s Global AIDS Fund initiative supported fourteen home-based care projects, training in antiretroviral therapy, HIV and AIDS education at local church level and orphan trust programme in Zimbabwe since 2004.¹⁵²⁴

In 2004, the effects of the pandemic on the United Methodist Church followers in Manicaland affected the church’s financial income. For the first time the council on finance and administration observed a decline in the church’s revenue which was associated with the effects of the pandemic on families and church followers: –The impact of HIV and AIDS is negatively affecting church members now supporting family members, orphans and home-based care programmes and the high cost of medical treatment.”¹⁵²⁵ The members of the United Methodist Church are obliged to maintain the financial viability of the church through committed giving, locally known as *rupawo*. In 2005 the council on finance and administration recommended that all the rural circuits receive budgetary support from the church’s treasury.¹⁵²⁶ This is usually done when a circuit fails to raise enough financial resources to support

¹⁵²⁰ Winkler, *Response of the United Methodist Church to the global AIDS pandemic*.

¹⁵²¹ Winkler, *Response of the United Methodist Church to the global AIDS pandemic*, 2, 9, 12, 15, 16, 18, 23 and 24.

¹⁵²² V. Chitimbire, same interview.

¹⁵²³ E. Kabungaidze, same interview.

¹⁵²⁴ Winkler, *Response of the United Methodist Church to the global AIDS pandemic*, 24.

¹⁵²⁵ AM, –Council on finance and administration report,” Zimbabwe East Annual Conference of the UMC fourth session, 9-12 December 2004, 93.

¹⁵²⁶ AM, –Council on finance and administration report,” 93-94.

its annual budget. The fact that in 2005 rural circuits received subsidy worth 7% of the annual conference budget¹⁵²⁷ was a case to suggest that AIDS impoverished United Methodist congregations.

In 2006 Bishop Nhiwatiwa took a bold step in reducing dependency on donors. This came under an initiative called *Chabadza*, a Shona word translated as: “Let us work together.”¹⁵²⁸ The initiative applied to all the development projects of the church’s including HIV and AIDS interventions and it created space for the participation of local communities. Church members brought in both tangible and intangible health assets especially in the care of PLHIV and OVC. Members of the United Methodist Church were encouraged to avail themselves and their resources to the service of others and to any church projects.¹⁵²⁹ In terms of healthcare, this meant that while asking for donations to care for PLHIV and OVC, church followers pledged to be involved in care services. With the state’s tight control on all donor funds, this affected the flow of money to the United Methodist Church’s HIV and AIDS projects. The input from the local members of the church as part of Chabadza was critical.

5.4.2. The Treatment of AIDS-Related Illness

The HIV and AIDS pandemic forced the United Methodist Church in Manicaland to review the services at the church’s healthcare centres. At Mutambara, Old Mutare, Nyangombe, Gatsi, Anoldine and Chinyadza, HIV and AIDS affected service delivery. In 2002 the annual conference’s health and welfare committee mentioned the work done by the church’s healthcare institutions in the treatment of the sick. The committee also observed a worrying trend as stated: “...as more and more people opt to come to our hospitals for better care and treatment, the demand has strained our hospitals’ meagre resources.”¹⁵³⁰ While it was common knowledge that members of the public relied on the church’s healthcare centres, the United Methodist Church took some time before realising the need to upgrade its services. The healthcare

¹⁵²⁷ AM, “Council on finance and administration report.”

¹⁵²⁸ MBDR, Bishop E. Nhiwatiwa, “Episcopal address,” *Official Journal of the Zimbabwe East Annual Conference of the UMC sixth session*, 14-17 December 2006, 20-28.

¹⁵²⁹ MBDR, Bishop E. Nhiwatiwa, “Episcopal address.”

¹⁵³⁰ SM, “Council on ministries report,” 25.

centres were usually stocked with better medicines than their Government and local council counterparts.”¹⁵³¹

The escalation in the number of patients from urban areas who visited the church’s healthcare centres created challenges. The charging of low fees caused this and the reasonable quality of services offered at church-related healthcare centres. Manyeza, the church’s medical secretary in Manicaland, associated this influx in numbers of patients with the pandemic and stated that —~~th~~ HIV and AIDS epidemic had the effect of overworking the staff and also led to a general shortage of medicines.”¹⁵³² This situation was not unique to church-related healthcare centres in Manicaland. The pandemic affected the healthcare system belonging to churches more than what the hospitals and clinics did to HIV. HIV and AIDS also forced the leadership of the United Methodist Church to review the working conditions of medical personnel. In 2002, the council on ministries suggested that the church’s annual conference session consider staff retention incentives to save the crisis at the church’s healthcare institutions.¹⁵³³ Apparently, the State’s failure to provide grants to church-related healthcare centres affected the capacity to deliver services to the PLHIV.¹⁵³⁴

The NGO Act of 2004 undermined the potential of the United Methodist Church to respond effectively to people infected and affected by the pandemic. As already noted above, the act imposed stringent controls on receiving external funding from international partners or friends (see chapter 2 section 2.4.2). The effects were felt on the church’s healthcare system as stated by Manyeza:

The challenging socio-economic climate has impacted negatively on our efforts to deliver the desired quality healthcare to the needy. The resulting poverty has predisposed our communities to malnutrition and the rampant spread of HIV and AIDS, tuberculosis, and the high malaria deaths.¹⁵³⁵

¹⁵³¹ T. Manyeza, same interview.

¹⁵³² SM, Medical secretary’s report to the Zimbabwe East Annual Conference of the UMC second session, 50.

¹⁵³³ SM, Council on ministries report, 25.

¹⁵³⁴ T. Manyeza, same interview.

¹⁵³⁵ Tendai Manyeza, private archives (TM), T. Manyeza, —Medical secretary’s report,” Zimbabwe East Annual Conference council on ministries, October 2004.

In 2004, the church's leadership resolved to implement staff retention schemes. The HIV and AIDS pandemic made working conditions for medical staff rather uncomfortable as stated:

There is need to improve on this to retain the overworked few who have decided to brave the harsh conditions. With the HIV/AIDS challenge workload continues to increase and yet the number of staff remains static or keeps dwindling.¹⁵³⁶

It took the church's leadership two years to implement previously recommended staff retention allowances. This affected staff morale. Without highly motivated medical staff, services to HIV positive people and other patients in general suffered. On a positive note, the need to respond to HIV and AIDS forced the church to expand its healthcare facilities and used the epidemic as a way to seek donor support. In 2004, ZACH and the United Methodist Church's donors jointly assisted in the construction and equipping of Chinyadza clinic also designated as a district referral clinic for Makoni.¹⁵³⁷

Whereas the church became actively involved in HIV prevention, care and awareness education, the lack of ART at its healthcare centres undermined the church's impact on the pandemic.¹⁵³⁸ The ARVs did not feature in the treatment plan at the church's healthcare centres including Old Mutare and Mutambara hospitals until as late as 2007. The economic decline experienced in Zimbabwe between 2000 and 2007 was seen as the major reason for the state's failure to roll out ART on a large scale. For example, in 2002, Manyeza stated: "...the country is so poor that retroviral medicines are still quite remote to ordinary people. The HIV drives should therefore focus on awareness, accessibility of VCT, PMTCT, and home-based care."¹⁵³⁹ Meanwhile, some of United Methodist Church healthcare centres only rolled out ART with assistance from the Global Fund and through ZACH in 2007. Given that in 2007 about 60% of the clients at Mutambara and Old Mutare hospitals were HIV

¹⁵³⁶ TM, Manyeza, "Medical secretary's report." See also AM, "Council on ministries report," Zimbabwe East Annual Conference of the UMC fourth session, 47. See also HCM, "Council on ministries report," *Official Journal of the Zimbabwe East Annual Conference of the UMC fourth session*, 126.

¹⁵³⁷ TM, Manyeza, "Medical secretary's report."

¹⁵³⁸ T. Manyeza, same interview.

¹⁵³⁹ SM, T. Manyeza, "Medical secretary report." 52.

positive,”¹⁵⁴⁰ the roll out of ARVs elevated the status of the church’s healthcare centres. The full potential of the church’s healthcare centres to rolling out the treatment of AIDS-related diseases could have been affected by bad publicity by the State in Zimbabwe. Some church members of the stated that several attempts at delaying the clearance of containers carrying medicines from the US in the years between 2004 and 2006 by the State had a negative effect on HIV positive people.¹⁵⁴¹ The restrictions could be associated with the effects of the NGO Act of 2004.

While most doctors shunned the deplorable working environment in Zimbabwe, the United Methodist Church benefited from an initiative known as the Zimbabwe Orphan Endeavour. The Reverend Greg Jenks from the church’s North Carolina Annual Conference in the US initiated the project in 2004.¹⁵⁴² Whereas the original focus was on OVC, teams of visiting voluntary medical doctors from the church’s annual conferences in the US offered free medical services to PLHIV and other people in Manicaland. Between 2004 and 2007 these voluntary doctors also donated medicines to communities in Marange, Mutasa-Nyanga, Makoni-Buhera and Chimanimani-Chipingwe districts.¹⁵⁴³ While the project was ‘noble’, its major setback was that it was politicised and that made it difficult for it to be sustained in areas such as Marange.”¹⁵⁴⁴ The fact that voluntary doctors came from the US caused the Government of Zimbabwe to be suspicious. While there was a perception that the United Methodist Church used HIV interventions to undermine the state, the church’s healthcare institutions filled in an important gap. One respondent mentioned: “It was the responsibility of the State to provide for the healthcare needs of the citizens and it was wrong for the government to hold the churches at ransom for the assistance they offered to ordinary people.”¹⁵⁴⁵ Manyeza’s position appeared to differ from an earlier position taken by the district superintendents of the church. The church’s senior

¹⁵⁴⁰ Mutasa-Nyanga UMC District archives, Mutare, (MNDM), “Council on ministries report,” *Official Journal of the Zimbabwe East Annual Conference of the UMC seventh session*, 7-10 December 2007, 89.

¹⁵⁴¹ I. Chowa, same interview. See also E. Kabungaidze, same interview. See also T. Manyeza, same interview. See also S. Sign, same interview.

¹⁵⁴² ZOE Ministry, <http://www.apexumc.org/main/index.php?option=com_content/> [Accessed 14 October 2011].

¹⁵⁴³ MNDM, “Council on ministries report,” *Official Journal of the Zimbabwe East Annual Conference of the UMC seventh session*, 89.

¹⁵⁴⁴ E. Kabungaidze, same interview.

¹⁵⁴⁵ T. Manyeza, same interview. See also MNDM, “District superintendents composite report,” *Official Journal of the Zimbabwe East Annual Conference of the UMC seventh session*, 67.

pastors argued that the Government had no right to dictate the pace in public healthcare because the United Methodist Church was one of the few churches that pioneered access to healthcare for the poor starting from the colonial era.¹⁵⁴⁶ This meant that the churches did not necessarily have to rely upon the State in finding solutions to the menace of AIDS.¹⁵⁴⁷

5.4.3. The Care of PLHIV and OVC

Between 2000 and 2007, the home-based care interventions were based at the church's local stations, circuits and healthcare centres. Voluntary caregivers were trained at these sites. In the previous years, the home-based care initiative received minimum attention as already noted earlier in chapter four of this study. The change in the approach to home-based care was necessitated by increase in the number of HIV positive people.¹⁵⁴⁸ The availability of funding for home-based care under the church's Global AIDS Fund is another reason. In February 2002 home-based care to PLHIV became a theme during the "Church and Society Week" under the theme: "HIV/AIDS, the church and home-based care."¹⁵⁴⁹ The church's lack of an autonomous or semi-autonomous FBO or HIV and AIDS desk meant to coordinate HIV interventions including home-based care, affected the operations of voluntary caregivers. In spite of such shortcomings, the council on ministries appeared to value home-based care:

Despite the havoc being wreaked by this killer disease [AIDS], there are a growing number of our congregations who are establishing [voluntary] home-based care programmes in order to alleviate the plight of those already suffering.¹⁵⁵⁰

The leadership of United Methodist Church in Manicaland could have held the understanding that voluntary caregivers were not a necessity because all Christians

¹⁵⁴⁶ MNDM, "District superintendents' composite report," 68. See also SM, "District superintendents' composite report." See also Chitando, *Living with hope*, 12.

¹⁵⁴⁷ For this see chapter 4 section 4.4.2 of the present research study.

¹⁵⁴⁸ T. Matsika, same interview.

¹⁵⁴⁹ SM, "Church and society report," Zimbabwe East Annual Conference of the UMC twenty-first session, 29.

¹⁵⁵⁰ SM, "Council on ministries report," 22. See also HCM, "District council on ministries report," Mutare District of the UMC charge conference session, 16-17 August 2002, 3.

had a responsibility to care for people in need including those living with HIV. At the leadership level, the church did little to explore the new dynamics associated with providing home-based care in the context of HIV and AIDS. The fact that voluntary home-based caregivers were at times inadequately equipped and feared contracting HIV led them to be reluctant to offer services to PLHIV.¹⁵⁵¹ Furthermore, visits to the sick by some members of the Rukwadzano and Mubvuwi guilds were often confused with home-based care in cases where the clients' HIV status was known.¹⁵⁵² In 2004 the church's healthcare centres intensified training in basic skills in voluntary home-based care. For example, in October 2004 Old Mutare and Mutambara hospitals were involved in home-based care programmes with funding support from some donors as stated:

We are grateful to the UMC [United Methodist Church] through the GBGM [General Board of Global Ministries] for the generous support with home-based care kits... We are grateful to PACT [Private Agencies Cooperating Together] Zimbabwe which has started a programme focusing on home-based care.¹⁵⁵³

The acute shortage of medical staff and other resources such as vehicles and fuel undermined the ability of the church's healthcare centres to expand the training of voluntary home-based caregivers. While the church was affected by logistical challenges in receiving foreign funding, from 2004 onwards the home-based care intervention received foreign funding through the church's institution, Africa University:

With the support of the health and welfare ministries of the GBGM [General Board of Global Ministries], workshops have been held under the auspices of Africa University to upgrade the skills of coordinators and pastors in the management of home-based care programmes.¹⁵⁵⁴

Whereas some progress was noted, the church's home-based care interventions in Manicaland lagged behind those at Epworth in Harare where a full time nurse was

¹⁵⁵¹ T. Matsika, same interview.

¹⁵⁵² J. Rukweza, same interview.

¹⁵⁵³ TM, Manyeza, "Medical secretary's report."

¹⁵⁵⁴ S. Sign, same interview. See also Fasan, *Africa University Cares*.

employed.¹⁵⁵⁵ However, similar services by the United Methodist Church in parts of Manicaland such as Rusape, Mutare, Chipinge and Nyanga were non-existent.

The leadership of the United Methodist Church appeared to believe that the acquisition of HIV and AIDS-related knowledge and skills was essential for efficient service delivery.¹⁵⁵⁶ This philosophy led the church's leadership to continue with the practice of organising workshops at different levels. For instance, the church's council on ministries report for 2007 made the following observations: in April 2007 a palliative care workshop for the medical staff serving at the church's major hospitals in Zimbabwe including Old Mutare and Mutambara was held in Harare, in October 2007 a workshop on the possible establishment of a respite centre at Old Mutare hospital was held in Mutare.¹⁵⁵⁷ Medical personnel were equipped with a wide range of skills that were critical in providing palliative care for AIDS patients. HIV and AIDS interventions under Old Mutare hospital received funding from the Friends of Tariro Project, US, and technical expertise from Africa University.¹⁵⁵⁸

Economic hardships in Zimbabwe did not deter the United Methodist Church from providing care to OVC. In 2000, the council on ministries stated that all the church's four districts in Manicaland paid school fees for OVC at varying amounts. The following records were provided: Mutare South district: paid school fees for 150 orphans (amount paid not stated), Mutare district: paid Z\$73,000, Mutasa-Nyanga district: paid Z\$19 420 and Makoni-Buhera district: paid Z\$3,000.¹⁵⁵⁹ This money was collected from the local membership and thus was mainly a grassroots led intervention. The need to care for AIDS-related OVC also made some church members to –shift from an annual donation towards the welfare needs of OVC to regular giving that was meant to meet escalating demand.”¹⁵⁶⁰ In 2000 the major sources of financial support towards school fees for the OVCs were the local

¹⁵⁵⁵ AM, —Council on ministries report,” Zimbabwe East Annual Conference of the UMC fourth session, 32. See also HCM, —Council on ministries report,” *Official Journal of the Zimbabwe East Annual Conference of the UMC fourth session*, 103.

¹⁵⁵⁶ A. Mhondoro, same interview. See also E. Kabungaidze, same interview.

¹⁵⁵⁷ MNDM, —Council on ministries report,” *Official Journal of the Zimbabwe East Annual Conference of the UMC seventh session*, 94.

¹⁵⁵⁸ MNDM, —Council on ministries report.”

¹⁵⁵⁹ SM, —Council on ministries report,” Zimbabwe Annual Conference of the UMC twenty-first session, 29.

¹⁵⁶⁰ I. Chowa, same interview.

members of the Rukwadzano and the Mubvuwi guilds.¹⁵⁶¹ In the same year the Rukwadzano guild donated cash and goods to the Fairfield Orphanage and other the areas.¹⁵⁶² Apparently the church's leadership in Manicaland also took advantage of the AIDS-related OVC plight to present itself as a caring community and in the same process build up new disciples.

In 2002, the church's Mutare district benefited from funds disbursed by the National AIDS Council. The Reverend John Rugayo, the district's programmes' director for the United Methodist Church in Mutare was elected vice chairperson of National AIDS Council in Manicaland.¹⁵⁶³ Rugayo worked closely with the church's circuits in Mutare and assisted them to benefit from council's funds that were disbursed by the National AIDS Levy. Part of the money was used for the care of OVC and PLHIV as well as HIV prevention activities.¹⁵⁶⁴ Few churches benefited directly from the National Aids Levy as mentioned by Bishop Mutume of the Roman Catholic Church.¹⁵⁶⁵ This was not unusual given the knowledge that the Mutare urban's National AIDS Council committee had one church representative who attended meetings on behalf of all the churches.¹⁵⁶⁶ The lack of a functional HIV and AIDS ecumenical platform for church leaders in Mutare might have affected this initiative. It is therefore possible that Rugayo's position granted him the privilege to access the National AIDS Levy ahead of other church leaders.

In 2002 a campaign entitled "OVC and Christian Responsibility" was launched and donations were sought from church members. A total amount of Z\$2 304,515 was collected and distributed to the church's districts and was used to pay fees for OVC.¹⁵⁶⁷ In 2002 the Headlands south circuit that falls under the church's Makoni-Buhera district initiated a local OVC support fund which raised Z\$3,500,000.¹⁵⁶⁸

¹⁵⁶¹ SM, "MUMC report," Zimbabwe Annual Conference of the UMC twenty-first session, 51-52.

¹⁵⁶² SM, "RW report," Zimbabwe Annual Conference of the UMC twenty-first session, 48-50.

¹⁵⁶³ HCM, Minutes of the previous minutes of the Mutare district UMC charge conference session, 14-15 September 2001 as read at the Mutare district of the UMC charge conference session, 16-17 August 2002.

¹⁵⁶⁴ HCM, Minutes of the previous minutes of the Mutare district UMC charge conference session.

¹⁵⁶⁵ P. Mutume, same interview.

¹⁵⁶⁶ P. Jani, same interview.

¹⁵⁶⁷ SM, "Concil on ministries report," Zimbabwe East Annual Conference of the UMC second session, 23. See also HCM, "Concil on ministries report," *Official Journal of the Zimbabwe East Annual Conference of the UMC fourth session*, 125.

¹⁵⁶⁸ SM, "Concil on ministries report," 26.

However, the hyperinflationary environment in the country made it difficult for the churches to adequately address the problems encountered by the OVC.

The United Methodist Church was one of the few churches in which AIDS-related care transformed OVC care systems. In 2003 the appointment of the Reverend Peter Mufute, director of Fairfield Children's Home, led to a facelift of the former orphanage.¹⁵⁶⁹ There was an understanding that the use of the word "orphanage" had the effect of stigmatising children at Fairfield. Previously, the children were housed first in the hospital and later in another building. Mufute created a small village and formed families out of OVC that were allocated a house with eight in each and a mothering caregiver."¹⁵⁷⁰ Although not all the children were infected or affected by the epidemic, HIV and AIDS had an effect on the OVC care system at Fairfield. Consistent with this observation a report noted: "Due to the rising number of AIDS orphans and the lack or inability of extended family to care for them, Fairfield Children's Home has become an essential source of community support."¹⁵⁷¹ Mufute stated at the close proximity of Fairfield to Old Mutare hospital facilitated easy access to ART for HIV positive children.¹⁵⁷² According to Mufute, a proliferation of AIDS-related deaths among farm workers is responsible for large numbers of OVC. Many of them turned to Fairfield for care and support. This situation overwhelmed the facilities at the children's home. One of the solutions crafted by Mufute was the launch of a new model of OVC care. In 2004 the Fairfield established an outreach programme in which OVC were given fees, food and other resources but the children remained in the homes of their deceased parents under the care of a relative or sibling."¹⁵⁷³

The NGO Act of 2004 also imposed restrictions on the church's chances to receive external donor funding earmarked for and HIV interventions. As in the case of home-based care mentioned above, the Faculty of Health Sciences at Africa University became a conduit for receiving funding towards the care of children orphaned by

¹⁵⁶⁹ P. Mufute, same interview. See also MNDM, "Concil on ministries report," *Official Journal of the Zeast Annual Conference of the UMC seventh session*, 88

¹⁵⁷⁰ P. Mufute, same interview.

¹⁵⁷¹ Background to the Fairfield children's home, <<http://gardens-of-hope.org/FCH.html>> [Accessed 4 March 2011].

¹⁵⁷² P. Mufute, same interview.

¹⁵⁷³ P. Mufute, same interview.

AIDS. Consistent with this observation, Peter Fasan, the dean of the faculty had this to say:

The Faculty of Health Sciences was selected in 2004 to coordinate a major project for orphans and vulnerable children. ...This project of the United Methodist Church in Zimbabwe, mediated by the GBGM [General Board of Global Ministries], provides educational support, health care, nutritional supplements, and psychological support for up to 3 000 orphans and vulnerable children, most of who have been orphaned by the HIV/AIDS epidemic.¹⁵⁷⁴

Apparently, the channelling of OVC funding through Africa University by donors could have been advantageous to the church. First, the NGO Act did not as badly affect the university and the church's donors were at least able to continue sending money for OVC-related care programmes. Second, the need for accountability and transparency meant that proper documentation was done. Third, the local church leaders and members were usually not well trained to handle projects and therefore received assistance from the institution.¹⁵⁷⁵ In 2004 the council on ministries proposed a number of OVC project management workshops. The workshops were intended ~~to~~ assist the church to deal with the challenges of orphan care in a better way."¹⁵⁷⁶ Therefore, the receiving of donor funds for AIDS-related OVC interventions led church members to develop new skills in the management of community projects.

AIDS-related OVC care intervention at Ishe Anesu, Hilltop expanded under the leadership of Maria Humbane. Humbane, a missionary of the General Board of Global Ministries based at Africa University also served as the church's community ministries coordinator for Mutare.¹⁵⁷⁷ Humbane's appointment to Ishe Anesu was done in order to facilitate the flow of donations mainly from the church's annual

¹⁵⁷⁴ P. Fasan, *Africa University cares in a region severely affected by HIV/AIDS*, <http://gbgm-umc.org/global_news/full_article.cfm?articleid=3027/> [Accessed 2 February 2011]. See also AM, District superintendents composite report to the Zimbabwe East Annual Conference of the UMC fourth session, 4.

¹⁵⁷⁵ S. Sign, same interview. See also E. Kabungaidze, same interview. See also A. Mhondoro, same interview.

¹⁵⁷⁶ AM, "Concil on ministries report," Zimbabwe East Annual Conference of the UMC fourth session, 49.

¹⁵⁷⁷ E. Kabungaidze, same interview. See also B. and M. Humbane, "Missionary minute: Wednesday of Holy week," 12 April 2006, <http://gbgm-umc.org/global_news/full_article.cfm?articleid=3983/> [Accessed 2 March 2011].

conferences in the US.¹⁵⁷⁸ Between 2000 and 2007 the project supported OVC through the provision of food and also paid for educational needs of beneficiaries at primary, secondary and tertiary institutions. In 2007 a total of 60 OVC were under this scheme.¹⁵⁷⁹ The apparent lack of jobs and the effects of a declining economy destabilised family life among Zimbabweans and this reduced the amount of care given to the OVC by foster parents. In the light of these realities, the church's district superintendents observed: "Some of our church members, leaders included, are failing to attend church programmes and services as they are often out of the country, trading and in search of basic commodities which are on shortage in the country."¹⁵⁸⁰ Within Zimbabwe, it became common for parents and other people to engage in small cross-border business ventures or to seek jobs in neighbouring countries and the intention was to boost dwindling financial and other essential resources.

5.4.4. Responses to HIV and AIDS at the Grassroots Level

The United Methodist Church in Manicaland appears to have struggled to overcome cultural practices and Christian understandings of sexuality that undermined the prevention of sexually contracted HIV. An informant had this to say: "The UMC [United Methodist Church] still has a long way to change culture where sex is a taboo subject and yet the government seems to have done more on this AIDS awareness issue."¹⁵⁸¹ This practice started to decline from 2002 onwards. For example, in the church's Makoni-Buhera district initiatives at educating male church members on cultural issues and HIV prevention were launched. Chowa stated that "HIV awareness campaigns were conducted with church groups and seminars were held with male participants including members of the Mubvuwi guild as well as traditional health practitioners."¹⁵⁸² The church's HIV awareness programmes mounted at station and circuit levels could have influenced married churchwomen's choice of safe sex.

¹⁵⁷⁸ E. Kabungaidze, same interview.

¹⁵⁷⁹ See HCM, "Hilltop charge conference reports," 2007. See also E. Kabungaidze, same interview. See also S. Sign, same interview.

¹⁵⁸⁰ MNDM, "District superintendents composite report," *Official Journal of the Zimbabwe East Annual Conference of the UMC seventh session*, 63-64.

¹⁵⁸¹ E. Kabungaidze, same interview. See also T. Matsika, same interview. See also E. Makunike, same interview

¹⁵⁸² I. Chowa, same interview.

Within the Rukwadzano guild, in Rukweza circuit, Matsika stated that some churchwomen became aware of possible risks of having unprotected sex and thus were strongly opposed to unprotected sex: *–Handingafi ndichiona* (lit: I cannot risk my life by indulging in unprotected sex’).”¹⁵⁸³ The pandemic led the majority of married churchwomen to live in fear of contracting HIV from their spouses. HIV and AIDS also infected and affected children, relatives, fellow Christians and friends. Given these realities, members of the Rukwadzano guild resorted to regular prayer which they believe was one of the strongest weapons in responding to HIV and AIDS.¹⁵⁸⁴

The leadership of the United Methodist Church in Zimbabwe continued to be hesitant in openly encouraging church members and the rest of society to use condoms to reduce the spread of sexually transmitted HIV. Kabungaidze stated that this attitude led to the church to lose some of the church’s active members who succumbed to AIDS. Pastors and church members also spent a great deal of time visiting the sick and attending funerals.¹⁵⁸⁵ At the grassroots level, programmes that targeted male members of the church and focused on the prevention of sexually transmitted HIV had limited results. Some church members stated that the Government of Zimbabwe did more work than United Methodist Church in HIV and AIDS awareness. Generally, the State’s approach to HIV prevention was also seen as being pragmatic.¹⁵⁸⁶

Initiatives at launching HIV prevention interventions for the youth were undermined by the church’s reluctance to expose the youth to condoms. There was a perception that the church’s young adults were immune to HIV. Consistent with this assertion, Chowa stated: *–It was unfortunate that young people in the church who were proud’ of their perceived immunity contracted HIV from experimenting with their bodies or from unfaithful partners.*”¹⁵⁸⁷ Africa University became the hub of the church’s HIV and AIDS workshops. In June 2002 participants at a workshop were sensitised on the

¹⁵⁸³ T. Matsika, same interview.

¹⁵⁸⁴ SM, *–MUMC report,*” 61.

¹⁵⁸⁵ E. Kabungaidze, same interview.

¹⁵⁸⁶ P. Mufute, same interview. See also E. Kabungaidze, same interview. See also J. Rukweza, same interview.

¹⁵⁸⁷ I. Chowa, same interview.

use of latex condoms.¹⁵⁸⁸ The proceedings of the workshop were meant to enhance new understanding of condom use. Thereafter some of the church's pastors supported the prophylactic use of condoms and others did not.¹⁵⁸⁹ Within circuits, some married churchwomen took exception to a woman's insistence on safe sex and the use of condoms within marriage. An informant had this to say:

Mukadzi haafaniri kunyima murume wake bonde nekuti zvinotuma murume wake kubuda kunze. Bonde haribikirwi sadza (A married woman should not deny her husband conjugal rights because that will lead him to look for other sexual partners. Sexual crave cannot be quenched by food).¹⁵⁹⁰

Among the grassroots church members in Manicaland the need to prevent sexually transmitted HIV divided the flock especially women. While some churchwomen insisted on the use of condoms, other churchwomen risked contracting HIV and saved marriages when spouses insisted on unprotected sex.

The introduction of the VCT and PMTCT interventions at Old Mutare and Mutambara hospitals in 2004 affected people's attitude towards HIV prevention and treatment. This was achieved with support from ZACH and the Zimbabwe Vitamin A for Mothers and Babies Project (ZVITAMBO), a local AIDS service organisation.¹⁵⁹¹ Increased access to VCT and PMTCT services enhanced the quality of healthcare services available to communities. Old Mutare and Mutambara hospitals relieved pressure on VCT and PMTCT services at Mutare provincial hospital. Within the United Methodist Church in Manicaland, the roll out of VCT services also enabled the church address denial and stigma. Some of the church's clergy and lay leaders were known to have encouraged people to know their HIV status and take precautions.¹⁵⁹² Some informants were of the opinion that increased access to VCT and PMTCT services led to a reduction in sexually related domestic violence. As some married couples gradually accepted to go for VCT and that the babies born to HIV positive

¹⁵⁸⁸ The Revd Samson Muzengeza made hard copies of handouts distributed at the workshop available to M. Mbona.

¹⁵⁸⁹ E. Kabungaidze, same interview. See also A. Mhondoro, same interview.

¹⁵⁹⁰ T. Matsika, same interview. See also J. Rukweza, same interview.

¹⁵⁹¹ TM, Manyeza, "Medical secretary report," Zimbabwe East Annual Conference's Council on ministries.

¹⁵⁹² S. Sign, same interview. See also T. Matsika, same interview. See also I. Chowa, same interview.

mothers were saved from contracting the virus, the impact of HIV declined.¹⁵⁹³ In some circuits including Chitenderano, church members especially young adults who were contemplating marriage also took the initiative to go through VCT.¹⁵⁹⁴ While VCT services were welcome to some, it is also possible that tensions within marriage were enhanced when couples or one of the partners tested HIV positive.

There were circuits and stations that established a number of AIDS-related care interventions. In 2004 in the church's Marange district it was reported:

The Gwese Orphan Trust is progressing well with more than 200 orphans, we are moving to Munyarari and Chitora with the same concept. The orphan plight shall continue to be an area of concern due to the HIV/AIDS pandemic.¹⁵⁹⁵

Similarly, in the Mutasa-Nyanga district church members provided assistance to OVC in cash and in kind.¹⁵⁹⁶ In 2005 OVC and home-based care programmes that were originally supported by a group of Americans in Makoni-Buhera district were discontinued. According to Chowa, local church members failed to sustain the needs of PLHIV and OVC.¹⁵⁹⁷ Consistent with this observation, Saungweme also stated that some circuits were unable to pay the pastor's salary and therefore there were no financial resources to carry out OVC interventions: "The priority of the church is the care of its clergy and where a circuit is poorly resourced very little could be done in caring for PLHIV and OVC."¹⁵⁹⁸

At some congregations HIV interventions were left to a handful of interested individuals.¹⁵⁹⁹ Generally, the HIV interventions were carried out within certain communities and operated without coordination from centralised structures. Some church members were involved in voluntary home-based care activities. A few examples cited include Makoni Central, Zambuko, Rusape, Makoni West, Rukweza

¹⁵⁹³ J. Rukweza, same interview. See also E. Humure, same interview.

¹⁵⁹⁴ MBDR, "Chitenderano circuit report," Makoni Buhera district charge conference, 27 July 2007.

¹⁵⁹⁵ AM, "District superintendents' composite report," Zimbabwe East Annual Conference of the UMC fourth session, 4.

¹⁵⁹⁶ J. Makunike, same interview. See also AM, "District superintendents' composite report," Zimbabwe East Annual Conference of the UMC fourth session, 5.

¹⁵⁹⁷ I. Chowa, same interview.

¹⁵⁹⁸ M. Saungweme, same interview.

¹⁵⁹⁹ See HCM, Hilltop circuit, Minutes of circuit council meeting, 9 August 2001. See also HCM, Minutes of the charge conferences, 2 July 2002, 21 February 2004, 1 July 2005.

and Rusape Inner City.¹⁶⁰⁰ However, perhaps with proper coordination these interventions could have reached out and served people. This intervention lacked resources such as home-based care kits, uniforms, and bicycles for meant to enhance the mobility of voluntary caregivers. This undermined the motivation that drove voluntary caregivers to deliver services to home-based care clients efficiently.¹⁶⁰¹ While AIDS-related care impoverished some people, others could have become rich. Apparently, a perception that some of the pastors from the United Methodist Church and other churches in Manicaland used funds earmarked for HIV and AIDS interventions for self-enrichment existed.¹⁶⁰² Given the fact that HIV and AIDS interventions under the United Methodist Church in Manicaland received donor support, it is not unusual for members of the public to make such allegations.

The leadership of the United Methodist Church also trained pastors and lay people to –assist with counselling of PLHIV, their families, caregivers as well as the OVC.”¹⁶⁰³ In May 2002, a major training workshop on pastoral counselling for pastors and their spouses was held at Africa University. The workshop assisted grassroots church leaders with counselling and care support to the PLHIV, OVC, widows, widowers and grandparents. One of the key facilitators, Lorraine Muchaneta from FACT delivered a presentation on the value of appreciating personal dynamics such as feelings of isolation, the need to be loved, feelings of depression, numbness, resentment, fear, anxiety, anger, bitterness, shock, guilt and insecurity that were often experienced by the PLHIV and OVC.¹⁶⁰⁴ Participants also benefited from a presentation entitled –Psychosocial Implications of HIV/AIDS” by Louise Thomas-Mapleh of the WHO Zimbabwe office.¹⁶⁰⁵ The paper sensitised participants to appreciate their social responsibilities to PLHIV, the dynamics of home-based care, shared confidentiality in the church, disclosure of HIV status, provision of essential resources such as food,

¹⁶⁰⁰ See MBDR, –Makoni central circuit report to the Charge conference, 6 April 2002, Zambuko circuit report to the Charge conference, 5 May 2005, Makoni west circuit report to the Charge conference, 12 March 2006, Rukweza circuit report to the Charge conference, 24 March 2006, Rusape circuit report to the Charge conference, 17 June 2007, Rusape inner city report to the Charge conference, 10 June 2007.

¹⁶⁰¹ T. Matsika, same interview. See also J. Rukweza, same interview.

¹⁶⁰² For this see L. Kupara, same interview.

¹⁶⁰³ A. Mhondoro, same interview.

¹⁶⁰⁴ SM, L. Muchaneta, FACT Officer, –Counselling and support of orphans, widows and grandparents,” Unpublished paper presented at a UMC workshop for pastors and spouses held at Africa University, (26-31 May 2002).

¹⁶⁰⁵ SM, L. T. Mapleh and P. O. Fasan, –Psychosocial implication of HIV/AIDS,” Unpublished paper presented at a UMC workshop for pastors and spouses, Africa University, (26-31 May 2002).

drugs and sanitary material through the church and the setting up of income generation projects.¹⁶⁰⁶

Another facilitator, Elizabeth M. Brisbane, of the church's Emory Annual Conference based in Washington DC, used Biblical theology to sensitise the participants on appreciating the importance of a theology of compassion for PLHIV. This presentation was based on Luke 7:11-17.¹⁶⁰⁷ The presenter argued that despite the Jewish rules prohibiting any contact with the deceased, Jesus acted out of compassion and thus offered hope to the bereaved community. Brisbane stated that although AIDS represented death, church leaders in particular and Christians in general, were expected to be agents of hope by offering psychosocial support to people infected and affected by the epidemic: "God entered into this community. AIDS can be and shall be eradicated. He will use Christian leaders as agents of change."¹⁶⁰⁸ Brisbane also explored the relationship between pastors and community gatekeepers, the critical assessment of community needs, the show of responsible Christian leadership, the use of updated HIV and AIDS information, congregation based HIV and AIDS education, the promotion of health and human sexuality discussions. Pastors were also reminded: "AIDS always wore the face of a loved one."¹⁶⁰⁹ The training and skills gained were meant to assist in harmonising the relationship between communities and church leaders as well as the church and PLHIV.

In March 2005, some United Methodist participants from all over Zimbabwe including the youth, the Rukwadzano guild, the Mubvuwi guild and the clergy attended a workshop at Hunnington Retreat Centre in Chinhoyi. One of the papers presented by the Reverend Andrew Mupfawa focused on human rights, gender and HIV and AIDS.¹⁶¹⁰ According to the Mhondoro who was one of the participants from Manicaland, the insights from the presentation "opened people's eyes to appreciate the connection between Christianity, HIV and AIDS, gender and human rights in

¹⁶⁰⁶ SM, Maple and Fasan, "Psychosocial implication of HIV/AIDS."

¹⁶⁰⁷ SM, E. M. Brisbane, "Developing community ministry to persons suffering with HIV/AIDS: A theological basis for the Shalom model/approach in HIV/AIDS ministry in Zimbabwe," Unpublished paper delivered at the same workshop, (12-31 May 2002).

¹⁶⁰⁸ SM, Brisbane, "Developing community ministry to persons suffering with HIV/AIDS."

¹⁶⁰⁹ SM, Brisbane, "Developing community ministry to persons suffering with HIV/AIDS."

¹⁶¹⁰ AM, A. P. Mupfawa, "Human rights, gender and HIV and AIDS," Unpublished paper presented at a training of trainers HIV and AIDS workshop, (14-18 March 2005).

Zimbabwe.”¹⁶¹¹ The relationship between gender and HIV and AIDS could have been seen as one of the topics shunned by Christian communities. Mupfawa’s paper concluded by observing:

Women lack access to care and treatment for prolonged periods because of lack of information and low risk perceptions. Cultural expectations, lack of clinic fees, lack of decision on sex, pregnancy and breastfeeding results in a highway of HIV and AIDS.”¹⁶¹²

In another paper, Mupfawa imparted skills on HIV and AIDS project design and management.¹⁶¹³ This could have been helpful in improving the church’s capacity of in responding to the pandemic. Chowa’s presentation on psychosocial support for home-based care patients at the same workshop,¹⁶¹⁴ also underscored the United Methodist Church’s vision of being a caring Christian community.

5.5. Synthesis

This chapter has shown that the turn of the new century saw the erosion of the gains of political independence and this affected HIV and AIDS interventions carried out by the churches. Briefly, in February 2000 the ZANU PF-led government faced a legitimacy crisis after losing in a referendum for a new constitution and thereafter embarked on massive invasion of former white owned commercial farms. The relations between some of the Western missionary-initiated churches took a further tumble in March 2000 when the Zimbabwe Council of Churches organised meetings that led to the formation of the Zimbabwe Election Support Network.¹⁶¹⁵ The formation of the Movement for Democratic Change under the leadership of Morgan Tsvangirai,¹⁶¹⁶ made the State to be suspicious about the involvement of churches and NGOs in carrying of HIV and AIDS interventions. While the National AIDS Council,

¹⁶¹¹ A. Mhondoro, same interview.

¹⁶¹² AM, Mupfawa, “Human rights, gender and HIV and AIDS.”

¹⁶¹³ AM, A. P. Mupfawa, “Project design and management,” Unpublished paper presented at a training of trainers HIV and AIDS workshop, (14-18 March 2005).

¹⁶¹⁴ I. Chowa, same interview. See also AM, I. Chowa, “Psychosocial support for home-based care patients,” Unpublished paper presented at a training of trainers HIV and AIDS workshop, (14-18 March 2005).

¹⁶¹⁵ Sisulu, “National unity or national exclusion?” 6.

¹⁶¹⁶ Chitando, “Down with the devil, forward with Christ!,” 2.

formed in 2000 as a collaborative project, incorporated some religious leaders and civic organisations international donors and development partners withdrew financial support from the State. The harsh economic environment had grave implications for the capacity of churches to respond meaningfully to HIV and AIDS.¹⁶¹⁷

This chapter concludes that after the State lost most of its external international donors, the churches became a crucial medium in receiving international donor support for public healthcare including the funding of HIV interventions. This forced the Government of Zimbabwe to become suspicious of the agenda of the churches and thus promulgated the NGO Act of 2004. This chapter has also established the ZCBC acted as the conscience of society by condemning the State for the introduction of repressive laws and the politicisation of financial aid to PLHIV, OVC and those families that were affected. In a study that focused on declining relations between the NGOs and the State in Zimbabwe Sibusisiwe Mpofu highlighted how the relationship affected the provision of services to the poor: –The relationship rapidly soured into hate or intolerant relationship when the Government construed that the NGOs (including churches) were pursuing ulterior agendas.”¹⁶¹⁸ The NGO Act of 2004 was passed by the State with the intention of limiting the influence of NGOs on politics. In a paper that focussed on the influence of US based NGOs, Bornstein has noted that such foreign organisations had new systems of control over the local political terrain: –In the case of Zimbabwe, what disturbed this secular academic was that Christian NGOs were good at what they did precisely because they saw their work as holistic: secular and sacred; material and spiritual.”¹⁶¹⁹ Thus the work carried out by the churches in responding to HIV and AIDS in Manicaland at a time when the State was facing socio-economic challenges could have stolen the limelight from the government.

This was also followed by a decrease in international aid to the State.¹⁶²⁰ Consistent with this observation, Kaseke and Dhemba have also stated:

¹⁶¹⁷ DOMCCPM, –HIV and AIDS and violence against women: Priorities for interventions in Zimbabwe,” Action AID international report, (2007), iii. This source was not authored by DOMCCP.

¹⁶¹⁸ Mpofu, –An investigation into the challenges,” 68.

¹⁶¹⁹ Bornstein, –Faith, liberty and the individual in humanitarian assistance,” 665.

¹⁶²⁰ Rodriguez, –AIDS in Zimbabwe,” 1.

Shortages of foreign currency and the international isolation of Zimbabwe have impacted negatively on healthcare delivery in Zimbabwe. Shortages of drugs and the high cost of drugs and medical care now characterise the health delivery system in Zimbabwe. A major challenge of the health delivery system is the HIV and AIDS scourge as this has a negative impact, not only on the health sector but the economy as a whole.¹⁶²¹

Many African countries were known for denying the existence of HIV and AIDS within their borders. In Zimbabwe the State did not give top priority to HIV and AIDS interventions. A study undertaken by Eldred Masunungure *et al.* on the ranking of topical issues among Zimbabweans for the period 2004-2005 indicates that –AIDS remains at the lower end of the league table.”¹⁶²² However, based on the findings from the present study, the ZCBC was one of the few religious institutions that critiqued the government’s ambitious goal of health for all by 2000 and pointed out the State’s weaknesses. Few church leaders in Zimbabwe were bold enough to openly accuse political leaders for the abuse of assistance to PLHIV and OVC.

According to Denis, church leaders were key players in determining church responses to the HIV pandemic.¹⁶²³ The participation of the church leaders and their followers in carrying out HIV interventions indicated their agency by actively using both tangible and intangible religious health assets. However it is important to note that the inherent interest and commitment of Christians in matters of public health accounted for the variety of church responses to HIV. Consistent with this assertion, James Cochrane has observed:

Many religious health assets have to do not with visible institutions, structures or organisations—say religious hospitals, clinics, dispensaries, hospices, care groups...but with invisible or intangible realities that nevertheless make a big difference in the way health is perceived, pursued and maintained.¹⁶²⁴

Having shown that the Roman Catholic, Anglican and United Methodist churches made strides in expanding HIV interventions, these interventions did not remove the

¹⁶²¹ Kaseke and Dhemba, —Zimbabwe country report,” 11. See also Rodriguez, —AIDS in Zimbabwe,” 2.

¹⁶²² E. Masunungure *et al.*, —People’s development agenda and Government’s policy performance in Zimbabwe,” Afrobarometer briefing paper, 28, (March 2006), 4.

¹⁶²³ For this see section on conceptual and theoretical frameworks in this study.

¹⁶²⁴ J. Cochrane, —Deliberations on religion and religious health assets,” in ARHAP, Case study papers and proceedings at the ARHAP international colloquium, South Africa, (July 2005), 21.

fact that church leaders were convinced that moral failure mainly accounted for the spread of HIV. This probably continued to fuel denial and stigma.

AIDS-care interventions under the churches in Manicaland amid the socio-economic decline of the country formed an important part of humanitarian aid. In a politically volatile Zimbabwe it could not be denied that such aid weakened public allegiance to the State as noted by Bornstein.¹⁶²⁵ This is significant in a context where HIV interventions under all three church denominations became major channels in receiving external donor funding. Comparatively, the AIDS-related care activities of the Catholic Diocese of Mutare were ahead of those of the Anglican and United Methodist Church in Manicaland.

Generally, the response to HIV and AIDS by parishes and grassroots church members of the Roman Catholic, Anglican and United Methodist churches in Manicaland revealed clear signs that denial and stigma were on the decline. The key functional role posited by Denis pertains to the meaningful effect, or lack thereof, that church members can make in HIV prevention and AIDS mitigation can be readily applied to the situation in Manicaland. The researcher noted that in all three church denominations women were at the forefront in responding to HIV. This could have been motivated by the fact that churchwomen were at high risks of contracting sexually transmitted. A study in Zimbabwe undertaken in 2003 by UNAIDS concluded that the majority of HIV-positive women were actually infected by their spouses.¹⁶²⁶ Weinreich and Benn also noted:

For many, the churches are more part of the problem than of the solution. They are associated with rigid sexual morality and the rejection of preventive measures. Particularly sensitive issues are sex education for young people, the use of condoms, and gender roles.¹⁶²⁷

The denial of the existence of AIDS and the stigmatisation of PLHIV by some church followers in Manicaland showed that the battle was far from over. Within this period, as the Roman Catholic, Anglican and United Methodist churches responded to HIV

¹⁶²⁵ Bornstein, "Faith, liberty and the individual in humanitarian assistance," 665.

¹⁶²⁶ UNAIDS, "Accelerating action against AIDS in Africa," <http://data.unaids.org/una-docs/icasa_report_2003_en.pdf> [Accessed 15 May 2011].

¹⁶²⁷ Weinreich and Benn, *AIDS: Meeting the challenge*, 98.

and AIDS in Manicaland, it became evident that some achievements were made amid a host of other challenges.

This chapter has shown that the political challenges that befell Zimbabwe between 2000 and 2007 and the resultant economic decline affected the input of the State in supporting PLHIV, OVC and healthcare in general. The unfavourable socio-economic and political environment faced by Zimbabweans affected HIV and AIDS interventions under the Roman Catholic, Anglican and United Methodist churches in Manicaland. The Anglican and United Methodist Church upgraded their capacities to respond to HIV and AIDS while the Roman Catholic Church expanded its HIV and AIDS programmes. The churches assisted PLHIV and OVC that were adversely affected by scarcity of food and medicines for the treatment of AIDS-related symptomatic conditions. This chapter also concludes that the ZACH assisted the churches' healthcare institutions in Manicaland to outsource funding and medicines. Church healthcare centres in Manicaland became sites for VCT and PMTCT and ART services. The HIV and AIDS interventions carried out by churches enriched them while the national economy was on the decline. When donors to the State withdrew their support the churches became conduits for receiving money and other resources. This increased the visibility of the Roman Catholic, Anglican and United Methodist churches in Manicaland. While the churches carried out the HIV and AIDS interventions in solidarity with the poor, the possibility of other agendas existed. The State reacted by passing the NGO Act of 2004 that drastically reduced the number of NGOs and FBOs involved in carrying out AIDS-related interventions. This translated to the further weakening of the partnership between the State and the churches.

Within the Anglican and United Methodist Church, HIV and AIDS led to the expansion in the number of healthcare institutions. This chapter has also indicated that the programmes under the National AIDS Council and Basic Education Assistance Module failed to provide adequate resources needed by PLHIV and OVC and the churches carried the burden of care. This chapter has shown that the Roman Catholic Church in Manicaland took a lead in using herbal therapies in the treatment of AIDS at a time when the poor could not afford to procure the scarce ARVs. This initiative launched in 2003 had the effect of increasing the visibility of the Roman Catholic Church. Within the Anglican Church, the openness about the pandemic shown by the

highest diocesan office made a positive effect on HIV and AIDS responses. The United Methodist Church expanded OVC care interventions. The church leaders maintained that moral behaviour change was the only tool to reduce the spread of HIV. This was ideal in the long-term but posed some challenges in the short-term. Generally, all the three churches made some attempts at addressing cultural factors that exposed women to high risk of HIV. This was demonstrated by integrating programmes on legal rights of women and education on laws of inheritance. The chapter has also shown changes in churchwomen's understanding of condom use became significant. At the grassroots level there was increased involvement by parishes in responding to the pandemic. Within the Anglican Church, women took a leading role in addressing denial and stigma and were supported by the MU worldwide office.

CHAPTER SIX

CONCLUSION

6.1. The Effects of HIV and AIDS on Church Institutional Structures

This research study indicates that religion, and in particular Christianity, became a key component in the public response to HIV and AIDS in Zimbabwe. The first theme identified by Prince *et al.* is that Christians deal with illness and death, treatment and care for the sick, and questions of morality, kinship, gender relations, and sexuality in the context of HIV and AIDS in Africa.¹⁶²⁸ In Manicaland, and indeed Zimbabwe HIV and AIDS had a visible effect on church institutional structures. Initially, church institutions did not know exactly how to respond positively to the presence of AIDS and thus pandemonium set in as church leaders and followers grappled to understand its origins and mode of transmission. The reaction of the churches to HIV and AIDS closely resembled the events during the influenza epidemic in 1918 as discussed by Ranger.¹⁶²⁹ In Manicaland in particular and Zimbabwe in general individual Christians including Ted Rogers and Geoff Foster, spearheaded Christian responses to HIV and AIDS in 1986 and 1987 respectively. At the institutional level, Rogers working with the Roman Catholic Archdiocese of Harare, the Roman Catholic Bishops of Zimbabwe and IMBISA initiated one of the earliest responses to HIV. It was also under the influence of Rogers that the Zimbabwean Catholic Bishops became the first Christian leaders in Zimbabwe to issue a public statement on AIDS in October 1987 followed by a similar ecumenical statement issued in 1989.

The second theme identified by Prince *et al.* concerns the place of Christianity in the public sphere in relation to civic society and government, development and public

¹⁶²⁸ For this see Prince, "Introduction to special issue," v.

¹⁶²⁹ Ranger, "Plagues of beast and men," 242. See also M. Mbona, "HIV and AIDS: An epidemic of 'pandemonium' amid denial and stigma by the Roman Catholic, Anglican and United Methodist Church in Manicaland (1985-2002)," *Studia Historiae Ecclesiasticae* XXXVIII (August 2012), 181-204.

health.¹⁶³⁰ The Zimbabwean Catholic bishops collectively became one of the few church leaders to critique the State for its failure to meet the welfare needs of citizens including healthcare in the context of an escalating AIDS epidemic. This indicates that the institutional responses to HIV by the churches were the product of a historical engagement with social issues by different church leaders. The Roman Catholic Church benefited from its long history of engagement in social justice and community development in Zimbabwe, to spearhead HIV interventions. The uninterrupted history of church involvement in healthcare in Zimbabwe became a vital resource in the treatment of AIDS-related illness and the carrying out of other HIV interventions. It can thus be concluded that HIV and AIDS turned church-related hospitals belonging to the Roman Catholic Church in Manicaland to ‘sanctuaries’ where people received AIDS-related care and treatment support. This has been illustrated by the fact that in 1992 the majority of the church’s diocesan healthcare centres rolled out critical HIV and AIDS interventions. The Anglican and United Methodist Church-related healthcare institutions followed later but had a different pattern.

The presence of HIV and AIDS led to the transformation of church structures and institutions. This refers to the third theme from Prince *et al.* that focuses on how church responses to HIV and AIDS led to transformation within Christian practices and worldviews in Africa.¹⁶³¹ Out of the need to respond meaningfully to the pandemic, the Roman Catholic Bishops of Zimbabwe created an additional national structure known as the “HIV and AIDS Commission.” The creation of such a commission serves to demonstrate that the Zimbabwean Catholic bishops showed great interest in the effects of the epidemic on society. The centralised and hierarchical structure of the Roman Catholic Church in Zimbabwe assisted dioceses to respond to HIV by pioneering the formation of AIDS-related community care organisations or FBOs. In Manicaland, as early as 1992, the Roman Catholic Diocese of Mutare operated one of the few FBOs that served communities infected and affected by HIV and AIDS besides FACT. While this could be applauded, at the parish level HIV interventions were weakened by a belief that responding to HIV and AIDS was the responsibility of hospitals, FBOs and NGOs.

¹⁶³⁰ For this see Prince, “Introduction to special issue,” v.

¹⁶³¹ For this see Prince, “Introduction to special issue,” v.

Within the Anglican Church, the carrying out of HIV and AIDS interventions of the Anglican Church were compromised by the fact that there was a blurred boundary between the input by the Lay Training, Relief and Information Centre and that of other diocesan institutions including the diocesan bishop, the HIV and AIDS commission and parishes. Generally, the delay in setting up AIDS desks by the Anglican and United Methodist Church weakened the capacity of churches to respond more forcefully to the epidemic. However, it is quite evident that the epidemic forced all the three churches in Manicaland either to create special structures which did not exist before or integrate it in existing departments of the church body.

At the institutional level, the Zimbabwe Catholic Bishops Conference was more aware of the plight of PLHIV, OVC and public healthcare in general than was shown by the leadership of the other two denominations. This was evident from that fact that this institution became one of the very few known religious bodies to openly remind the Government of Zimbabwe to exercise responsibility, honesty and solidity in serving the poor. The same Roman Catholic institution was also the only church organ to denounce the State's politicisation of humanitarian aid obtained through international donor agencies. The HIV and AIDS interventions under all the three churches in Manicaland in that period indicate that the churches remained committed to serving ordinary citizens including HIV-positive people and children orphaned by AIDS. Thus amid the socio-economic decline in Zimbabwe (2000-2007), the churches responded to this crisis by further intensifying HIV and AIDS interventions. For this, the churches were accused of using such activities to undermine the State. As a consequence, church responses to HIV and AIDS in Manicaland in the period 1985-2007 took place within the context of an unfolding dynamic of church and State relations.

6.2. HIV and AIDS and the Churches' Discourse

Based on insights drawn from this study, generally it can be concluded that reactions to HIV and AIDS by the churches in Manicaland in particular and Zimbabwe in general evolved over time from silence, denial and stigma to acceptance of the epidemic. At the institutional level, though some church leaders fanned the spread of

HIV by moralising the epidemic, data from this research study indicates that some church leaders denied the existence of the epidemic, as did the Government of Zimbabwe. The findings from oral sources show that the ordinary church followers' perceptions of AIDS as either *runyoka*, or the product of witchcraft, as well as the outcome of promiscuity, exacerbated the spread of HIV. This is also supported by the fact that, based on oral sources, and throughout the three periods, Christian understandings of HIV and AIDS were shaped by morality. The failure shown by church leaders and followers to address Christian teachings and cultural traditions that discriminated women fanned the spread of the epidemic and exposed married churchwomen to the risks of HIV. According to a study by Gregson *et al.* which focused on AIDS-related mortality in Manicaland, wives became HIV-positive after their husbands and this led to increased mortality.¹⁶³² In Manicaland AIDS-related denial and stigma among Christians declined as a result of State led HIV awareness programmes and church members having lost loved ones to AIDS.

While the influence of AIDS-related denial and stigma by the churches could not be precisely measured, according to Rosenberg, in the history of epidemics, denial and stigma have been hallmarks of the initial responses to disease and HIV was thus non-exceptional.¹⁶³³ Thus the 'righteous' and 'guilty', 'holy' and 'undean', and 'them' and 'us' paradigms delayed the launch of AIDS-care programmes at the parish level. The case of changes to chalice use in the Anglican Church is an example of how AIDS-related stigma transformed Christian practices. Before the AIDS era, Anglicans in Manicaland used to drink wine from the same chalice and this changed because of fear of contracting HIV from fellow parishioners. In tolerating this 'new' practice, AIDS became divisive in part of the Anglican Communion in Manicaland. Therefore Anglican communicants in Manicaland indirectly became 'agents' of AIDS-related stigma. This negative outcome could only be understood in the wider context of responses to HIV in the early years in Zimbabwe, whereby, in 1985, the State enforced the mandatory screening of blood for HIV before transfusion.

¹⁶³² Gregson, "Recent upturn in mortality in rural Zimbabwe," 1279.

¹⁶³³ For this see observations by Denis in chapter 1 section 1 and see also a similar point made by Rosenberg in chapter 2 section 2 in this present thesis.

AIDS-related stigma by church members had the undesirable effect of treating PLHIV as ‘others’ and therefore affected care support. This could have been linked to the fact that church leaders were not ready to admit their own pain from losing loved ones to the pandemic. In the early years of the epidemic in Zimbabwe those people who were identified by medical experts as having contracted HIV became the ‘moving dead.’ They were treated as lepers that deserved to be isolated and denied the privileges of sharing utensils and food with others. Data from oral sources shows that it also took sometime before Christians openly embraced PLHIV. This was not unique to the HIV and AIDS era as was noted separately by Ranger and Niehaus.¹⁶³⁴ Thus, the failure to stem the harsh tide of HIV by the churches’ healthcare centres in Manicaland amid high public expectation to do so, discredited mission healthcare systems in the eyes of Zimbabwean Christians and non-Christians.¹⁶³⁵ AIDS-related stigma gradually decreased in all the three church denominations due to availability of VCT, PMTCT (2002) and ART from 2007 onwards at localised church healthcare sites.

The use of condoms in the prevention of sexually transmitted HIV became one of the most contentious issues that dominated the discourse of the churches. The church leaders from the Roman Catholic, Anglican and United Methodist churches also exacerbated the spread of sexually transmitted HIV by taking the position that condom use cannot reduce the spread of HIV. In all their statements, church leaders emphatically stated that strict moral behaviour guaranteed an HIV free life and that the indiscreet distribution and use of condoms fanned the spread of HIV. Thus, generally, between 1985 and 2007 the input to the HIV prevention discourse by the church leaders remained moralistic in nature. In view of the fact that condoms had the effect of reducing the passage of the virus from one person to another, it was logical for the government to protect the citizens that way. Within the province of Manicaland and nationally in Zimbabwe, church leaders exposed ordinary Christians and the public to HIV by taking a rigid stance against the prophylactic use of condoms. The Zimbabwean Catholic bishops became the leading group, and understandably so, because of the church’s long history of prohibition of artificial contraception. The leadership of the Anglican and United Methodist Church, which both accepted the contraceptive use of condoms, failed to openly encourage church

¹⁶³⁴ For a detailed discussion on this see chapter 1 section 5 of this present thesis.

¹⁶³⁵ For this see chapter 1 section 5 in this present thesis.

members to use them especially with concurrent sexual partners, thereby increasing the spread of HIV.

Throughout the period from 1987 until 2007, and at the leadership level, there was consistency in the position that the use of condoms led to moral degeneration and thereby destroyed marriages and society at large. Based on oral sources, within the Roman Catholic Church, church leaders chose to ignore the silent voices of HIV infected married churchwomen by ‘preserving’ the sanctity of marriage. The recommendations by Catholic theologians such as Fuller and Keenan who resorted to traditional moral theology such as casuistry to justify the use of condoms as a way of preserving lives, as discussed in chapter 3 (see section 3.2.2.4), had minimum influence. Comparatively, the conservative position taken by the ZCBC on the use of condoms appeared to have been shared by the SACBC. However, it has to be noted that there is literature to suggest that a significant number of Catholic Bishops’ Conferences in Africa, particularly in French-speaking Africa, chose to remain silent on the issue of condoms. One such an example was the Senegalese Catholic Bishops’ Conference whose HIV prevention strategy since 1996 did not make any reference to condoms.¹⁶³⁶ The Symposium of Episcopal Conferences of Africa and Madagascar of the Roman Catholic Church issued a statement on HIV and AIDS after the meeting in Dakar, Senegal in October 2003 and it was silent on condoms.¹⁶³⁷ However, there were some Roman Catholic Church clergy in Manicaland such as Father Martin O’Regan¹⁶³⁸ and later Father Ted Rogers¹⁶³⁹ in Harare who similar to Bishop Dowling of Rustenburg appreciated the need to use condoms widely to save lives (see section 3.2.2.4). The Roman Catholic Bishops of Zimbabwe were quite consistent in guarding the tenets of the faith in matters of sexuality.

While medical personnel serving at the Roman Catholic Church’s healthcare centres often referred HIV positive couples to the priest for further pastoral guidance, their counterparts at Anglican and United Methodist Church healthcare institutions openly

¹⁶³⁶ See Green, —‘Fait-based organisations: Contribution to prevention,’ 10.

¹⁶³⁷ —‘The Church in Africa in face of HIV/AIDS pandemic,’ Message issued by symposium of Episcopal Conferences of Africa and Madagascar (SECAM), 7 October 2003, <<http://www.oikoumene.org/en/resources/documents/other-ecumenical-bodies/church-statements-on-hiv-aids/episcopal-conferences.html>> [Accessed 20 November 2012]

¹⁶³⁸ M. O’Regan, same interview.

¹⁶³⁹ T. Rogers, same interview.

recommended the use of condoms. Based on collected views of oral sources as documented in this study, women from the Roman Catholic Church felt that the episcopal leadership of the church failed to appreciate the sexual complexity surrounding Roman Catholic married women. Therefore, out of the fear of contracting HIV Roman Catholic married churchwomen strayed from the official position of the church and solicited condoms. Thus within a context of HIV, ordinary Christians were prepared to ‘bend the rule’ in order to attain self-protection against the risk of contracting HIV. Generally, this illustrates that the churches had a negative effect on the epidemic and further confirms that ‘religious institutions shape[ed] the common discourse on HIV and AIDS in a manner that is not always helpful.’¹⁶⁴⁰

The association of condoms with promiscuity and the perception of the same device as being ‘dirty’ or ‘unholy’ affected the prevention of sexually contracted HIV among Anglican and United Methodist Church communions. Thus AIDS hit hard on members of the Mother’s Union and Rukwadazono guilds respectively. While the moral behaviour change approach to HIV prevention could yield acceptable results in the long term, such a strategy was less helpful in reducing the spread of the pandemic in the short term. In their study of the impact of national HIV prevention programmes on HIV decline in Manicaland, *Gregson et al.* observed that it was very difficult to assess the effects of behaviour change: ‘For women, attendance at community based HIV/AIDS meetings were directly associated with adoption of safer behaviours and a substantial but nonsignificant reduction in HIV incidence.’¹⁶⁴¹ The present study indicate that married churchwomen from all three church denominations based in Manicaland, became aware of the potential to contract HIV by not using condoms but were in a weak positioned to openly insist on safe sex.

While within Zimbabwe and sub-Saharan Africa, the spread of the pandemic was mainly through heterosexual contact, church leaders in Manicaland failed to stem the tide of HIV because they focused more attention on morality than on sexuality. This could not be resolved easily because it became a dilemma. As Denis observed, church leaders were,

¹⁶⁴⁰ Denis, ‘HIV, AIDS and religion in sub-Saharan Africa,’ 71.

¹⁶⁴¹ Gregson, ‘Did national HIV prevention programmes contribute to HIV decline?’ 4.

...caught in a dilemma...of preserving moral values in sexual matters and by doing so they may reduce risk behaviour, thus preventing the spread of HIV. But at the same time their moral discourse can lead to stigma and discrimination, a phenomenon that contributes to the spread of the epidemic.¹⁶⁴²

On the one hand, church leaders were interested in peoples' health and yet on the other hand, church leaders were faced with the question of what to do if people did not follow their teachings. Thus, their members as well as the public often misunderstood the church leaders and viewed them as being uncaring shepherds. On the contrary, the motivation for starting home-based care was that the churches cared for people infected and affected by the pandemic. While the Government of Zimbabwe and church leaders had the same goal of preventing the spread of HIV, ultimately the government did not mind about people's sexual habits.

The church leaders from the Roman Catholic, Anglican and United Methodist churches believed that people should reduce sex in order to avoid HIV and yet none of the three churches had regular programmes to strictly control people's sexuality. This study shows that this was the case in the three churches unlike in the Apostolic-type churches for example. This was identified by Gregson *et al.* whose study concluded that married men from the Western missionary-initiated churches in Manicaland were less likely to follow church teachings on avoidance of pre-marital and extra-marital sex than their counterparts from Apostolic and Zionist sects.¹⁶⁴³ Similar findings were found in Garner's study which concluded that the mainline churches deliberately softened the strict or conservative moral teachings that were normally associated with Christian fundamentalists. Such stances conspired to weaken the potential of mainline Christianity to be a source of change in sexual behaviour.¹⁶⁴⁴ The present study established that generally all the three churches were not well-informed on the close connection between morality and sexuality and how this influenced the spread of sexually transmitted HIV among married couples. The churches either opposed the State's sexuality programmes or launched alternatives, as was the case of the Roman Catholic Church's HIV and AIDS booklet entitled *The*

¹⁶⁴² Denis, "HIV, AIDS and religion in sub-Saharan Africa," 68.

¹⁶⁴³ Gregson, "Apostles and Zionists," 189-190.

¹⁶⁴⁴ Garner, "Safe sects? Dynamic religion and AIDS in South Africa," 65.

Christian Approach to Sexuality.¹⁶⁴⁵ Unlike in Uganda where church leaders collaborated with the Government by not opposing condom use in HIV prevention,¹⁶⁴⁶ church leaders in Manicaland and Zimbabwe openly opposed the State's messages. However, it must also be acknowledged that the work done by church leaders in admonishing their followers to strictly adhere to religious-based norms of sexual behaviour possibly reduces the risk of infection.¹⁶⁴⁷

6.3. Church-Related HIV and AIDS Interventions

The scale at which all three church denominations carried out HIV and AIDS interventions in Manicaland largely depended on three factors: (i) the willingness or lack of thereof by church leaders to launch interventions, (ii) the enthusiasm shown by the local Christians, and (iii) the availability of funding and other material support. One of the earliest interventions was AIDS-related care. The greatest strength shown by all three church denominations in responding to HIV and AIDS was their ability to provide care to people infected and affected by the epidemic. Ordinary people, including grassroots Christians, were among the first who initiated the care of PLHIV and OVC. This was a commonly shared experience in Manicaland, Zimbabwe as well as other sub-Saharan Africa. In Manicaland, some Christians, especially churchwomen, were among the first to care for PLHIV including their spouses, family members, church members and other members of the community. This study concludes that these initial care interventions, often done outside parish structures, lacked critical resources and training but were carried out as part of Christian charity. In relation to care giving, insights from this study lead to the conclusion that the earliest voluntary home-based caregivers were mainly churchwomen from across the denominational divide. They were recruited and received training from FACT.¹⁶⁴⁸ Thus FACT, having pioneered HIV interventions in the province, became a critical resource for the churches.

¹⁶⁴⁵ ZCBCH, ZCBC HIV and AIDS desk programme, 2009.

¹⁶⁴⁶ Putzel, —History of state action,” 178.

¹⁶⁴⁷ Denis, —HIV, AIDS and religion in sub-Saharan Africa,” 72.

¹⁶⁴⁸ For this see G. Foster, same interview.

While within the entire period of study all three church denominations exercised AIDS-related care at varying degrees, at the institutional level the Roman Catholic Church did more work than the Anglican and the United Methodist Church. Variations in the AIDS-related care interventions provided by all three church denominations confirm the observation by Denis that the commitment shown by church leaders and their members is an important feature of HIV interventions.¹⁶⁴⁹ The Roman Catholic Diocese of Mutare established an AIDS-related community care project in 1992, this initiative being the first of its kind among the churches in Manicaland, and having followed after the Archdiocese of Harare. This initiative of the Roman Catholic Church had a strong impact, having been well funded and evenly spread across the province. Care resources included food, medical drugs, school fees and the funding for income generation projects. It also emerged that the Roman Catholic Church AIDS-related care projects in Manicaland took a holistic approach by addressing the basic needs of clients as well as caregivers and communities. This study also highlights the fact that the payment of block grants for OVC at particular schools became a viable financial resource at a time when the education system in Zimbabwe was generally underfunded.

There were very limited AIDS-related care interventions in the Anglican Church in Manicaland from the mid-1980s until the election of Bishop Bakare in 1999. At diocesan level, institutionally organised care of PLHIV was almost non-existent. The priorities were elsewhere. Members of the church's MU guild carried out much of the home-based care work for the PLHIV as part of their social responsibility programme. The Kubatana project, established in 1995 under St. Augustine's clinic, became a model of AIDS-related care for the church's new leadership. Mukai home-base care project at St. David's Bonda hospital, Munyaradzi at St. Mary's Magdalene, Nyanga, St. Werburgh's clinic at Chigodora, and Nedziwa clinic in Makoni district were born after Kubatana. The Lay Training, Relief and Information Centre was of value to the Anglican Church as it spearheaded the training of voluntary caregivers as well as running HIV and AIDS awareness programmes. The capacity of local Anglicans in Manicaland to raise money and goods to support the care of the PLHIV and OVC appeared to be at the lowest.

¹⁶⁴⁹ For this see Chapter one, section five of this present thesis.

The care of OVC by the United Methodist Church in Zimbabwe gained new significance in the time of HIV and AIDS. The effect of the pandemic on families led the church's guilds including Rukwadzano and Mubvuwi to increase forms of material and financial support towards the care of OVC. The effects of AIDS on society led to the adoption of multiple OVC care models by the United Methodist Church. At Fairfield Children's Home, Old Mutare, AIDS-related stigma was a factor in having the new concept of 'family homes' with a mother figure permanently present.¹⁶⁵⁰ The same institution was also overwhelmed by the increased number of OVC and thus launched an OVC outreach programme in 2003. In Mutare the Ishe Anesu OVC care programme at Sakubva was born as a response to need for AIDS-related care in Sakubva. Generally, the care of orphans by the Christian church has a long history as Messer observes:

Christians since the time of Jesus have understood the care of orphans not as a religious duty, but as a spiritual opportunity to show love and to nurture life. Christians may be divided over condom use or sexual issues, but there is no division on the caring of children, parents or family.¹⁶⁵¹

The communities of the United Methodist Church were given basic training in home-based care but the training of voluntary caregivers was launched quite late. The Government of Zimbabwe's tight controls on foreign donations to churches, among others, and the NGO Act of 2004 forced the church to use its institution, Africa University, as a conduit for receiving funding for PLHIV and OVC.

This study has shown that the treatment of AIDS-related illness was a second area on which performance by the churches could be measured. Data from primary written and oral sources used in this study point to the fact that between 1985 and 2007 healthcare centres belonging to the Roman Catholic, Anglican and United Methodist churches in Manicaland treated AIDS symptoms. The onset of HIV and AIDS in Zimbabwe created new challenges in the treatment of diseases and the provision of healthcare services by medical institutions belonging to all the three churches. Church-related medical institutions in Zimbabwe had often relied on the State for

¹⁶⁵⁰ P. Mufute, same interview. See also S. Sign same interview.

¹⁶⁵¹ Messer, *Breaking the conspiracy of silence*, 131.

support and this became quite evident at the height of disease outbreaks. Insights from the present study mirrored McCulloch's observations on the responses to the outbreak of disease in the 1930s by the colonial administration as Western missionary-initiated healthcare systems requested grants.¹⁶⁵² However, a major difference was that while relations between the leaders of all three church denominations and the State were at times strained, the churches availed their healthcare institutions for the benefit of disadvantaged rural communities. Thus the churches entrusted their healthcare institutions unreservedly to the treatment of AIDS-related diseases other than waiting for the government to provide all the requisite resources.

The treatment of AIDS-related illness in Zimbabwe was threatened by socio-economic decline coupled with the withdrawal of international donor support from 2000 onwards. The fact that Zimbabwe is a country with an integrated public healthcare system in which the churches, the State, and local authorities are free to serve members of the public, ensured that healthcare centres run by the churches assisted everyone in need. With 126 healthcare centres, mainly located in rural areas, and in a time of AIDS, church hospitals and clinics carried the burden that should have been the responsibility of the State. HIV-positive people were drawn to mission hospitals and clinics where charges for medical services were generally below market rates or even free. The launch of medicinal herbal therapies by the Roman Catholic Church in Manicaland provided limited assistance in the treatment of AIDS-related illness. The Roman Catholic Church's network of healthcare institutions served the poor by initiating herbal AIDS-related treatment therapies and supplied medicines to people in need.

A major finding is that the churches in Manicaland did little to ensure wide access of ARVs in the public sphere. The fact that not a single denomination in Manicaland rolled out ARVs at church-related hospitals prior to 2007 indicates that all the three denominations lacked of resources to do so. The data used in this study has led to the conclusion that starting from 2007 and onwards, ZACH, with the support of the Global Fund, became influential in assisting church healthcare institutions to roll out ARVs. Thus out of the desperate need to increase access to ARVs for PLHIV the

¹⁶⁵² For this see McCulloch, "The management of venereal disease in a settler society," 195-216.

church leaders used ZACH as a collective platform. This appeared different from the situation in South Africa whereby in 2003 the Roman Catholic Church in KwaZulu-Natal became involved in accessing ART to AIDS patients.¹⁶⁵³ The churches in South Africa including the Anglican Church of Southern Africa joined the Treatment Action Campaign that denounced companies that –engaged in restrictive practices by refusing licences to other firms making their own low-cost generic versions of AIDS drugs.”¹⁶⁵⁴ When the leadership of the Roman Catholic, Anglican and the United Methodist Church entered the territory of civil society in the late 1990s, the State in Zimbabwe became suspicious of church involvement in AIDS-related treatment and other care interventions. The fact that the churches treated AIDS-related illness at low fees and had access to medicines revived the earlier positive role played by the Western missionary healthcare centres as argued by Gelfand,¹⁶⁵⁵

Generally, the HIV interventions carried out by the churches were extended beyond the sphere of simple healthcare provision and stretched to include community welfare in the name of assisting PLHIV and OVC. Thus, this trend confirmed an important observation by Prince who noted: –What we see today is a return to nongovernmental and faith-based healthcare, not through mission hospitals but through FBOs and NGOs.”¹⁶⁵⁶ The fact that external donors funded HIV interventions carried out by all the three churches was a reason for the State in Zimbabwe to be suspicious as Bornstein has remarked: –NGOs have specialised agendas, and tackle arenas that states tend to ignore. ...As NGOs have access to international financial and volunteer resources that supersede states, they bypass states in both global and local arenas.”¹⁶⁵⁷ Out of the need to assist ordinary citizens ailing from the effects of HIV, the churches were forced to adopt diverse coping mechanisms. The collaborative ventures were characterised by partnerships with other AIDS service NGOs as well as the use of alternative channels to receive funding.

HIV and AIDS interventions carried out by parishes, congregations and circuits of the Roman Catholic, Anglican and United Methodist churches in Manicaland told a

¹⁶⁵³ For this see Joshua, –The Catholic response to HIV and AIDS in South Africa,” 250.

¹⁶⁵⁴ Mission and Public Affairs Council, *Telling the story: Being positive about HIV/AIDS*, (April 2004), 12. This was accessed as a pdf.

¹⁶⁵⁵ See chapter one, section 5 of this present thesis.

¹⁶⁵⁶ Prince, –Introduction to special issue,” x.

¹⁶⁵⁷ Bornstein, *The spirit of development*, 99-100.

different story. Though oral and written sources have shown that there was a general improvement in the uptake of AIDS awareness and AIDS-related care interventions, the presence of large numbers of Christians were not always a guarantee for positive action. Thus the findings differed from the picture painted by Elphick on the influence of Christianity on South African history.¹⁶⁵⁸ By being in the majority, the church followers from the Roman Catholic, Anglican and the United Methodist churches in Manicaland did not become involved in HIV programmes in huge numbers. In fact, given the economic decline experienced by Zimbabwe from 2000 to 2007, some Christians trained as voluntary caregivers because of material benefits associated given to those involved in carrying out AIDS-related care interventions. Such scarce resources were critical in a poverty-stricken environment and included donations of foods, farming inputs, school fees, medical supplies and allowances.

6.4. Conclusion

In conclusion, church responses to HIV and AIDS in Manicaland, Zimbabwe constituted an important part of the way Christianity contributed positively and negatively to the pandemic. Based on Gelfand's perspective that the mainline churches in Zimbabwe have had a long history of involvement in public healthcare, the churches were an essential factor in responding to HIV and AIDS. Though at varying degrees, all the three church denominations used their institutions sometimes positively and also negatively in responding to the pandemic. The history of the national response to the pandemic in Manicaland could be incomplete without acknowledging the fact that nationally, and in Manicaland, the Roman Catholic Church took a leading role. At the institutional level, the HIV interventions carried out by the Anglican and United Methodist churches suffered from leadership crisis especially in the early years. These findings, therefore, agree with the observation made by Denis that different church actors responded to the pandemic in specific ways.¹⁶⁵⁹ It can thus be concluded that the history of church responses to HIV and AIDS in Manicaland was characterised by actors at each church level playing unique roles, sometimes complementing each other and at times holding opposing views.

¹⁶⁵⁸ For this see chapter one section 1.5 of the thesis.

¹⁶⁵⁹ Denis, "The church's impact on HIV prevention and mitigation," 68.

Generally, the extent to which HIV and AIDS affected the churches and also illustrates the ways in which churches as religious entities brought tangible and intangible assets that had an effect on the pandemic.

HIV and AIDS affected the three churches by bringing the doctrines of the Roman Catholic, Anglican and United Methodist churches into the spotlight especially on human sexuality and reproductive health. The pandemic also challenged the churches to review their teachings on matters of human sexuality. For instance, the pandemic forced the leadership of the Roman Catholic Church to make public statements against the use of condoms in the prevention of sexually transmitted HIV. While the Roman Catholic bishops in Zimbabwe generally maintained a conservative stance, recent pronouncements on condoms by the Pope have been widely welcomed.¹⁶⁶⁰ Generally, all the three churches were weak in fighting denial and stigma and thus their moralistic approaches undermined efforts at HIV prevention. Thus the churches input to the discourse on HIV prevention in Manicaland showed weaknesses.

In the long term, moral behaviour change messages delivered by the churches might have positively affected HIV prevention and could have led to a decline in HIV prevalence in Manicaland. In the view of the churches, behaviour change could have provoked what Gregson *et al.* identified as “a delay in age at first sex, a reduction in casual sex.”¹⁶⁶¹ The fact that some church leaders and the State in Zimbabwe were opposed to each other’s HIV prevention strategy sent mixed signals to society at large. AIDS-related denial and stigma by some of the church leaders worsened the situation. Zimbabweans needed to learn lessons from Uganda where collaborative initiatives by the church and the State yielded positive results. In the case of Uganda, the political will that was shown by leadership also made an enormous difference to HIV prevention. In 1986, President Museveni had declared that “it was the political duty of all Ugandans to prevent AIDS [HIV] and encouraged what later became known as ABC.”¹⁶⁶²

¹⁶⁶⁰ M. O’Regan, same interview. See also L. Kupara, same interview. See also M. Chitsungo, same interview.

¹⁶⁶¹ Gregson, “HIV decline associated with behaviour change,” 666.

¹⁶⁶² J. Youde, “Ideology’s role in AIDS policies in Uganda and South Africa,” *Global Health Governance* 1/1 (January 2007), 3. The article was downloaded at: <<http://www.ghgj.org/>>.

A key strength shown by the churches as they responded to the pandemic was their ability either to create new structures or to integrate HIV interventions in already existing structures. This became quite peculiar to the Roman Catholic Church. While HIV and AIDS affected the inflow of church revenue from ordinary members, the three churches effectively sourced external funds earmarked for HIV interventions. The other strength shown by the churches was the pioneering of AIDS-related care by Christians, mainly women, who formed battalions of voluntary home-based caregivers. Christian volunteers, with or without material support from the leadership of their respective churches, were among the first to carry out this “ministry of presence” among HIV positive people and their families. While within the churches, the care of OVC by Christians had a long history, this study concludes that the three churches in Manicaland emerged with new and competent models of OVC care. Within the scope of AIDS-related care and treatment, one of the identified weaknesses was that the churches tended to abuse resources that were earmarked for PLHIV and OVC.

The network of healthcare institutions belonging to the three churches in Manicaland, with the support of ZACH, had a positive effect on treatment of AIDS-related illness. The fact that the church healthcare institutions in Manicaland became critical in providing treatment support towards PLHIV clearly indicates that the churches were an essential factor. Western missionary-founded healthcare centres in Manicaland and Zimbabwe went through three phases: between 1985 and 1994 they played a complementary role; between 1995 and 1999 they supplemented the State’s healthcare services; and finally from 2000 to 2007 they “replaced” the government’s healthcare system. The effects of HIV on Zimbabweans could have been severe without the involvement of church hospitals in the provision of treatment of AIDS-related medical conditions. Generally, the effect made by the churches on HIV was initially weak because “in many circles in the early years of the epidemic, religion was not only invisible but was also viewed with narrow-eyed suspicion...by 2000 this attitude had largely begun to change.”¹⁶⁶³ This was when increased attention was given to the pandemic by various world bodies and religious entities and with it the

¹⁶⁶³ J. Oliver, “Religion and policy on HIV and AIDS: A rapidly shifting landscape,” in Haddad, ed., *Religion and HIV and AIDS*, 82-83.

necessary opportunities for funding. As a result, the churches increasingly gained the limelight and became a force to be reckoned with in the response to HIV.¹⁶⁶⁴

The Roman Catholic Church in Manicaland made the strongest impact on the pandemic as evidenced by moving quickly from a position of ‘ignoring’ the epidemic, to confronting it, and finally mainstreamed its response to HIV and AIDS. The launch of the first strictly church-based FBO in Manicaland in 1992 bears testimony to this strength. The United Methodist Church followed with moderate responses characterised by initially ‘ignoring’ the epidemic for a decade, followed by low profile interventions, gradually confronted and then later mainstreamed. The response to HIV and AIDS by the Anglican Church illustrates the fact that the church denomination largely ignored the pandemic for almost two decades and gradually moved to confronting it (1999), until finally mainstreaming it. These differences between the three churches in Manicaland suggest lack of ecumenical collaboration on HIV and AIDS at the provincial level. While the national church leaders’ forum provided an important national ecumenical platform for church responses to HIV and AIDS, within the province, the churches competed with rather than complemented one another’s effort. Nationally in Zimbabwe, in the mid-1990s the Roman Catholic Church established similar AIDS-related projects in all the dioceses making the church’s influence and impact even strong. While the HIV interventions carried out by Anglican and United Methodist churches came late, comparatively, the construction of new healthcare centres within the province was a major input to AIDS-related care and treatment.

Finally, having declared the researcher’s biases as an Anglican priest from Manicaland, the present study has given voice to different church actors by separating between what was done and not done by church leaders and Christians at the grassroots level in responding to the pandemic. In reference to the existing literature as noted by said by Gregson, this thesis shows that the responses to HIV by the churches in the three time periods undeniably made a mark on communities in Manicaland. While Gregson addressed the aspect of HIV prevention in Manicaland, insights from my thesis are different in the sense that they cover critical AIDS

¹⁶⁶⁴ For a discussion of this see the periodisation in chapter two section five of this present thesis. See also Oliver, ‘Religion and policy on HIV and AIDS.’ 82-86.

mitigation work carried out by the churches. Consequently, the churches in Manicaland and Zimbabwe became important players in the sphere of public health. Theologically, church leaders' insistence on morality as the sole weapon in preventing sexually transmitted HIV had the unintended effect of stigmatising PLHIV including faithful married churchwomen. The pandemic is still present in Manicaland and Zimbabwe and no cure has yet been found. Christian church denominations in Manicaland and elsewhere in Zimbabwe as well as in sub-Saharan Africa could draw important lessons from this study in order to shape present and future HIV and AIDS interventions.

6.5. Ramifications and Areas for Further Research

Although the Western-missionary founded churches in Zimbabwe had a long history of involvement in public healthcare their responses to HIV and AIDS were generally slow and often ambiguous. The leadership of the Roman Catholic, Anglican and United Methodist churches and grassroots church members undermined State approaches to the prevention of sexually transmitted HIV by largely adopting a moralistic approach. The message on the prevention of sexually transmitted HIV in Manicaland in particular and Zimbabwe in general was affected by having almost two opposed views in the public space. There could be a need for the churches to draw lessons on this experience and play a positive role by adopting a multi-faceted approach to HIV prevention. This study has also shown that based on the work carried out by church leaders and grassroots members, Christian communities were assets especially in AIDS-related mitigation. It could also be concluded that while the State in Zimbabwe established the National AIDS Levy and carried out a number of HIV interventions, this was generally undermined by competing priorities. Despite the negative effects of an evolving socio-political landscape, the churches generally became beacons of hope for people infected and affected by HIV and AIDS amid accusations of pursuing ulterior motives. Public health policy makers and healthcare practitioners in Zimbabwe could benefit from this study by strengthening collaborative approaches to HIV between the State and churches.

The following areas need further research: First, this study was based on qualitative and descriptive analysis of data and is therefore limited. It is important to carry out a quantitative study in order to determine accurately the impact of church led HIV and AIDS interventions on communities. Second, the study has observed that the churches accused the State for neglecting the poor including PLHIV and OVC and the State alleged that the churches pursued ulterior motives in responding to HIV. Thus a further area of research could be to glean primary written and oral sources in order to establish the validity of both these claims. Third, the findings presented here were largely based on Manicaland province and therefore quite limited. Similar studies on church responses to HIV and AIDS could be done in other geographical provinces in Zimbabwe. This could allow for a comparison of findings with those of the present study and thus arrive at a generalised national picture. Fourth, a comparative historical study of the responses to HIV by the African initiated churches and Pentecostal and Apostolic churches in Manicaland might bring out fresh insights to this field. These churches have had a strong presence in Zimbabwe and a historical study of their response to HIV could bring about new knowledge to what is already a very promising area of enquiry.

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Appendix I. Interview Guiding Themes

Questions will be formulated around the following themes

- (a) Earliest awareness of HIV and AIDS in Zimbabwe
 - Sources
 - Initial general responses
 - Church related responses
 - Responses of the government

- (b) Stigma mitigation
 - Experiences in the Church
 - Reasons for denial and stigma
 - Effects on HIV and AIDS
 - Reducing denial and stigma

- (c) Prevention of HIV Transmission
 - Prevention of Mother to child transmission
 - Use of Condoms
 - HIV and AIDS awareness programmes by the Anglican, Catholic and United Methodist Church
 - Role of Culture and tradition for example wife inheritance

- (d) Treatment of the AIDS disease
 - Availability of treatment
 - Accessibility of treatment
 - ARVs
 - Role of the church-related hospitals
 - Challenges encountered
 - Traditional medicine

- (e) Care of PLHIV and orphans
 - Home-based care and role of Christian communities
 - Other community support groups
 - Training and resources availability
 - Challenges in AIDS care
 - Education and other needs
 - Institutionalised care versus other forms of care

- (f) Sexual education
 - Church programmes for women, men and youth
 - Moralising on HIV and AIDS
 - Condom controversy
 - Other initiatives

- (g) Other issues: relationship between church and government in health care, the church and other faith based organization etc.

Appendix II. Schedule of Interview Guiding Questions

1. Kindly tell me about your background as it relates to your church.
2. When and how did you start to know about HIV and AIDS?
3. Have you always been an Anglican/Catholic/United Methodist Church member?
4. What were the earliest forms of involvement of the your church in the HIV and AIDS crisis?
5. How would you compare the your church's response to HIV and AIDS since 1985 with other churches in Manicaland province?
6. Do you think denial and stigma affected the response of the Church to HIV and AIDS? If yes please explain why and if not can you also explain why.
7. What kind of support do you think should be given by the Church to those infected and affected by HIV and AIDS?
8. Do you think churches could have done more in caring for PLHIV? Are there any instances in when people worked together at the community level?
9. In your opinion what are some of the advantages and disadvantages of the using condoms in HIV prevention? What other methods of HIV prevention have you know or have heard about and how do you evaluate them?
10. How would you outline the developments in the Anglican/Catholic/United Methodist Church's response to AIDS in Manicaland between 1985 and 2007?
11. What has been the position of the Anglican/Catholic/United Methodist Church in the province on AIDS treatment?
12. What is your opinion about the Anglican/Catholic/United Methodist Church's ethics and sexual education programmes in relation to the HIV and AIDS AIDS crisis?
13. What did the Anglican/Catholic/United Methodist Church do in response to the increase of AIDS related orphans and widows since 1985?
14. Do you think culture and tradition has a role in responding to HIV and AIDS?
15. In your opinion did the Church take over the role of the government in medical care especially in its response to HIV and AIDS?
16. How did HIV and AIDS affect the Church and how did the Church affect the epidemic?

Appendix III. Consent Form

My name is Michael Mbona. I am a PhD student in the School of Religion and Theology at the University of KwaZulu-Natal in South Africa. I am doing a research as a part of my studies on the response of the Anglican Church, Catholic Church and United Methodist Church to HIV and AIDS in Manicaland province, Zimbabwe, from 1985 to 2007. I kindly request you to participate in an interview which I will conduct myself in order to gather enough information on the subject. Although you may not directly benefit from this research, results of this study will help the church and other religious organizations in creatively responding to the AIDS epidemic in future.

If you will agree to participate you will be asked to take part in an interview that will last for about an hour. An interview is simply a session whereby I will ask you certain questions and then you will respond on the basis of your memory and experience. Some of the questions that you may expect to answer are attached to this form (see Appendix 1).

Your participation is voluntary. If at any time during the study you wish to withdraw your participation, you are free to do so without prejudice. You are welcome to ask any question prior to your participation or even after. You are free not to answer all the questions. On the day of the interview you will also be kindly asked to fill in an interview release form. Its main purpose is to obtain your permission to use the interview for future research. This will be further explained to you.

AUTHORIZATION: I have read the above and understand the nature of this study. I understand that by agreeing to participate in this study I have not waived any legal or human right and that I may contact the researcher on (207511186@ukzn.ac.za), telephone number +27 0785 988 683 or his supervisor Professor Philippe Denis (Denis@ukzn.ac.za) at the University of KwaZulu-Natal if I have any concern about my treatment during this study or if I need any clarification. I agree to participate in this study and I understand that I may refuse to participate or I may withdraw from the study at anytime without prejudice.

My names and the information may be used for academic as well as publication writing:

Yes _____ or No _____ (Please tick the appropriate response)

Participant's Names: _____

Participant's signature: _____ Date: _____

Appendix IV. Interview Release Agreement Form



Interview Release Form

CAT

NO: _____

This agreement ensures that your interview is added to the archived collections of the Sinomlando Centre for Oral History and Memory Work in Africa in accordance with your wishes.

I, _____ (interviewee), hereby authorize _____ (interviewer) to record my name, likeness, image, and voice on tape, film, or otherwise to be used in the archived collections of the Sinomlando Centre.

In consideration of my participation in said recording, I agree that:

- The 'original' recording will be conserved at the University of KwaZulu-Natal. Copies will be held and made available as a public reference resource for possible use in research, teaching, publication, electronic media (such as the Internet or the World Wide Web) and broadcasting (such as radio or television). Copies may be made available, in whole or in part, in any and all media, in perpetuity, throughout the world, subject to limitations stated below.
- All public use is made in strict accordance with the uses and restrictions mentioned below.
- All public use is made in strict accordance with copyright law and 'fair use' provisions.
- The Sinomlando Centre, and thereby the University of KwaZulu-Natal, shall hold the copyright in this recording and I hereby cede any copy-right that I may have in my contribution to it.

- Any and all revenue acquired from this recording will be used to subsidise future research and archival projects of the Sinomlando Centre.
- This agreement represents the entire understanding of the parties and may not be amended unless agreed to by both parties in writing.

The use of the recording is subject to the following restrictions (if any):

1. I require my name to be kept confidential and anonymity to be preserved.
 YES - NO

2. Other restrictions _____

| |
|---|
| <p>Interviewee signature: _____ _____</p> <p>Signed at: _____ _____</p> <p>Date: _____ _____</p> <p>In the presence of (interviewer): _____ _____</p> |
|---|

Administrative Use Only

Interviewee details

Full names: _____

Home address: _____

Home telephone: _____ **Work** _____
Mobile _____

Work address: _____

Fax number _____ **E-mail address:**

Interviewer and project details

Full Names _____

Research Project title _____

Location of interview (s):

Number of tapes: _____ **Total length of interview (s):**

Transcribed by:

Additional Comments: _____

Sinomlando Centre for Oral History and Memory Work in Africa
School of Religion and Theology, University of KwaZulu-Natal
Private Bag X01, Scottsville 3209.
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Appendix V. Transcribed Interview

NAME OF INTERVIEWEE: Dr Ruth Bakare (RB)

NAME OF INTERVIEWER: Michael Mbona (MM)

DATE OF INTERVIEW: 18 August 2010 **VENUE:** Murambi East, Mutare

MM: Mrs. Ruth Bakare it has been a very wonderful privilege for me to meet you again particularly for the research I'm carrying out, and I would like to thank you for accepting to be one of the participants.

RB: Hmmm

MM: If we may start by getting to know who you are, perhaps your journey briefly to Manicaland as a wife to Bishop Sebastian.

RB: How much you want to know? Well we obviously came to Manicaland when my husband was elected bishop. Something that really happened out of the blue. We were very well settled in Harare where I was working. I was no longer teaching. I used to teach but I then moved and was in administration. I was an administration manager in the private sector with Anglo American. And we were well settled in Harare and really the call to Manicaland came as a surprise. But always as Christians we are on a journey and we probably have to realise that God already has a plan for us and things happen that way never foresaw would happen. So we took the challenge and I was made aware that as wife of the bishop a lot of expectations were made to me especially as far as women were concerned. And I will never forget my first encounter at a conference in St. Augustine mission in 1999. I think it was in 1999, after my husband had been elected when he started I was still working in Harare. But I attended the conference just as a visitor and I was faced with this whole big church full of women and it was quite scaring to look at all those women and to sort of asked myself what is it that I can really do with these women and what are their needs it will take me time to find out. It didn't take too long I think. We soon found out what the needs were. Maybe I should stop here.

MM: Well thank you very much for those remarks. If you could move into your experience of HIV and AIDS, when did you first become aware of this pandemic?

RB: I was already aware of this in my work in my position as the deputy head of a big girls high school in Harare where I taught for ten years from 1982 to 1992. And I think it was in the late _80s...when we first heard about HIV and AIDS and at a fairly early stage we invited a young woman who was positive and who talked to our girls in

our school. I still vividly remember that because she also brought some slides along. But I think the most fascinating thing was her own story and that she stood in front of us as a person who looked very normal but had this virus that nobody knew very much about. I think for me that was an enormous impact and realisation that this is a topic that we cannot ignore especially when we deal with young girls.

MM: Thank you very much for that one. Basing on the fact that you were involved in a school as an administrator while at the same time you were wife to a clergyman who perhaps was also looking after a parish what would you say about how the parishioners responded in those very areas if you compare what happened in those first ten years you were in a school?

RB: I was not really exposed to that because my husband was not a parish priest he was a senior chaplain at the University and as such I as a wife had very little involvement in his interaction with students. I was very much of a private person in those days, not really much involved in parish work. I was active at my own church at the cathedral in Harare, where we had an informal education programme. I was chairperson of the education committee. One thing actually I did get involved in at the time was to organise talks at the cathedral, being right at the centre of Harare for young people because we had our cathedral hall was rented out to young people who could not fit into the school system and it was then referred to as an informal education system. So they took classes in our cathedral hall and I organised talks for them where different speakers were invited and that topic also came up in those days but especially I think we were trying to find out what were the problems of the young people. Certainly one problem that came out was that young people said they did not get any help from their parents about sexual education which was very important now but the pandemic had become known in the country and that they felt that they had to rely on what friends told them which they thought was not the best way of doing it. So I do remember those sorts of issues coming up in that context. Yah!

MM: What would be your take on issues like stigma particularly when you focus on church groups? Although you pointed out in those years you were quite a private person, but how would you assess the way women and men ventured into this area of stigma.

RB: I don't remember quite a lot about stigma. But certainly there was a very strong stigma-related with HIV and AIDS and I don't recall that one talked about it much. I

do remember that it was mentioned in some of our sermons at the Cathedral but not in a very helpful manner.

MM: Uuuuuu

RB: It was also kind of...and it appeared as something that probably some people felt Christians could not possibly be involved in something like that. And I still remember much later actually when I was already in Manicaland that ah a woman actually said to me you know I always thought Christians don't do things like that otherwise they cannot become HIV positive and I was quite shocked that somebody would think like. This was around 2000 or so. So that stigma actually ordered also wrong understanding that Christians are somehow better than other people therefore will not be affected by such a pandemic was very strong in some people for a long time. And I think it goes along with sort of wrong understanding of self-righteousness that a lot of Christians had, sort of feeling that we are a bit better than the rest. I think it was unfortunate.

MM: That sounds quite interesting. Maybe let us move on to the years when you came into... when you joined Manicaland as wife to eh Bishop Sebastian Bakare. You may have grown up to know that women in the church have a lots of expectations on the wife of a bishop, more so the wife of a priest. What did you find in the diocese? Did you find any programmes? Did you find any initial responses in the field of HIV and AIDS such that it became easy or difficult for you to...to...start venturing into the aspects of human life?

RB: Unfortunately, I found myself in a situation where there had been no handover takeover from the previous bishop and wife because it was still a tradition that the bishop's wife was the president of the Mothers' Union. And while I initially quite took to that idea I could see that since there was no handover takeover there was virtually no record of the activities of the Mothers' Union in which I got more and more involved. I had to just take the challenge and try to reorganise the Mothers' Union in which actually existed in terms of members who were there and who I saw at the first conference. But there is no other record there was nothing about activities, there were no minute books there was virtually nothing. So I very much started from scratch building up the structures and at that time it was 2000 when I really started HIV and AIDS had become so much more known such that there was no way we could ignore this in the Mothers' Union. And we also started having an outreach sub-committee with special emphasis on attending to that. But apart from the committee

we really made HIV and AIDS an integral part of all our activities. We had annual meetings where women from the whole diocese met and especially at conferences four times every year. And HIV/AIDS was always part of those programmes. We would invite speakers. This was very much still about conscientising the women about the existence of HIV and AIDS, what it is really all about. Maybe there were some very wrong understandings of the disease, also some traditional beliefs which were in the way of really acknowledging the existence of this virus in this pandemic. So we had, we really tried to make it a point that there was attention paid to HIV and AIDS by way of talks. We had youth drama groups from within the diocese who came and performed some dramas to sort of illustrate the issue which usually works very well especially with rural women who may not always stay on to long talks they would really enjoy a drama. And we also had the Tamar campaign in the diocese you may remember this, where attention was drawn to child abuse which was also really closely linked to the pandemic. This is a way of transmitting the virus as well. So....and then in 2005 I believe if my memory serves me right I think there was a breakthrough in that we had one of our members standing in the front of probably a thousand women at one of our conferences confessing that she was HIV positive. This was something we had been hoping for. We had been encouraging that people come out and speak about it. Don't hide it and be positive about it and so on. But it was not a very easy thing especially in this diocese. I think the people in this part of Zimbabwe are very secretive people. They don't really like to talk about very private things. So it took a lot of time, you know repeating things over and over before we could come to a point where a woman would actually stand up and tell her sisters that look I am HIV positive but I have accepted it and I really live a fairly normal life, and yes I had to take medication I had to change my diet but I really want to be there for my children. And that was a wonderful thing for me personally. That was a wonderful breakthrough. We also were able to hand over this woman to a support group in St. Agnes at one of our churches at the time that's where she came from. And so that we didn't just use her to speak but we also gave support at her home parish where we started an HIV support group. I think that at the time this was one of the very active ones. Again we were encouraging people to come out and once they came out they would then receive some support from others and also from congregation.

MM: That sounds interesting. Perhaps looking at the example of that woman you mentioned who openly confessed publicly that she was HIV and AIDS positive or

rather living with HIV and AIDS what would you say about the way women at that conference reacted to AIDS?

RB: Well, I think they were very stunned because there is a lot of pretence especially where we use a uniform and then a lot of myth about the uniform that once you put on this uniform you are a better person and so on so forth. I think a lot of them thought that she was unfortunate. This woman was standing there and just like themselves in a uniform I think it really it was very quite in that church nobody was talking and one could tell people were quite stunned. We also used to encourage people at these conferences...There was always the sessions where they were asked first of all to submit anonymous questions that they had because we knew there was a lot of questions they wouldn't come out and dare raise in front of everybody. So we asked them for anonymous questions and a lot of questions that came up were actually related to HIV/AIDS. And this showed how important it was that we had somebody who had come out and you know I don't know whether it led to some more people coming out in their churches because we wouldn't have necessarily heard about it but I want to believe it encouraged people. I can only mention as I remember one of those anonymous questions was "I'm HIV positive and I'm pregnant. Should I abort." And of course she would have never dared ask that question. Now we tried to address those questions and then we also had some of our nurses who had trained as counsellors, offered to talk to people who felt that they had this problem that they wanted to address. Very few people unfortunately made use of this offer. I think again there is that feeling that maybe this person would talk to others about it although of course it would have been done in confidence. But I think that the fear was still there that somehow she might know somebody from my family. And she, you see people were still very secretive about it, but it only confirmed that the problem was so deep and real. I do know that one of the things in those sessions was always questions relating to women who knew that the husbands were HIV positive. Sometimes still the sort of traditional settings where the wife is in rural area the husband works in town. They knew the husbands were promiscuous had another woman, wife or girl friends or whatever, and often knew that the symptoms were already there that the husbands were positive. What should they do as a wife? Can they do sexual intercourse with their husbands? That was always the question and this is where our nurses helped us to address those issues.

MM: In terms of the this last part you have just been explaining whereby we are looking at women and men or human sexuality from a Shona cultural perspective, how did the Mothers' Union try to help women to go through the barriers of culture, whereby for example the African men is not blamed, is not accused if he is found not to be sleeping around if I may say, and yet if the wife is supposed to be faithful she must stick at home she must stick with husband and look after her children and afford him all the sexual liberty that he may ask for so to speak. How did Mothers' Union try to help women deal with that aspect of their lives?

RB: Well, I think in general we were trying to kind of empower our women. We did quite a lot of leadership courses which were done on a TOT (training of trainers) basis where we trained a core group and they went out to train others. And let alone the leadership training always at an HIV/AIDS component as well. But not only that. I'm trying to say this really led a lot of our women to become much more self confident, and I think it's only that self confidence that could ultimately make them maybe question one or two things or not necessarily just always be on the receiving end as far as relationship with the husband was concerned. As far as more practical questions were concerned, definitely the nurses would have promoted the use of condoms for women who are married and who cannot refuse ultimately sexual relationship with their husband. So that that was definitely the only answer for them. But of course that also is not a problem in itself because it could have been refused by the husband and all that. But as far as generally we sort of got the women away from just being the receiving end or being the victim really to be having more self esteem and as such maybe not just accept everything. But it's not very easy. It's a very strong cultural sort of compounded influence that cannot be just changed overnight. But I think that's the only way to do it that women simply become a little bit more assertive because I do remember although it doesn't relate it's not the husband wife relationship but I do remember some women who had also undergone our leadership training, they were actually widows. And they started programmes for orphans in their church and they called me to help them launch the project. And they said to me –Well our priest just wanted to do this launch together with our patronal festival day but we felt that this is such an important thing because they were really also dealing with AIDS orphans. This is such an important thing. We would have liked a special Sunday just for that. We didn't want to be an appendix to some other function". And they really stood their ground against priest who was trying to quash them and I said to myself well there is

a little bit of positive steps. You know that they simply had gained quite a bit of confidence and they have even said so that that encouraged them to really become leaders in their congregation. So I think in that sort of way also possibly became an example to other women. So ah it's a very gradual process. I don't think this is something that can change within a short space of time.

MM: What, what do you remember as the way women who attended the conference did in response to a talk on use of condoms?

RB: (Laughs) That I really don't know. I had no way of knowing how this had impacted on their lives. That's very difficult to know. I do also remember that maybe it's not quite what you asked but there was a point actually when women said: "We've heard enough of HIV and AIDS." So there was uh...once you keep bringing up the same thing I think there was also this feeling that we we've come to this conference... We are away from home we kind of left our problems behind. And we want to enjoy ourselves. But as Christian women we could not just meet to have fun. Ok fun was part of it and I'm sure there was some of that in these conferences all the time especially the dancing and so on. The singing and dancing and so on which I think is very therapeutic really helped them to get rid of some of the tension and burden which they carried. But we could not really stop talking about it but we tried to bring in different perspectives and not sort of tackle it in same way. But in how far this really impacted on their lives, it is very hard for me to know, I wouldn't really want to make any assumptions.

MM: Alright! Yeah thank you very much for at least that explanation. Perhaps before we move onto another theme, we could, I could maybe raise the issue of how you approached the subject of HIV and AIDS where you could get speakers. Were they always from the Mothers' Union itself or they were from outside? How did you pick up speakers and presenters for various sessions, if you could elaborate further on that one?

RB: Well, as far as HIV and AIDS was concerned we did usually use our own members, because we also felt that was not...not bad at all because certain things they will take well from fellow members. There were other topics where we needed specialists from outside, more legal issues where we invited legal NGOs who gave their time freely. Or even asked a lawyer once talked to them about inheritance, it's all in a way HIV related too because it was like we had a lot of widows with HIV and AIDS, therefore we had to talk about inheritance and laws in Zimbabwe. And for that

we invited experts from outside. But as far as HIV itself was concerned we have so many nurses in the Mothers' Union and some very much specialised in this area of HIV and AIDS that it seemed quite prudent to use those resources that we had within ourselves and they did very well. They were really knowledgeable and some of them were highly specialised in HIV and AIDS in particular. So they were, they were really the best we could get.

MM: Hmmm. Thank you mum. Perhaps we would move on to the area of caring for people living with HIV and AIDS and orphans and women, I'm looking at the point that the Christian women live in communities and as such may be close to cases where people are living with HIV and AIDS or there are orphans or they maybe infected or affected. You could elaborate on how the Mothers' Union tried to venture into the area of caring...especially if you could also look at whether there were any cases of home based care clubs, support groups established with the support and the Mother's Union of the maybe diocese.

RB: We didn't do much on the home-based care I must admit, however, I think where we tried to, we as a diocese organisation had very limited funding. So it was not possible and also the issue itself is so widespread and it's so prevalent that there was no way we could attack it from the centre. What we felt was we could keep raising the issue, we could encourage the people, give them skills like leadership skills that they could then use to also start their own project in their own churches. And I do remember that we handed out questionnaires at one conference where we said: "Can you find out about child headed families." We gave out forms to see the magnitude of the problem and to see what it was that we could do possibly. One of the responses to that was soup kitchen that was started here in Mutare at one of our churches, which was feeding mostly orphans or even those from the child-headed families. We had others I think in many of our churches from what I could see when going around with my husband for confirmation and other duties. That in most churches they had actually started something for orphans like paying school fees, some were also trying to visit the homes of the children where you know... where there was no adult maybe the oldest was the teenager to give some kind of moral support other than just material support. But I was talking earlier of the orphans project that was started in a rural church outside Mutare at St. James where these women were as I said they were the church widows, they were also really victims in a way and also people who struggled very much that they were still able to start a group for orphans. I mean a support

group, which I thought, was wonderful because they had very few means themselves. But they managed to get support so what we would then do if we were told about such a group like they had an official launch at the time we used to get some practical support from Scotland from a church I had visited or diocese that I had once visited although we had no special links with them. But because I had visited them when I had told them about our situation they used to send us parcels with toys for children and also homemade toys that were knitted and what not. And also children's clothes and pullovers etc. and we used to get them regularly. Now when we had a launch like that I was able to go there with little bit of money from the central funds to just say this is not going to take you far but we are just supporting you and acknowledging what you are doing and also with some of these things. At that particular launch to actually able to give each child each of the orphans something either a teddy bear or a pullover or whatever. And I still have some of those photos where these children really clutched these things like nobody is going to take this from me. It was very, very touching actually. And so this was a sort of way we were trying to promote and encourage local groups to start their own projects because we felt the problem was just too big for us to actually tackle it you know from the centre.

MM: Well, maybe if you could take this aspect a little further because you have sited a particular station and parish St. James Zongoro. And it's not my first time to hear some people talking about the good work that was going on amongst some even disadvantaged members of the Mothers' Union in seeking to help orphaned children. Would you think that our... for example women in the parishes would have done more on their own using their own locally available resources to support others rather than having this notion of coming to the central fund or diocesan committee and saying we need this kind of support we need this kind of support?

RB: Well, I think such things really can be done much better at local level. Also they are the people who know the issues better. They even know the most needy people better. There was no way for us to really identify all the needy people unless you know through the local leadership. So but I do however think that maybe if I had stayed longer because time was limited. We had you know... It took time to set up a lot of the programmes that we were trying to do and also with always very limited funds. And again another big constraint we had in those years was the fuel problem (laughs). We were very, very restricted on our movements and being a very big rural diocese it's very difficult to do things without actually getting there. So I remember

starting widow's project where we gave loans to widows. Again this was an HIV...related thing as well because we, we, were specifically targeting widows who wanted to start income generating projects. And they had to form small groups and each got a small loan and then they paid us back after six months they started paying us back in instalments whatever we had given them as a group. So we encouraged them to work together and the constraints were that that should have been able to monitor those projects with our full-time worker at that time. But we simply couldn't get fuel. Buses were very few to go to those places. So we had a lot of constraints during those programmes and think if we had more time like now, this sort of problems really don't exist. We can now easily get to places. That's not really a problem. I really think more needs to be done. I think what maybe your idea in raising the question is that it may not be enough to just leave it to local people. Although they should always be the people who own a project, but there is probably need for some kind of coordination, there is need for maybe training also of people. And I think the Mothers' Union would be well advised now although I am no longer you know involved in the activities. It could be good to have actually a full time HIV person. I know one of our members who is very good in one of our churches here who is HIV positive, she is also open about it. And it's a good opportunity. She has spoken to other churches and she even goes to some other organisation to get pamphlets so that she can leave some information like that. She is a person like that, she is not highly skilled, but a person like that you take her, maybe send her for some courses with some fact or other NGOs. And you later employ her or do nothing else but you know coordinate such project and encourage people to start project in their own congregations and also do a lot of awareness raising. I think the Mothers' Union still has to come out of this wrong understanding of motherhood. For me I was quite shocked. This is a very personal thing. You were there though when my sister-in-law died only a few months ago. I think you were at the service, I saw you. She had denied having HIV and AIDS. She had full blown AIDS. We had suspected for a long time that this was the case. We had tried to talk to her husband but they were not prepared to really open up which is very difficult in settings. Since we are the older people in the family and they are the younger ones so we actually came and said please say yes if you are HIV positive. It's...it's was very difficult for them although we would have never asked any questions. There was no point in asking, where did you get it, how come and all that. Because they denied so we really failed to make

them to understand and act accordingly. So what shocked me so much at that service when at the funeral service was on how so many members of the Mothers' Union were talking of what a wonderful mother she was. And yes indeed I fully agree she was a very good mother, she really raised those children. She also had to take over the children from her husband which is not an easy thing to do. And she was very good. But she was never ever in a position to accept that she was positive and that she had AIDS. And if I can believe what her husband tells us our brother-in-law that she refused to take the ARVs, then we had failed in the Mothers' Union. Being as good a mother as she was, but she could not accept this and then act accordingly so that she could easily have lived. To me she didn't have to die. I'm sorry to say. I mean I don't know but we say it was God's will but I think we also have a responsibility. And she had really been on ARVs you know early enough I'm sure it was not necessary for her to die at that point. And all those years she could have given to those children you know would have made a big, big difference. But she was nurturing six children between the ages of six and thirteen, you know, and that is terrible. It really I will never forget it and I was shocked about the Mothers' Union totally ignoring that of course, we are not able to talk about that in church yet. And first of all pretending it wasn't there. And then supporting this thing of what a good Mother she was and what will take her straight to heaven this sort of thing. I mean sorry I'm not trying to ridicule it but I think first of all we are not to judge that anyway. And the judgemental attitude of Mothers' Union was something that I had the biggest problem with personally because I...I... I do not believe that you know we have a right to judge each other. And unfortunately the Mother's Union is very good at that. (laughs)

MM: Yes, but mum you have you have really got to a point where...you have said something of course. You say it's personal but I think that it's eh something that many people or a few people rather ah would want to share. Is the church in your opinion based on that example you have given, do you think the church in its wider sense, because I was there of course at the funeral. I left because I had an appointment in relation to this research, which I was going to fulfil. But do you think the Church is doing enough, do you think the Church did enough?

RB: You know I don't think so.

MM: What would be your take on that, the church as a whole?

RB: I went to the priests and I said you know you have a lot to do, a lot to do. Because this attitude of the Mothers' Union has to go. We pretend so much, we are

saying, yes I fully agree, I really miss my sister-in-law. She was a very nice person, very good supporter of the Mothers' Union and all that. But that aspect she had completely neglected and yes there maybe a lot of reasons why she behaved the way she did and I'm also not too judgemental at that at all. But I only say if we as the church had been helping her more. We tried as relatives we failed. But if the church had more of these supporting network, where we acknowledge our sinfulness because we all we all are whether HIV or not (laughs) that's the only sin there is. So also there are a lot of victims you know in this whole scenario as we very well know. So if we could only get away from this judgemental attitude that we seem to still very good at and come to accept who we are and do something about it for the sake of children for the sake of the family. That for me became painfully obvious at this instance where I was so personally involved and really hurt. I was very, very hurt, visiting my sister-in-law two days before she died everybody was seeing what was happening to her, she said to me I don't know what is happening and you know it just showed that there was complete denial. And why are we allowing that to happen to us is always a big question. I think as a church we still haven't done enough at all. There's still encouragement of keeping quiet about it. I wonder whether it's also a problem with our priests who some of them may be positive themselves and don't even want to tackle it (laughs). And I'm quite sure that is true but even if they're not, they're not equipped, they're not, eh they haven't got the capacity to deal with it. It's not part of their training and as you would have heard from my husband that there was a programme that started unfortunately was interrupted by my husband's retirement, which I think had a lot of promise in that direction. But we are expecting a lot from very young priests who sometimes also grapple with all these issues in their own personal lives. Whether or not they're positive is not important, but so to expect them to really deal with it is almost asking them of too much unless we really equip them well. Another aspect here that comes in or comes to mind is that are we have been asking for women priests. And I think somehow it's not unrelated to the HIV thing, because they would find it very difficult as a woman to go to male priests. And that it has cultural connotations. But I don't think only in terms of the cultural side. Women especially if you're more mature find it difficult to go to a very young priest. A lot of our priests are now very young and actually talking about issues maybe that relate to sexual, sexuality and things like that, which are difficult to talk about anyway but to talk to a young man for our women is completely taboo. And they're saying we really

need women who can understand that to be women priests and that's another aspect that the church has got a long way to go.

MM: That draws us to the aspect of sexual education, related to what you've just explained. Do you think the church made a contribution to this aspect of human life whereby the youth, men and women are exposed to the issues of human sexuality in respect to HIV and AIDS?

RB: I think we didn't do. I don't think we've done enough as a church in that regard. I'm not sure, I can't speak for the youth I haven't really worked much with the youth, but when recently I came across a constitution that youth association ...and I was quite shocked about the very judgemental and self righteous tone of it. So again I think we have failed to help those youngsters, because they tend to, I think there's so much pretence when they stand in front of congregation and whatever they do and drama and so on they put on a very pious face. I mean put it very bluntly but (laughs) in actual effect what they do out there is another story because I cannot believe that a young person at that age is not exposed to such kind of issues. Just hold on...

The interviewee pauses to pick up a phone call.

RB: It's an area that younger age. I think child ministry was something that had only started in our diocese not too long before my husband retired because it was a new aspect that had come in ah by then gone very far. So I think there's a lot to be done and I don't think as a church we have done enough. We still consider it a taboo really to talk about sexuality in the church. I remember doing this in long back in Harare when I was a member of the Mothers' Union myself without anything such a being in leadership or what. And I said because I was a teacher, because I knew and as a deputy head I had a lot to do with social issues of girls who had problems. And what I could see was that most of the children had no one to talk to. In the urban context some of them they still had their mothers being *kumusha* in the rural areas. And staying with the father it was totally taboo to talk to the father about certain aspects of their sexuality. If they need a sanitary towel or sanitary pads they wouldn't dare ask their father or managed to do that because it was just not done. And then probably didn't have the traditional aunt around who could intervene or who could help. And there was definitely a big gap and need for those young girls to really be able to talk to somebody about whatever it means to grow up. And I brought this up in the Mothers' Union once and then there was a film that was done. Actually those were

the early days of AIDS and there was a film that was done called ~~More~~ "More Time," I don't know if you ever saw this film, it will be very good and...

MM: No I haven't.

RB: Because it was actually done with some of the girls in the school I taught, they were playing in that film. It was done by a Zimbabwean and it's all about youngsters, young girls especially being exposed to pressure by young boys to have sex and how some obviously succumb and others say ~~No~~, "No, I need more time." That was the whole idea of it, the theme in the film was ~~I~~ "I need more time, I'm just not ready for it". These were youngsters in school, in high school. Very well done and you'll find another girl who gets pregnant has a child is HIV positive, loses her child. It's a very good film actually, so I suggested to show this in the Mothers' Union and we did watch the film and then. I was shocked to hear that some of the so called modern women in Harare, who in top jobs well educated who said they could not talk to their own daughters about such issues. So there is a lot to be done because in the past there were in traditional Shona society from what I know about it. There was such practice that made definite provisions for this. There were people whom the young girls could talk to and all that. But that traditional society is no longer there especially in the urban context. So very often you know as I said my youngsters were telling me at these other functions at the church that we have nobody to talk to. They said we talk to our friends. And depending on what sort of friends we have that's the advice we go by and you know that can be very negative. So definitely there's a lot of need for the church and this has a lot to do with the question of whether again the leadership equipped. It does. Is this on the curriculum of our theological training, you know, it's probably not there. Then all of a sudden we expect these young priests to be able to cope with something, they have never maybe coped with themselves. So I think it goes back all the way to theological education and.

MM: Hmm. Well Mrs. Bakare, I think we are drawing to the end of this interview session. It has been very interesting. In just a nutshell, what would you say where some of the positive contributions [achievements] of the Anglican Church.

RB: In the diocese or...?

MM: In the diocese.

RB: Well, I think we did, we did have a programme. The diocesan synod had made a decision that HIV and AIDS was you know to be treated as a very important part of our activity and the program was started. And there were support groups even at the

cathedral and I remember one of the churchwardens of our cathedral in Mutare also came out in the open about his status. The same person is still alive after having identified being positive in 1994. So that's a good example of somebody living positively. Actually at the time we felt, I had a lot of respect for him. We really supported him a lot because we really felt he was very courageous to do that. He was also very active in the support group that was started at the Cathedral at that time. And I was worried at that time, I said how does the wife cope with it cause it's not very easy to be open like he was as much as we really supported. And but I took the opportunity to talk to the wife and later on managed to get her involved in Mothers' Union activities to just give her something to do outside the house and so on. But anyway I am mentioning that because that was a case which I think was very positive and encourage others. And they had a very active project there which unfortunately now because of the events in our diocese has died. But I think other support groups I know of as well as soup kitchens. Those two things were there as HIV and AIDS support in terms of you knowing other people getting together and help each other live positively and cope with stigma and all that. But there was also care for the orphans and for the widows, mothers. I remember raising a bit of funds for AIDS infected widows. Because I was working in the bank I actually appealed to my colleagues before Christmas and we managed to collect a bit of money and did a Christmas party for this particular project for the children. And I was shocked to see that a lot of women who came with their children there were widows, also look very sick. Quite a few actually died you know at the time of this project was applying, so that orphans were left behind. It was a breakthrough because they got I think they had three meals a week by the time things you know things changed in our diocese. So I think those were very encouraging examples that had started. And as far as the Mothers' Union is concerned, I think awareness of HIV there's nobody who can say that, -They didn't know, it hadn't been discussed. They had been encouraged also to address it in their own congregations even to come up with their own little interventions like orphans schools so on and so forth. So I think definitely there were some positive signs. But I would also say far more is to be done and if I was in that sort of position today as I said earlier, I think it needs a full time person to actually address that and it should be done also with some kind of capacity building first because sometimes in the church we are too naive, we don't equip people well and then we may not go very far. So I think there's need for that maybe, among the

women, for the youth, children ideally eh start at an early age. But I think we made a start and in a very rural setting those things do take a long time, things don't change really, because we are dealing with people's attitudes, cultural values and you don't change those overnight and I believe we made a beginning, we made a start.

MM: Thank you very much Mrs. Bakare for your contributions. We have tried to explore a number of themes around the contributions that were made by the Mothers' Union. Your contributions will be used in writing a thesis. Already you mentioned that we still have a long way to go as a church not in the distant future in which we need to come back to this issue and have a longer impact... You have raised a very important issues like the way clergy are trained, ways in which clergy are exposed to these issues at the seminary level, with workshops and so on, that can make a very big difference. Your voice will be part of a research which will be compiled after this work. I am sure once the thesis is done you will be part of the first people to have your hands on it.

Appendix VI: Letter: University of KwaZulu-Natal



UNIVERSITY OF
KWAZULU-NATAL

11 February 2010

**RE: Letter of Introduction: Michael Mbona (Revd), PhD Student No. 207511186,
University of KwaZulu-Natal, South Africa**

To whom it may concern

This letter serves to introduce Michael Mbona, an Anglican priest from Zimbabwe who is a registered doctoral student under my supervision in the History of Christianity Programme, School of Religion and Theology at the University of KwaZulu-Natal, South Africa. For his PhD, Michael's research topic is: "The response of the Anglican, Catholic and United Methodist churches to HIV and AIDS in Manicaland, Zimbabwe (1985-2007)." At this stage the candidate has to go into the field and collect data mainly from archives or written sources and oral sources in the form of conducting interviews. The university research office has given full ethics approval of this project through Protocol Reference Number: HSS/0979/09D.

As part of preparation to conduct fieldwork, Michael took modules in: Retrieval of Oral Memories in Christian Communities and Research Methodology. Apart from attending these courses, has also had the experience of doing research work in church and public archives in Pietermaritzburg at Honours and Masters level. I have no doubt that the skills that he has gained over the years will assist him to carry out research for this project. I therefore seek your support in affording Michael the opportunity to conduct research in the form of interviews and provide access to written sources that are critical for this project.

Your cooperation in this regard will be highly appreciated.

Yours faithfully

P. Denis

SCHOOL OF RELIGION AND THEOLOGY - Pietermaritzburg

Postal Address: Private Bag X01, Scottsville, Pietermaritzburg, South Africa.

Telephone: +27 33 260 5540 Facsimile: +27 33 260 5861

Appendix VII: Letter: Roman Catholic Diocese of Mutare



DIOCESE OF MUTARE

Bishop's House, P.O. Box 47, Mutare, Zimbabwe

Telephone: (020) 62347
Fax: (020) 62347
E-mail: redomu@commone.co.zw

Friday May 7 2010

The Priest-In charge

Ref: Grand of permission to Michael Mbona PhD Student No 207511186 to capture data in our Catholic Missions.

I do hereby dully and canonically grand permission to Fr Michael Mbona, an Anglican Priest to visit our Roman Catholic Missions for the sole purpose of data capturing for the partial fulfillment of his PhD in church History.
May you kindly assist him to the best of your ability for him to successfully accomplish his endeavour.

Thank you for your usual cooperation.

Fraternally yours

+A.C Muchabaiwa
Bishop of Mutare

Appendix VIII: Letter: Anglican Diocese of Manicaland



Church of the Province of Central Africa
THE DIOCESE OF MANICALAND

THE RIGHT REVEREND, DR JULIUS TAWONA MAKONI

STANDING COMMITTEE OF DIOCESAN SYNOD, DIOCESAN TRUSTEES, SENATE, DIOCESAN SECRETARY,
DIOCESAN EDUCATION SECRETARY, DIOCESAN TREASURER, ARDEZ, HEALTH SERVICES, CLERGY
LAY TRAINING, MOTHERS UNION, WABVUWI, YOUTH

3 Augusts 2010

TO WHOM IT MAY CONCERN

REF: GRANTING OF PERMISSION TO REVEREND FATHER MICHAEL MBONA PhD, UNIVERSITY OF KWAZULU
-NATAL, SOUTH AFRICA

Greetings in the name of our Lord and Saviour Jesus Christ.

I write this letter to inform you that Rev. Fr. Michael Mbona is an Anglican Priest, Diocese of Manicaland under the Church of the Province of Central Africa (C.P.C.A.). Currently he is doing a doctoral degree in South Africa. He would want to do a research project in the Diocese of Manicaland as part of his studies. He will be visiting church congregations, schools, projects, and any other relevant stakeholders.

May you please assist him. Your cooperation will be highly appreciated. His research does not only benefit the Diocese but our communities and the nation at large.

Yours in Christ's service



REVEREND LUKE TEDDY CHIGWANDA

(DIOCESAN SECRETARY)

146 Hebert Chitepo Street, Mutare
Telephone: 020 - 68418, Cell: 091 3 027 140

Appendix IX: Letter: United Methodist Church



THE UNITED METHODIST CHURCH
Zimbabwe East Annual Conference
CONFERENCE COUNCIL ON MINISTRIES

Telephone: (020) 64043
Fax: (020) 64043
Email:

No. 9 Second Street
P.O. Box 666
Mutare

05/05/2010

To whom it may concern

RE: GIVE ASSISTANCE TO REV. MICHAEL MBONA:

Grace and peace to you in Jesus' name

Rev. Michael Mbona is a PhD student at the University of Kwazulu Natal, South Africa, and is researching on how the Churches are responding to HIV and AIDS. One of the denominations he is seeking information is UMC, focusing on the Manicaland province, so please feel free to assist him.

For further information see attached letter.

Thanks for your co-operation.

Be always blessed

Yours in Christ's Vineyard

Rev. Z. Sign

(CCM Director)

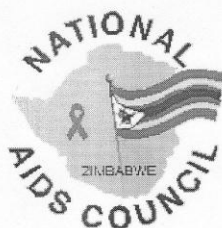
THE UNITED METHODIST CHURCH CENTRE
P.O. BOX 666
MUTARE. TEL. 64043
DIRECTOR
DATE 05/05/10

"..... and shall be like a tree planted by the rivers of water". Psalms 1:3

Appendix X: Letter: National AIDS Council

10 263-4-791171/2/8

Fax No.: 263-4-791243
Email: secretariat@nac.co.zw



P.O. BOX MP 1311
MT PLEASANT
HARARE
ZIMBABWE

100 CENTRAL
AVENUE HARARE

30 September 2010

Attention: Ms Medelina Dube
The Communications Director
National AIDS Council
100 Central Avenue
Harare

**RE: LETTER OF INTRODUCTION: MICHAEL MBONA (REVD), PHD
STUDENT NO. 207511186, UNIVERSITY OF KWAZULU-NATAL, SOUTH
AFRICA**

To whom it may concern

This letter serves to introduce Michael Mbona, an Anglican priest from Zimbabwe who is a registered doctoral student in the History of Christianity Programme, School of Religion and Theology at the University of KwaZulu-Natal, South Africa. For his PhD, Michael's research topic is: "**The response of the Anglican, Catholic and United Methodist churches to HIV and AIDS in Manicaland, Zimbabwe (1985-2007).**" The university research office has given full ethics approval of this project through Protocol Reference Number: HSS/0979/09D.

The work of the National AIDS Council of Zimbabwe (NAC) since its inception in the late nineties has a bearing on Michael's study. Churches have constituted and contributed to the multi-sectoral response to HIV and AIDS in Zimbabwe. While the study draws much of its findings from the three named mainline churches, it would also stand to benefit from NAC's input with particular focus on Manicaland provincial office, Makoni district and Mutare urban. The researcher seeks to conduct interviews with relevant NAC personnel focusing on the role of three named mainline churches including other faith based organisations to HIV and AIDS interventions in Manicaland province (1985-2007).

Your usual cooperation in the national response is greatly appreciated in advance.

Yours faithfully

**DR. TAPUWA MAGURE
CHIEF EXECUTIVE OFFICER**