A Critical Analysis of the HIV and AIDS Policy Document of the Evangelical Lutheran Church in Zimbabwe (ELCZ)

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Abstract

Despite efforts by the government, non-governmental organizations (NGOs), faith-based organizations (FBOs) and churches, the HIV epidemic remains one of the major challenges in Zimbabwe. Its impact cuts across all sectors of life and society. The context of HIV in Zimbabwe reflects that the economic and political decisions and policies have contributed to the spread of HIV. The spread of HIV is also exacerbated by some socio-cultural practices in that context. Among these socio-cultural factors are marriage practices, stigma and discrimination.

This study is an investigation of the response of the Evangelical Lutheran Church in Zimbabwe (ELCZ) to HIV and AIDS. This is done through analysis of the ELCZ HIV and AIDS policy document (ELCZHAP). The ELCZ HIV and AIDS policy document is analysed by using the "HIV competent framework" (Parry 2008:20) in an attempt to understand the strengths and weaknesses of the response to the HIV epidemic by the ELCZ. From this analysis the policy document shows that the ELCZ has some competence but it needs to be strengthened in order to address socio-cultural and political factors, as well as improve engagement with government policies. The study reveals that the ELCZ lacks a comprehensive theological discourse in responding to HIV. Through this investigation, recommendations are made in order to strengthen the ELCZ HIV and AIDS policy document and indicate areas needing further research.

Acknowledgements

Acronyms

AIDS	Acquired Immuno-Deficiency Syndrome
ARV	Antiretroviral
ART	Antiretroviral Therapy
CBOs	Community-Based Organizations
CSM	Church of Sweden Mission
CUAHA	Churches United Against HIV and AIDS
ELCZ	Evangelical Lutheran Church in Zimbabwe
ELCZHAP	Evangelical Lutheran Church in Zimbabwe HIV and AIDS Policy
ESAP	Economic Structural Adjustment Programme
FBOs	Faith Based Organizations
FTLRP	Fast Track Land Reform Programme
HIV	Human Immuno-Deficiency Virus
HBC	Home Based Care
IEC	Information Education and Communication
IMF	International Monetary Fund
IOM	International Organization for Migration
LDS	Lutheran Development Service
LWF	The Lutheran World Federation
MDC	Movement for Democratic Change
NGOs	Non-governmental Organizations
NHAPZ	National HIV and AIDS Policy of Zimbabwe
NAC	National AIDS Council
OM	Operation Murambatsvina
OVC	Orphaned and Vulnerable Children
PMTCT	Prevention of Mother to Child Transmission
PEP	Post Exposure Prophylaxis
POSA	Public Order and Security Act
SPT	The Solidarity Peace Trust
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV and AIDS
USAID	United States Agency International Development
VCT	Voluntary Counselling and Testing

WCC	World Council of Churches
WHO	World Health Organisation
ZANU-PF	Zimbabwe African National Union-Patriotic Front
ZNASP	Zimbabwe National AIDS Strategic Plan

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Chapter One

Introducing the study

1.1 Introduction

The challenge of the Human Immunodeficiency Virus (HIV) epidemic globally has received a variety of responses from many institutions such as families, governments, non-governmental (NGOs), faith-based organizations (FBOs) and the churches. Despite all these efforts, HIV continues to greatly impact human life in Zimbabwe (Bird and Busse 2007:7). Zimbabwe is one of the most affected countries although recent statistics have shown that there is a 50% decline in HIV prevalence (UNAIDS 2012).

The impact of this epidemic is signalled by the increase in the number of widows and orphans as well as child-headed households in both rural and urban Zimbabwe (Bird and Busse 2007:7). In the 1990s both government and churches began to shift from the denial that had contributed to an increase of HIV prevalence to acceptance and positive responses (Whiteside 1993:218). That has seen the government of Zimbabwe establish an AIDS Council and issue the National HIV and AIDS Policy document in 1999. It is argued that these structures have been used to implement some intervention strategies that have led to the current decline in HIV prevalence (O'Brien and Broom 2011:281). This study seeks to examine the contribution made by the Evangelical Lutheran Church in Zimbabwe (ELCZ) in responding to the HIV epidemic in Zimbabwe. The ELCZ issued an HIV and AIDS policy document in 2005 which was later revised in 2011. This study seeks to critically analyse this policy document in order to understand if it indicates the ELCZ's competence to respond to the HIV epidemic in Zimbabwe.

1.2 Background of the study

During my studies in the Theology and Development programme I was exposed to various developmental issues that encompass food security, climate change, poverty, economic justice and HIV and AIDS. These issues equally affect peoples' well-being in my context. However, due to my own experiences of the impact of the HIV epidemic Zimbabwe, I became more interested in studying issues around this epidemic. I have also participated in diaconal projects in the ELCZ working with those infected and affected by the HIV epidemic. I was involved in these programmes without the knowledge of the ELCZ HIV and AIDS

policy document. This has generated my interest in examining the competence of the ELCZ in addressing HIV and AIDS through analysing its HIV and AIDS policy document.

HIV and AIDS is a global crisis, but particularly in Sub-Saharan Africa where it has caused untold suffering. The daily reality in Zimbabwe is that many people are sick and some are dying due to AIDS-related illnesses (Igo 2009:10). The increase in the number of orphans, widows and child-headed households shows that the epidemic remains a crisis (Bird and Busse 2007:7). Some recent reports show that there is decline in HIV prevalence in Zimbabwe. According to the National AIDS Council (NAC) (2010:6), in 1997 the HIV prevalence in Zimbabwe was estimated to be 26.5%; it then declined to 14.3% in 2009. It is reported that there is almost a 50% decline in the HIV prevalence in Zimbabwe (UNAIDS 2012, USAID 2010). This decline is attributed to HIV intervention programmes and changes in sexual behaviour by sexually active age groups (UNAIDS 2012:2, Halperin *et al* 2011:6). These interventions are from role players such as government and churches.

It must be noted that in the early years of the disease, churches in Zimbabwe first responded negatively, by being judgmental toward HIV positive persons. They closely associated HIV with sexual immorality, hence blamed HIV positive persons for promiscuity (Nurnberger 2005:295). Nhamo rightly points that "The way HIV/AIDS is talked about in most churches perpetuates stigma by suggesting that people who contract HIV are sinful and by emphasizing personal blame" (2011:36). Their responses were biased with morality, characterised by an emphasis on abstinence before and faithfulness in marriage, and continued downplay the use of condoms (O'Brien and Broom 2011:284). A second, now positive, response is currently realized among the churches, similar to what Haddad has observed in South Africa. "Currently, churches are recognized for the work they do in counselling and caring for those living with HIV and AIDS" (Haddad 2005:32). These responses represent a partial approach to the epidemic as they seem to focus on the people affected and infected instead of addressing the root causes of the problem. The HIV pandemic needs churches to have a holistic response. Parry (2008) has suggested the term "HIV competence" which addresses various skills and tools needed to respond adequately. This study will use Parry's framework to analyse the ELCZ policy document on HIV and AIDS.

1.3 Research questions and objectives

The key research question in this study is: How relevant is the ELCZ HIV/AIDS policy document in addressing the HIV pandemic in Zimbabwe? The following sub-questions are used to answer the above key question.

1. What is the shifting landscape of HIV and AIDS in Zimbabwe?

2. How has the Lutheran church responded to HIV and AIDS in Zimbabwe?

3. What are the strengths and weaknesses of the ELCZ HIV and AIDS policy document as a basis for the ELCZ's response to the HIV pandemic in Zimbabwe?

4. How could the ELCZ HIV and AIDS policy document be strengthened in order for it to become a more HIV competent church?

The objectives of this study are:

1. To explore the shifting landscape of the HIV pandemic in Zimbabwe.

2. To investigate the ELCZ response to the HIV pandemic in Zimbabwe.

3. To evaluate the strengths and weaknesses of the ELCZ policy on the HIV and AIDS.

4. To explore the ways in which the ELCZ HIV and AIDS policy document may be strengthened enabling it to become a more HIV competent church.

1.4 Research methodology

This research is non-empirical. There is extensive use of data collection and analysis from various secondary sources. The starting point is social analysis through the use of reports, books and journal articles on HIV and AIDS in sub-Saharan Africa and Zimbabwe in particular. An analysis of the socio-cultural, economic and political situation in relation to HIV prevalence in Zimbabwe is done. Second, a discussion on unhelpful and helpful theological discourse in the context of HIV is explored. This is meant to show how the church has shifted from theologies of retribution to life-affirming theologies that enable the church to respond to the HIV epidemic in helpful ways. Finally, the ELCZ HIV and AIDS policy document is analysed using the "HIV competent framework" (Parry 2008) as a way to evaluate the strengths and weaknesses of the ELCZ policy document in shaping the competence of the church to respond to its HIV context.

On methodological approaches, the researcher uses analytical lenses where he evaluates the ELCZ document in light of its context and a framework of an HIV competent church. This is meant to explore the competence of the ELCZ's response to the HIV pandemic in Zimbabwe.

This study has certain limitations. First, some church documents are not accessible and are not posted on the web. Second, there is limited literature researched and written directly about the ELCZ and HIV and AIDS work and theological reflections. However, the researcher has managed to get some reports on the ELCZ HIV programmes. This study also utilizes some research documents from similar church contexts that deal with theological reflections on HIV and AIDS.

1.5 Theoretical framework

Underpinning this study is the theoretical framework outlined by Parry (2008) on being an HIV competent church. Parry (2008) has attempted to help churches to respond to the HIV pandemic in a meaningful way by providing an extensive framework that outlines how a church can become what she terms "HIV competent". Parry (2008) asserts that an HIV competent church needs to have "inner and outer competencies". In order to ensure that inner competencies are able to translate into outer competencies, there is need for leadership, knowledge and resources to act as a bridge between the two (Parry 2008:20).

Inner competence is characterised by four aspects, namely, personalisation and internalisation of the risk, recognizing short and long term impact of the HIV pandemic, assessment of the factors that drive the epidemic and dealing with stigma and discrimination (Parry 2008:20). Internalising and personalising the risk is accepting that the HIV is in the church and community and everyone is vulnerable (LWF 2003:1). On the other hand, "Churches should understand that HIV and AIDS is a complex issue that relates to a number of factors such as poverty, socio-economic status, gender, sexual ethics, and culture" (Happonen *et al* n.d:17). Inner competence takes seriously the issue of social analysis.

According to Parry (2008:44), outer competence has seven components. These include theological competence, technical competence, being inclusive, socially relevant, networking and collaboration, engaging in advocacy and lastly, dealing with restoration of dignity and hope in a compassionate manner (Parry 2008:44).

According to Parry (2008:32), leadership, knowledge and resources are integral in linking the inner and the outer competencies. Leadership is important in the context of HIV and AIDS in policy development, decision making, initiatives, commitment to actions and implementing policies (Parry 2008:33). It is through a committed and knowledgeable leadership that the church is prepared to respond appropriately to the pandemic. Knowledge is another important aspect. Here leadership should have up-to-date information about HIV, factors which fuel the spread and its impact (Parry 2008:35). Besides leadership and knowledge, there is a need for resources. These are in the form of financial, structural, human, spiritual and material resources (Parry 2008:37). None of these resources should be given preference over the others for they are equally important.

This study uses Parry's (2008) framework as theoretical framework for analysing the ELCZ HIV and AIDS policy document. This work is important to this study as it enables the researcher to analyse how the policy document shows that the church internalises the problem, assesses its contextual effects, and accepts its call to respond compassionately (Parry 2008:20). The framework also enables the researcher to assess the church's theological and other outer competencies that may or may not be reflected in the ELCZ policy document on HIV and AIDS.

1.6 Outline of the study

Chapter two focuses on the HIV landscape in Zimbabwe. It explores the causes of the rise and decline in HIV prevalence in Zimbabwe. The chapter argues that although there is a statistical decline in HIV prevalence, the epidemic remains a crisis in Zimbabwe. This is due to the various political, economic and socio-cultural factors that fuel the spread of the HIV epidemic in Zimbabwe.

Chapter three discusses how the church has generally responded in its theological discourse. It explores the church's shift from a theology of retribution to liberation and prophetic theological discourse that aims to be life-affirming in the context of the HIV epidemic.

Chapter four is a discussion on the "HIV competent church" framework, including a definition of competence and the need for HIV competence.

Chapter five provides an analysis of the ELCZ HIV and AIDS policy document. A brief background of the ELCZ is given in order to link it to the formulation of the policy document. There is summary and analysis of the document using the HIV competence framework.

Chapter six focuses on conclusion and recommendations. Issues raised by this study are discussed and a way forward is suggested. Finally, recommendations for areas of further research are given.

Chapter Two

The shifting landscape of HIV and AIDS in Zimbabwe

2.1 Introduction

The impact of the Human Immuno-deficiency Virus and Acquired Immune Deficiency Syndrome (HIV and AIDS) is a global crisis. Reports show however that it is particularly acute in sub-Saharan Africa with it constituting 69% of the people in the world living with HIV world (UNAIDS 2012:8). This is due to the socio-economic and political context of the region (UNAIDS 2005:17). The region is associated with poverty and high unemployment as well as political instability. These factors among others contribute to poverty, high numbers of economic and political migrants and refugees. This situation leads people to engage in multiple sexual partnerships and unprotected sexual contact, which increase people's risks of contracting HIV. Despite these challenges, there has been some decline in HIV prevalence from the mid to late 2000s (UNAIDS 2012:8). In Zimbabwe in particular, although the country has politico-economic challenges which are more likely to fuel the spread of the epidemic, a decline of almost 50% has been noted (UNAIDS 2012:9). However, the epidemic remains a threat to the peoples' life. Even with the decline in prevalence, "in 2007, one in every seven adults in Zimbabwe was still infected with the life-threatening virus and mortality rates remained at a crisis level" (Gregson *et al* 2010:1311).

This chapter describes the shifting landscape of HIV and AIDS in Zimbabwe, showing the reasons for the decline of HIV prevalence. Then it discusses the various factors that influence the spread of HIV in Zimbabwe. The objective of this chapter is to show the extent of the HIV epidemic, thus calling for a response from the church.

2.2 The rise and decline of HIV prevalence in Zimbabwe

Since 1985 when the first HIV case was identified in Zimbabwe, the prevalence rose rapidly and unabated (USAID 2010). "The first AIDS case in Zimbabwe was reported in 1985, yet for most of the 1990s, as HIV spread to over one-fifth of the Zimbabwe adult population, the government remained in denial about AIDS and failed to enlist the expertise and resources of its NGO community" (Bastell 2005:59). The rise in HIV prevalence was due to denial and cover up by the government during the early years (Whiteside 1993:218). "As HIV infection

skyrocketed in Zimbabwe in the 1990s, the government largely swept AIDS under the carpet, making it more difficult for AIDS NGOs to make headway against the conservative mores of Zimbabwean society" (Bastell 2005:69). According to Whiteside, "People with AIDS were officially discouraged from announcing their illness and at one point a ministry spokesperson actually accused the medical profession of misdiagnosing cases and thus over reporting" (1993:219). This cover up and denial are also emphasized by Hore when he says, "Whilst the reported total cases for 1990 was 4 362, it is estimated that the actual figure was 17 992 (four times the actual cases) because of under reporting" (1993:242). Denial by the government resulted in inaction hence the increase in HIV prevalence. By 1997 the prevalence was estimated to have escalated to 26.5% (NAC 2010:6). The prevalence further rose to 32.1% in 2000 but started to decline to about 29.6% in 2002 and by 2004 it had further declined to an estimated 23.9% (Mahomva *et al* 2006:i44).

The shift from denial to action by the government and its now positive responses has seen a drop in the HIV prevalence. This is witnessed by the decline from 32.1% in 2000 to 14.3% in 2009 (NAC 2010:6). Recent reports suggest that Zimbabwe's HIV prevalence had further declined by 2011 when it was estimated to be 13.1% (UNAIDS 2012:2). "The decline is attributed to successful implementation of prevention strategies especially behaviour change, high condom use and reduction in multiple sexual partners" (UNAIDS 2012:2). It is the government who is seen as the major player in assisting in reducing HIV prevalence.

The Zimbabwean government's commitment is proved by its formulation of the 1999 National Policy on HIV and AIDS and the use of multi-sectoral approaches in responding to the epidemic (UNAIDS 2012:2). The government's initiative of the HIV and AIDS policy through the National AIDS Council (NAC) shows its commitment to tackle the problem and reduces the spread of the epidemic. This called for the public and private sector as well as churches and many other institutions to participate in mitigating the HIV epidemic (NHAPZ 1999:3). The change in the government stance on HIV paved a way for AIDS NGOs to operate in Zimbabwe in the same period (Bastell 2005:72). According to NHAPZ "Collaboration with international agencies/organisations and government, will be maintained in order to support national efforts against HIV/AIDS" (1999:3).

Some of the government strategies which have been helpful in reducing HIV prevalence are criminalization of willful transmission and addressing issues of HIV within communities that are mobile especially at the workplace (IOM 2006:10). Protection of vulnerable groups in the

context of HIV in Zimbabwe has been promoted by the policies, bills and rights passed by the government (NAC 2011:xii). "These include the National Gender Policy (2004), the Sexual Offences Act (2001), the Children's Act (2002), and the Social Welfare Assistance Act (1998), and the Disabled Persons Act (1992)" (IOM 2006:10). In addition, the government introduced "the Sexual Offences Act of 2000, the 2006 Child Adoption Act, and the 2007 Domestic Violence Act" (NAC 2011:xii). The instrument such as the Sexual Offences Act was meant to criminalize any deliberate transmission of HIV even in the marriage relationships (NHAPZ 1999:25). These legal instruments are necessary for the country to successfully reduce the spread of HIV.

The government through its Zimbabwe National AIDS Strategic Plan (ZNASP) has deliberately responded to different sectors of employment to curb the spread of HIV. This is a mitigation strategy meant to cover sectors such as mining, uniformed forces, construction, transport, cross border trades and sex workers (IOM 2006:10). According to the International Organization for Migration (IOM),

> The ZNASP seeks to address high risk vulnerabilities arising from spousal separation through workplace policies that minimise spousal separation. It also provides a framework for the development of policies/programmes that regulate sex work with particular focus on areas where high commercial sex trade is concentrated and the development of a minimum service package (prevention and mitigation) for the commercial sex industry. It also provides a framework for the development of specially tailored programmes for mobile populations that address and mitigate their vulnerability to HIV (2006:10).

The interventions through the development of workplace policies show how the commitment and political will of the Zimbabwean government contributed to the decline of HIV prevalence.

Condom distribution and the rolling out of antiretrovirals (ARV) came as a result of the government efforts to reduce the spread of HIV in Zimbabwe. "The improvement of condom distribution in Zimbabwe can be noted as a major contributor to the decline of HIV in Zimbabwe. From 2004-2007, female condom distribution increased 150% and public sector distribution tripled" (NAC 2011:xiv). Condoms have been promoted by the government although some groups such as churches and faith-based organizations (FBOs) resented them. "Despite the ambivalence about promoting condoms, they are a crucial HIV-prevention

technology in Zimbabwe and their use has been high by African standards" (O'Brien and Broom 2011:285). "While condoms were a family planning tool in the early 1990s, they became a risk reduction tool in casual and commercial relationships as the AIDS epidemic unfolded, and there are reports of more consistent condom use in recent years" (NAC 2011:xvi). O'Brien and Broom have noted that "A number of recent studies have suggested that Zimbabweans have not only used more condoms but have done so in a way that has had an epidemiological impact" (2011:285). Although there may be cultural and religious challenges which do not promote condom use, research has shown their contribution to the decline of HIV prevalence in Zimbabwe. Gregson et al (2010:1321) have indicated that the decline in HIV incidence, especially in the Zimbabwe's Manicaland province, is as a result of the increase in condom use by men.

On the other hand the Zimbabwean government also promoted and provided antiretroviral medication (ARVs). In order to acquire more drugs and funding other HIV-related programmes, the government introduced a 3% AIDS levy deduction on all workers in 1999 (O'Brien and Broom 2011:284). This has come as a major relief and a positive response by the government. "Zimbabwe's roll out of antiretroviral therapy (ART) is also an achievement for which the state can take partial credit, even though it is financed by external donors" (O'Brien and Broom 2011:286). There has been a gradual increase in antiretroviral supply and coverage "from 55% in 2009 to 79.7 % in 2011" (UNAIDS 2012:2). The availability of ARVs has helped in prolonging the life of many people living with HIV and has reduced annual deaths in Zimbabwe (NAC 2011:8). However these could not be accessed by all people living with HIV especially those in rural areas. The other challenge is that due to poverty many people do not have the capacity to buy ARVs.

Researchers such as Mahomva et al (2006); and Gregson et al (2010) have cited behaviour change as one of the effective and sustainable methods of HIV prevention. It has made an impact in Zimbabwe as it did in some parts of the world such as Uganda (Halperin *et al* 2011:1). A focus on behaviour change was also accelerated by the government's introduction of the "Behaviour Change Strategy". "The National Behaviour Change Strategy 2006-2010 is a multi-sectoral framework to reduce sexual transmission of HIV by promoting responsible sexual behaviour" (NAC 2011:xiii). "Behaviour change is complex; it involves knowledge, motivations and choices, which are influenced by socio-cultural norms, as well as risk assessment in relation to immediate benefits and future consequences" (UNAIDS 2012:16).

In addition to avoiding early sexual intercourse initiation by youths, and the consistent use of condoms, people have been encouraged to desist from engaging in sex with multiple sexual partners (UNAIDS 2012:16). Behaviour change has also been influenced by the firsthand experience of the impact of the HIV epidemic amongst families where people have lost loved ones (Avert 2010). It is argued that noticeable change in behaviour that has contributed much to the current decline of the HIV epidemic in Zimbabwe is sexual partner reduction (Halperin *et al* 2011:6).

The economic crisis has also impacted the HIV decline in many ways. For example, recent studies have shown that due to unemployment and lack of disposable income men have not had the means to engage in casual sex (Halperin *et al* 2011:3). According to O'Brien and Broom "Poverty can play other roles in addition to reducing Zimbabwean men's capacity to keep 'small houses' and to engage in casual sex" (2011:285). Due to the political and economic crisis, most men spent the majority of their time looking for ways to generate income and fend for their families instead of looking for extra-marital relationships which would increase their economic burdens. Some got involved in small businesses while other engaged in cross-border trading. "The severe economic and political instability in the country also led to extensive international migration" (Halperin *et al* 2011:3). O'Brien and Broom (2011:285) argue that the displacement of people due to the crisis of the Fast Track Land Reform Programme (FTLRP), political violence, and Operation Murambatsvina (OM) broke unsafe sexual networks and reduced the spread of HIV. This might have contributed to the decline as some of the HIV positive migrants had to deliberately leave the country in order to access medication.

Factors such as mortality and migration cannot be underestimated as they contribute to the decline in HIV prevalence. One of the most important factors that contributed to the decline of HIV prevalence in Zimbabwe is the rise in the adult mortality rate since the 1990s (UNAIDS 2005:43). The high unemployment rate and poverty have caused many Zimbabweans to migrate looking for employment and business opportunities elsewhere. "Migration has risen sharply since 2000, both within Zimbabwe and internationally. Tens of thousands of professionals have left the country to find work abroad in the region and in Europe, and an estimated 3 million Zimbabweans have fled to South Africa" (Bird and Busse 2007:4). Amongst those who migrated were people who were HIV positive. Gregson *et al* suggest that "selective out-migration of HIV-positive individuals could have contributed to

the decline in HIV prevalence" (2010:8). These factors may have been overlooked as the researchers focus on the decline in the statistics of HIV prevalence in Zimbabwe.

Although the statistics show a significant decline in HIV prevalence, there are still questions regarding the actual impact on the lives of people in Zimbabwe. Thus these statistics must be read with caution. O'Brien and Broom argue that "While the estimations of HIV prevalence and incidence in Zimbabwe are extremely useful indicators of broader shifts, they do not provide the context" (2011:287). They argue that the Zimbabwean context with its socio-cultural norms, bad governance and the economic and political climate actually influence the spread of the epidemic in the same period when statistics show decline. "Examination of social and cultural factors must augment statistical representations; especially there is a need for in-depth and rigorous exploration of the 'social life of HIV' and how the virus continues to impact on the daily lives of the people" (O'Brien and Broom 2011:287). One may also argue that these socio-political and economic challenges need serious consideration otherwise the statistics may lead to misunderstanding the HIV landscape in Zimbabwe.

Challenges such as the collapse of health systems, lack of donor funding, the disbanding of AIDS NGOs as well as the migration of both HIV positive people and health professionals are not taken into account when the issue of decline is reported (Avert 2010). After evaluation of the interventions, statistical decline and the challenges around the issue of decline, one may want to find more about the factors that fuel the spread of HIV in Zimbabwe.

2.3 Factors fuelling the spread of HIV in Zimbabwe

2.3.1 Economic and political factors

Since independence in 1980, Zimbabwe experienced some significant political stability and economic growth. Soon after Independence it was ranked amongst the countries with the most diversified economy in Africa (Carmody and Taylor 2003:55). "The government implemented a range of progressive social policies, including increasing education and health expenditures. Economic policies were implemented to redistribute income, and credit was extended to low-income farmers" (Amon and Kasambala 2009:533). However, economic challenges that began with the inception of Economic Adjustment Programme (ESAP) in 1990 were worsened by the Fast Track Land Reform Programme (FTLRP) introduced in

2000 (Marquette 1997:1143; Bird and Busse 2007:2). These policies led to unemployment and poverty that increased vulnerability to HIV. According to Chikomborero "the current economic conditions in Zimbabwe were seen as aiding the rapid spread of HIV in that they encouraged risky practices such as prostitution and relationships between young girls and 'sugar daddies'" (2007:369). In this section I would argue that poverty, the Economic Structural Adjustment Program (ESAP), Fast Track Land Reform Program (FTLRP), Operation Murambatsvina (OM), and political violence created a favourable environment for the spread of HIV in Zimbabwe.

Ngwenya defines poverty as "…deprivation from resources, and necessities of life. It is powerlessness and lack of representation and freedom in society" (2009:20). Freedom to access the basic needs of life may be the result of the socio-economic and political situation in the country. "Hyperinflation combined with unemployment has been a major driver of poverty, particularly in urban Zimbabwe" (Bird and Busse 2007:8). "Unemployment now stands at 80%. Economically active adults strive to find paid work and even those in work struggle to meet their own immediate needs, and have little or nothing left over to help support other members of the family" (Bird and Busse 2007:8). Poverty has been found to be closely linked with HIV. "The relationship between HIV/AIDS and poverty is synergistic and symmetrical. As much as HIV/AIDS exacerbate poverty through mobility and mortality of productive adults, poverty facilitates the transmission of HIV/AIDS" (Nduku 2008:43). "HIV/AIDS worsens poverty which in turn affects many other aspects of life in society" (NHAPZ 1999:7). Economic insecurity and mobility leave "women and girls more vulnerable to sexual and physical abuse" (Tibaijuka 2005:45). Poverty has forced many people to migrate looking for employment while others have engaged in sex work which puts them at risk in the context of the HIV epidemic. Poverty worsens people's vulnerability as they may be left without financial means for medical care and a good diet, which may easily cause them to succumb to the effects of the virus and die quickly.

In Zimbabwe, poverty was aggravated by the introduction of ESAP. "In 1990, the government subsequently launched a fully-fledged International Monetary Fund (IMF) and World Bank-monitored program of economic structural adjustment programme which aimed to deregulate the domestic economy (prices, employment, and wages)" (Marquette 1997:1143). One may argue that in Zimbabwe poverty has been aggravated by ESAP with its multiple effects on the socio-economic life of the people. "The 1995 Poverty Assessment Survey provides some evidence of the adverse impacts which these changes in employment

and wages may have had on poor households to 1994" (Marquette 1997:1145). "The austerity measures imposed by the ESAP led to, inter alia, the massive retrenchment of skilled and unskilled labour and of the civil service; the closure of many manufacturing industries; general price increases; and the deterioration of social services" (Tibaijuka 2005:16). "Under ESAP, the state retrenched over 40,000 workers, who were mostly men, from the civil service" (Osirim 2003:156). According to Grant and Palmiere (2003:216), these retrenchments from the formal sector pushed unemployment up to 40% in the same period. Unemployment led to poverty since most of the people remained without financial means to access food and health services.

ESAP did not only lead to a lack of financial means but also pushed the prices of goods and services up such that people could not afford them. "As liberalization and adjustment measures were introduced the real price of fertilizer quadrupled during 1990–93 and maize prices during 1990–91" (Bird and Shepherd 2003:595). This affected the rural households which depend on subsistence farming as their source of food, income and wealth. This also affected health services. "User fees for health services actually existed in both rural and urban areas prior to ESAP but were not strictly enforced. With ESAP in 1990, fees were both enforced and increased in order to achieve cost recovery" (Marquette 1997:1144). Grant and Palmiere assert that "As such, people tend to drop out of treatment due to cost, or seek traditional or self help health care" (2003:216). These health care costs and increases in food prices had double impact on the people living with HIV and their families since they were not able to access treatment and a good diet. "ESAP-driven health care cuts have come at a time when the HIV/AIDS pandemic has worsened measurably every year" (Grant and Palmiere 2003:216). Accessibility to healthcare was made difficult due to a rise in hospital fees, costs of drugs and the shortage of fuel which led to a transport shortage (Bird and Busse 2007:8). In the context of HIV, ESAP fuelled poverty and the spread of HIV because it left many people unemployed and without income for food and health services (Grant and Palmiere 2003:216). Costs for health services became so high that most people could not afford them, resulting in deaths from AIDS-related illnesses.

The abovementioned problems were coupled with various shortages in delivering health services in Zimbabwe. "Health sector is beset by shortages of drugs and equipment from retrenchments and funding cuts and overwhelming demand as a result of the HIV/AIDS epidemic" (Grant and Palmiere 2003:216). Retrenchments affected the health system when the health sector needed to be strengthened due to the spread of the HIV epidemic (Bird and

Busse 2007:7). Besides ESAP, there was the introduction of the Fast Track Land Reform Program (FTLRP) which also had a far-reaching impact as far as poverty and the spread of HIV was concerned.

According to the Solidarity Peace Trust (SPT), the FTLRP was not only an economic but a political decision by government which had various ripple effects on people's livelihood. "As a result of political decisions, around a million farm workers and their families have been deliberately deprived of their livelihoods, homes and infrastructure" (The Solidarity Peace Trust 2004:8). This displacement led to dispossession and destitution since the farm workers lost their jobs and shelter. "Due to FTLRP unemployment rose to 80% and former farm worker were forced migrate to try and find work somewhere" (Bird and Busse 2007:4). The situation automatically led to an increase in unemployment, poverty and vulnerability to HIV infection. The evictions and loss of jobs experienced by former farm workers led to displacement and created new vulnerable groups who lack access to essential services and are often chronically food-insecure (Bird and Busse 2007:2).

FTLRP led to forced displacement of farmers, farm workers and their families, hence they had no place to stay and no food to eat and some went far from educational and health facilities (Amon and Kasambala 2009:533). It meant that people living with HIV would not have access to treatment as they relocated to new places. The FLRP left farm workers without the income to pay the hospital and clinic user fees (Nduku 2008:50). This increased the vulnerability of people to the HIV epidemic. The failure to access treatment due to lack of income would mean that people living with HIV were the most affected. "In this context households are increasingly unable to afford education and health services, leading to increasing numbers of school drop-outs, rising numbers of people debilitated by treatable illness and a sharp growth in maternal and neo-natal mortality" (Bird and Busse 2007:8). The impact of the FTLRP was almost similar to that of the Operation Murambatsvina (OM) which led to forced urban-rural migration in Zimbabwe (Tibaijuka 2005:63).

By mid-2005 the government introduced the OM programme which implied cleaning up the towns and cities by the government. "While Government has translated this to mean "Operation Clean-up", or "Operation Restore Order", the more literal translation of "Murambatsvina" is "Drive out the Filth" (The Solidarity Peace Trust 2005:5). Although this seemed to be a socio-economic policy of creating order in towns and cities, some authors argue that this was a political decision for a political end by the government and the ruling

party. Among other things OM "was a pre-emptive strategy designed to prevent popular uprising, in light of deepening food insecurity and other economic hardships, and establishing a system of political patronage over urban areas by political leadership" (Tibaijuka 2005:20). The government was afraid of an uprising due to the escalation of poverty, social hardship, and political anger against the government (SPT 2005:25).

OM targeted urban dwellers and their property since they were suspected of belonging to the opposition party. "Initially targeted at street vendors and those operating in the informal urban economy, the Operation rapidly extended to the demolition of informal and formal settlements, and small and medium enterprises countrywide" (Tibaijuka 2005:31). "While there is a degree of overlap between those who lost their homes and those who lost their businesses, the total figure of 650,000 to 700,000 people directly affected by the Operation is considered plausible" (Tibaijuka 2005:33). Government agents such as police were used in the demolitions. Those who lost their homes and businesses were forced to move to rural areas. "The relocations from cities to villages have affected thousands throughout Zimbabwe and the displaced have placed an additional burden on the rural community to which they used to provide financial support" (Bird and Busse 2007:8).

OM had both an economic and a social impact on the victims which in turn had a bearing on the spread of HIV. "Economically, substantial housing stock has been destroyed, and the informal sector has virtually been wiped out, rendering individuals and households destitute" (Tibaijuka 2005:31). Most of the people who were driven into informal sector businesses by the impact of ESAP and the FTLRP had their business destroyed by OM. "In social terms, the Operation has rendered people homeless and destitute, and created humanitarian and developmental needs that will require significant investment and assistance over several years" (Tibaijuka 2005:31). This socio-economic impact of OM led to economic deterioration and family disintegration which increased transactional sex which put people at risk of contracting HIV (Amon and Kasambala 2009:534). OM thus had a direct influence on the spread of HIV and also directly affected people living with HIV.

Due to OM, poverty increased as displaced people had no income or means of production. OM influenced the spread of HIV because those who lost their accommodation and business had to find some means for survival. "Medium to long-term consequences include increased transmission of HIV, leading to higher infection rates and a more rapid progression of the disease that may only be detected over the next few years" (Tibaijuka 2005:39). The

"Operation has led to an increase of vulnerability and probably, risky sexual practices and gender-based violence" (Tibaijuka 2005:39). Some women were forced to engage in unprotected sex as a way of getting food and accommodation as they lost their informal trading spaces and accommodation. "Whatever the conditions under which sex is sold, women are generally concerned more with surviving and feeding their children today than with possibility of developing AIDS in years to come" (Jackson *et al* 1999:17).

Traditional safety nets were destroyed because families were forced to separate as the children were settled with other relatives or friends while parents were looking for an alternative business and accommodation (Tibaijuka 2005:42). "In addition, separation of family members and the erosion within the family and community weakens traditional restraints on promiscuity, particularly for youth" (Grant and Palmiere 2003:229). During this forced migration some people engaged in extra-marital relationships as they went to live far from their spouses. Children were vulnerable to abuse and would end in them contracting HIV (Tibaijuka 2005:42).

OM had direct impact on the people living with HIV as they lost their home-based care facilities as well as their treatment facilities. "It has also led to a disruption in HIV/AIDS services, particularly ARV treatment, home-based care and prevention. In cases where ARV treatment has been interrupted, this could result in drug resistance, declining health, and ultimately death" (Tibaijuka 2005:39-40). Displacement did not only affect people living with HIV's ability to get treatment but also affected their ability to access good nutrition for their diet to enable them maintain their health while on treatment (Jackson *et al* 1999:15; Tibaijuka 2005:40). OM contributed to silence and stigma that promoted the spread of HIV. "Following the destruction of their homes by government forces, PLWHA feared openly declaring their HIV status because they risked becoming evicted again by relatives or landlords where they had taken shelter" (Amon and Kasambala 2009:533). The displacement by OM is closely related to the displacement caused by political violence in Zimbabwe.

So while Zimbabwe had experienced relative peace since independence in 1980[1], it is clear from the above discussion that from early 2000 it began experiencing political instability due to attempts to introduce a one-party political system (Tibaijuka 2005:15). While this attempt

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[1] The researcher recognises that relative peace in Zimbabwe is a contentious issue because of the instablity that took place in Matabeleland from 1982-1987 during which time over 20 000 supporters of Joshua Nkomo were massacred by ZANU-PF. For a fuller discussion see, The Catholic Commission for Justice and Peace 1997. "Report on the 1980's Disturbances in Matabeleland and the Midlands". http://www.rhodesia.nl/Matabeleland%20Report.pdf. Accessed on 7 February 2014.

failed, the Zimbabwe African National Union-Patriotic Front (ZANU-PF) did not tolerate any opposition and hence has continued to suppress it for nearly two decades (Tibaijuka 2005:15). In 1999 ZANU-PF felt threatened by the formation of the Movement for Democratic Change (MDC) which ended up taking 56 seats in parliament after the 2000 elections (Carmody and Taylor 2003:54). During this period the political environment of Zimbabwe became volatile. "Between 1999 and 2007, political violence and state-sponsored human rights violations escalated" (Amon and Kasambala 2009:533). The government and the ruling party became ruthless and engaged in political violence in order to remain in power.

There was the use of legal instruments as well as direct attacks on MDC members and the so-called 'MDC sympathizers'. "The last four years have seen a relentless clampdown on all those who are perceived as opposing the ruling party, ZANU-PF. State repression has relied on key new pieces of legislation that give the state almost unlimited powers against its own people" (SPT 2004:5). Amongst the legal instruments is the draconian law known as the Public Order and Security Act (POSA). This piece of legislation was meant to prevent civilians from holding meetings, and doing so would lead to arrest by the police (SPT 2004:5). "Since it was passed in January 2002, POSA has been used weekly to silence democratic voices, and hundreds have been arrested in terms of its clauses" (SPT 2004:5). The arrests would result in many forms of humiliation and torture in police camps, and the right to treatment and medicine was violated during detention. This situation mostly affected those who were on ARV treatment. "The repressive political environment has also prevented activism and debate about HIV/AIDS and human rights in civil society" (Amon and Kasambala 2009:533). POSA prevented civil society groups from gathering people together as they were suspected of supporting MDC. Hence denial of this space affected HIV programmes.

In this case the civilians suffered violence through legal instruments which suppressed their freedom of assembly and speech. Many people who went through these arrests due to POSA and those who were hunted for organizing public meetings left their homes to stay in places of hiding inside and outside the country. As has been suggested earlier, this led to the displacement of people and separation of families which increased HIV prevalence through engagement in unprotected sex. People living with HIV had their treatment programmes disturbed by political violence as their service providers were forced to stop or they themselves were forced to migrate.

Besides the use of the law and law enforcement agents, the government instituted political violence using youth militia. It was the use of militia to perpetrate violence that led to many violations of human rights. "Such violations include torture, destruction of homesteads, massive displacement of persons fleeing political persecution or farm invasions, and the denial of food to those perceived to support the opposition" (SPT 2004:7). Osirim further asserts that "It is alleged that wives and daughters who sympathized with the Movement for Democratic Change (MDC) or who were connected to MDC supporters, as well as women farm workers were victimized by ZANU youth brigades" (2003:159). In the process of victimization and harassment, women and girls were not only beaten but some of them were gang raped by the militia (Osirim 2003:159). Victimization led to the displacement of people and raping of women and girls, increasing their vulnerability to the HIV epidemic.

There was, and still is, general discrimination when it comes to issues of health and food distribution as everything is politicized as a way of destroying the MDC (SPT 2002:13-14). "However, this is not necessarily straightforward and examples of people being denied the right to purchase maize, because they are considered to support the opposition are well documented" (Bird and Busse 2007:3). "Post election reports from key informants, including parents of affected families, indicate children, including those suffering with diarrhoea and burns, being thrown out of clinic queues because their accompanying adults were accused of being MDC supporters" (SPT 2002:13). Amongst the people affected by the denial of access to food and treatment are the people living with HIV who fall into this category. This has increased their risk of drug resistance and further HIV infection.

2.3.2 Socio-cultural factors

Amongst the socio-cultural factors that increase people's vulnerability are gender inequality, marriage systems, gender violence, stigma and discrimination, euphemism, silence and taboo.

"In many African cultures, men play a dominant role in most relationships while girls and women are generally expected to be submissive thus leading to the risk of contracting HIV/AIDS" (Nduku 2008:48). In Zimbabwe such gender inequality is created by the socio-economic situation of women. Grant and Palmiere (2003:229) advance that Zimbabwean women have subordinate positions to men similar to South African women that expose them to risk in the context of HIV and AIDS. In Zimbabwe boys are socialized to dominate women

while girls are taught to be submissive to men and especially their husbands. In the same manner the socio-economic development favours men more than women.

According to Chirongoma "Pervasive gender inequality, poverty and the violation of women's rights is propelling the spread of HIV and AIDS among the women of Zimbabwe" (2006:49). Gender inequality in Zimbabwe connected to cultural background has promoted power and superiority of men over women. Women are regarded as "second-class citizens" hence treated as subordinates to men (Kambarami 2006:5). Women do not take an active role when it comes to decision making. Gender inequality has placed women, especially wives, in subordinate positions where they cannot negotiate for safer sex (Haddad 2005:35). Ayanga asserts that "Women's fidelity in marriage, monogamy and the use of condoms to prevent AIDS are of little help to the African woman while their social status is such that they cannot insist on such measures" (2008:45). Due to their subordinate position, women are faced with gender violence when they suggest safer sex practices such as condom use (Haddad 2005:35). This kind of experience puts women at risk as they are forced to be submissive even if they know of the infidelity of their husbands.

Gender inequality continues disempowering women as they are bound by the social construction of society. Sexual behaviour of men is viewed differently from that of women in the Zimbabwean context. "Marital fidelity in a man is not questionable, but a man can inform his wife about his extra-marital sexual contacts" (Shoko 2007:21). Culturally women are bound to be faithful to their husband but men are free to have multiple sexual partners in and outside marriage. "Since fidelity is not strictly required of them, men keep consorts or mistresses (sometimes several of them) in the city while periodically going 'home' to visit their wives and children" (Ayanga 2009:43). "In contrast men are not associated with prostitution. Sex for a man is obvious. A man can have sex with a woman at will" (Shoko 2007:21). "Women are at risk because they lack the power to determine when, where and even whether sex should take place" (Gichaara 2008:196). Again men are also privileged to show and express their sexual desire and inclination but women are not expected to do so (Gichaara 2008:198). In the Zimbabwean context this ideology fuels the spread of the HIV epidemic as men engage in multiple sexual encounters outside their marriage relationships.

Furthermore in Zimbabwe some of the marriage systems which are believed to have contributed in the spread of HIV are polygamy (*barika*), levirate or wife inheritance (*kugara nhaka*) and sister-in-law taking over to have offspring for the barren or dead sister (*sara*

pavana) (Shoko 2012:101). These marriage systems put both men and women at risk but especially women (Gichaara 2008:195).

Polygamy is practiced in Zimbabwe especially among the Shona people who constitute 80% of the Zimbabwean population. "Technically the term polygamy should mean what its Greek components imply and that is, marrying many wives, husbands or times" (Mbiti 1989:138). In the Zimbabwean context a man can marry more than one wife from either those who are related or unrelated (Shoko 2007:19). The reasons for such marriages vary from increasing agricultural labour and the need for children especially the sons for family descendants. "Polygamy, therefore, ensured a constant source of procreative gratification to men…Polygamy also guaranteed that men would have descendants in their names" (Kanyoro 2006:96). According to Machyo (2012:60), "Polygamy operates to create concurrent sexual networks within marriage between multiple wives and their husband and to any extra-marital sexual contacts the spouse may have". The main problem with polygamous marriages is that they increase vulnerability if the husband continues to have extra-marital sex contacts outside his marriage. "Similarly, wives in the polygamous marriages may also be tempted to seek sexual gratification outside their circle, which can lead such marriages to risk of HIV infection" (Materu 2011:82). In cases of any one of the partners in polygamous family contract HIV, it is easily spread to the rest of the partners in that marriage.

Another commonly observed traditional marriage practice which fuels the spread of HIV is widow inheritance (Gichaara 2008:195). "According to Shona custom, when one's husband dies, the widow is expected to marry one of her late husband's brothers. If the woman fails to comply she risks being sent back to her parents leaving behind her children and all that she toiled for" (Kambarami 2006:8). This kind of marriage system fuels the spread of HIV especially if the inherited widow is HIV positive thus the man would spread HIV to his wife or other wives. This could be true for the widow as well, as her new husband may be HIV positive. According to Nicolson,

> Traditional practices like polygamy or the inheritance by a man of his brother's widow may in the past have been seen as giving protection to women, but in reality they often lead to women having very little say over their own lives and little say over their sexual relationships. It is extremely difficult for women to insist that their men use condoms, or to question any sexual relationships, which their men might have outside of their relationships. This certainly contributes significantly to the spread of AIDS (1995:47).

Wife inheritance is also associated with the loss of the widow's rights and her disempowerment, increasing male domination and making her even more vulnerable. Widow inheritance thus contributes to the spread of HIV as it leaves the woman with no sexual choices except to agree to male subordination for protection (Oxfam 2009:8).

There is also marriage practices meant for child bearing in case the couple fails to have children. These include *sarapavana* (where, in the case of a woman failing to conceive then her sister takes over as a surrogate), and *kupindira* (whereby a brother takes over the responsibility of producing offspring with his brother's wife for his brother) (Shoko 2012:101). In the custom of *sarapavana*, the woman who takes the role of surrogate to her sister or aunt "has no right to the children she gives birth to" (Hallonsten 2012:118). Similarly, children born out of *kupindira* belong to the sterile brother (Shoko 2007:23). "Women are, therefore, compelled to have unprotected sex, thus placing themselves and their babies at risk" (Gichaara 2008:196). These practices increase the chances of spreading HIV as they promote multiple-sexual encounters. Both the fertile and the infertile women from both relationships become exposed if anyone in these relationships is living with HIV.

Besides the marriage practices discussed above, gender-based violence is one of the key cultural practices that fuels the spread of HIV in Zimbabwe. "It includes any act or threat by men or male dominated institutions to inflict physical, sexual or psychological harm on a woman or girl because of their gender" (Human Rights Bulletin 2011:1). Gender-based violence is influenced by cultural beliefs that set men above women hence male domination is regarded as a norm (Human Rights Bulletin 2011:3). "In Zimbabwe, as well as in most societies, rape and domestic abuse are clear illustrations of some of the ways in which men exert control over women" (Osirim 2003:155). Due to cultural beliefs that prescribe code of dress and behaviour of women, they are not protected from violence. In addition women sometimes shun reporting rape and other forms of abuse for fear of being ridiculed or labelled as loose and immoral by the police who would even not consider their plight (Chirongoma 2006:55). Another significant challenge is that in Shona culture marital rape is not viewed as a crime (Duff 2005:24). This leaves many women subjected to marital rape without legal protection. Such cultural constructs lead women to suffer from gender-based and sexual violence in silence. Gender violence leads to "devastating consequences for victims including health complications such as HIV and other sexually transmitted diseases; psychological problems" (Human Rights Bulletin 2011:4).

Patriarchy has taught married women to suffer in silence as they are not expected expose their crisis in the public sphere. "It is unheard of in Shona culture for a wife to report her husband in a court of law; it is tantamount to revoking his authority as the family head" (Chirongoma 2006:56). Women are not in a position to challenge men or their husbands' authority hence cannot be in a position to report any abusive relationships. "As women are unable to confront men and take a stand for their rights, they are left at the mercy of angry husbands and of men in general" (Ward 2009:54). Through gender-based violence and stigmatization women are made more vulnerable to the HIV infection. "Women who are exposed to gender-based violence are more vulnerable to HIV infections. In most instances, their male partners are likely to have multiple partners and unlikely to use protection" (Chitando and Chirongoma 2012:16). Gender-based violence faced by wives and women in general also extends to young girls and children thereby increasing risk of infection.

Girls and young children are exposed to violence from both old men and boys. "Male youth are socialized to believe it is a sign of manhood to be able to control sexual relationships, whilst women, conversely, are brought up to believe that males are superior in all spheres of life and should be the masters of sexual relations" (Gichaara 2008:195). Male domination coupled with myths about the cure for HIV infection fuels gender violence among girls and children. "Girls and children are exposed to rape due to the belief that they are not yet infected and the myth that HIV infection can be cured by having sex with a virgin" (Osirim 2003:163). Similarly, Jackson *et al* contend that "Anecdotal evidence suggests that girls in Zimbabwe and Malawi are at risk because traditional healers believe that sex with a virgin will cure HIV/AIDS and or bring success in business" (1999:18). Cultural socialization and myths about the cure for HIV infection are thus putting girls and young children at risk.

Gender-based violence and rape is also rife in different social spaces where women are forced to yield to the sexual advances of men. "There is growing evidence that a large number of new cases of infection in Africa is due to violence in homes, schools, the workplace and other social centres including churches" (Gichaara 2008:196). Chirongoma argues that "Sometimes girls are victimized for refusing sexual advances from teachers by being ignored in class, punished or given low marks" (2006:56). The situation of gender violence puts women at risk of contracting HIV.

Furthermore, the spread of HIV is also exacerbated by taboo and silence around issues of sex. Due to socio-cultural influences, sexual issues are regarded as secret matters not to be

discussed publically and only referred to in euphemisms. "In many African societies, it has always been considered immodest to talk about sexual matters in public. In particular, an African woman is never expected to express her sexual preference or inclinations" (Ayanga 2008:41). Shoko also asserts that "Open discussion of HIV and AIDS, sexuality and reproduction issues is often considered to be sensitive and controversial. Sex is believed to be secret and sacred, so much so that no one speaks about it in the open" (2012:105). Hence the Shona people associate discussions around sex and related issues with embarrassment to the individual and the community (Chirongoma 2006:56). This is a major obstacle to appropriate sex education in the context of the HIV epidemic in Zimbabwe.

Due to secrecy and taboos on human sexuality, the Shona people prefer to use euphemisms when talking about sex and HIV and AIDS. This is an unhelpful way in dealing with the epidemic because it fuels stigma around HIV and hinders sex education among the youths. Euphemism leads to stigma because sometimes it is used as a way of making the HIV positive condition or AIDS disease secret to the one who is experiencing it. "When discussion on sex and human sexuality are held among adults, the language used is mythological. It is intended to hide the meaning of what is being discussed" (Amaze 2010:79). Use of such euphemistic language is most common among the Shona in Zimbabwe where metaphors are used to avoid open talk about sexual matters (Amaze 2010:87). According to Shoko "Sexual intercourse is called *kukwirana,* which means "to sleep with one another" (2012:105). "Genitals are either called *pamberi* (front)" (Amaze 2010:88) or "*zvinhu* (things)" (Shoko 2012:105). Various names are given to HIV and AIDS. The names that refer to the supposed source(s) of HIV and AIDS are few. "These are *Chakauya* (a mysterious disease), *Shamhu yaMwari* (God's curse), *Akarohwa nematsotsi* (one stroke by thieves) and *Chipedzamahure* (prostitute killer)" (Mashiri *et al* 2002:226). Some of the names which the Karanga people use for HIV and AIDS are: "*jemedza* (one who causes pain), *paradzayi* (one who destroys), *chazezesa* (scaring), *shuramatongo* (warning of disaster that wipes out everyone), *mukondombera* (fatal diseases), *gukurahundi* (rains that falls in autum), *Jehova ndouyoko* (Lord I am coming) and *zvamazuva ano* (contemporary things)" (Shoko 2012:106). Similarly the Ndebele have specific names for the HIV and AIDS. "Some Ndebele terms such as *'IDA Sibanda'* or *'UmaSibanda',* for AIDS also portray the woman as the source and carrier of HIV/AIDS" (Mashiri *et al* 2002:227). According to Mashiri *et al,* "Such terms motivate the stigmatisation and blaming of people affected or infected with HIV/AIDS and

could also be disharmonious" (2002:227). It is this euphemistic language that perpetuates stigmatisation of people living with HIV.

The condition of a person living with HIV is described as "*Ane pemu* (thin with loss of hair shine), or *akarohwa nematsotsi* (attacked by thugs) (Amaze 2010: 88). The physical symptoms of people living with HIV are described as *"Mudonzvo* (loss of weight)*, bhemba* (head becomes as thin as a hoop-iron), *pemu* (thinning and loss of shine of hair)*, go slow* (gradual deterioration of health/long illness) and *tsono* very thin (like a needle)" (Mashiri *et al* 2002:227). Even condoms are not taken seriously as part of HIV prevention methods. "Also disregarding its effectiveness as a protective device, a condom is also considered humorously as *jombo* (gumboots or raincoat) that one can easily do without" (Shoko 2012:107).

Mashiri *et al* indicate that societies employ "The use of indirect and diplomatic devices of communication in taboo topics such as HIV/AIDS, where violating linguistic taboo could invite stigmatization" (2002:225). The spread of the HIV epidemic is fuelled by "mythological aspects that do not allow frank discussion on matters of sex" (Amaze 2010:89). This kind of mythologizing and making sex a taboo disempowers people especially the youth and hinders the process of prevention. It also increase stigma and discrimination as the people living with HIV seem to be struggling with problems that cannot be openly discussed like any other disease.

Furthermore, according to Khathide, "In most African countries the issue of silence is compounded by both our cultural socialization and spiritual or theological perceptions" (2003:2). It is guided by upbringing in the context where sex is regarded as sacred. In some cases it has some negative implications hence it is relegated to peripheral discussions outside public spaces. "We often find that when we talk about sex in public, we are faced with comments like, "Don't talk about sex, we are Christians" or "Don't talk about sex, we are Africans." (Khathide 2003:1). In Zimbabwe people are guided by cultural and Christian values that have removed sex talk from public spaces. This is unhelpful in the context of the HIV epidemic because it is mainly transmitted through unprotected sexual contact. There is no way people can talk about HIV and AIDS without talking about sexual matters. Therefore, the secrecy and taboo which leads to either mythologizing issues about sex or prevents opens discussion hinders sex education and HIV prevention efforts and contributes to stigma and discrimination.

2.3.3 Stigma and discrimination

Stigma associated with HIV contributes to the spread of the HIV epidemic in Zimbabwe. Osirim (2003:163) asserts that stigma around HIV is still high in Zimbabwe. According to UNAIDS, stigma "implies the branding or labelling of a person or a group of persons as being unworthy of inclusion in human community, resulting in discrimination and ostracization" (2005:11). This is 'naming' and in the context of HIV this is done in order to exclude somebody due to his or her HIV positive status. Stigma may be caused by ignorance due to lack of education and awareness about the epidemic or fear of HIV and incapacity to handle the epidemic (UNAIDS 2002:5). Ignorance about HIV leads to some misconceptions on how its spread and hence may generate fear which causes some people to avoid and label people living with HIV as dangerous to the community. "Instead, like responses to diseases such as leprosy, cholera and polio in the past, it plays to deep-rooted social fears and anxieties" (UNAIDS 2002:6). Therefore, stigma is the label or mark given to the person living with HIV, which results in discrimination. "First the person experiences structural discrimination: which is not the same thing as stigma, although it is one of its consequences" (Paterson 2005:39). In other words, stigma leads to discrimination hence they work hand in hand in the context of HIV and AIDS.

Discrimination is isolation or exclusion of people believed to be unworthy. "Discrimination occurs when a distinction is made against a person that results in his or her being treated unfairly and unjustly on the basis of their belonging, or being perceived to belong to a particular group" (UNAIDS 2002:10). "Expectations are lowered in terms of job opportunities, marriage possibilities and housing. Eventually, stigmatized people come to internalize the stereotyping they receive and to believe it" (Paterson 2005:39). Different community sectors may discriminate against people living with HIV as they may exclude them - such as denial of access to treatment by the health providers, termination of employment by employers, and rejection by family members (UNAIDS 2002:10).

"Despite the progress that has been made, stigma and discrimination continues to be experienced in Zimbabwe" (Chitando 2004:17). The fact that the main transmission of HIV is through sexual contact, those who are affected are stigmatised and discriminated against as "wrong doers". "The dominant reading of HIV and AIDS as a form of divine and ancestral retribution has resulted in stigma and discrimination against infected individuals" (Chitando 2008:82). Men and women who contract HIV are associated with societal wrong doing such

as prostitution and homosexuality, hence they are punished (UNAIDS 2002:8). "Stigma is an obstacle to care, treatment, prevention and practical assistance for orphans and other children affected by the epidemic" (Paterson 2011:250). Stigma and discrimination dehumanize and impede access to the necessary assistance needed by those infected and affected by the HIV epidemic.

"Because of stigma or because of fear of stigma, people who are infected or affected are likely to deny the impact of HIV on their lives and ignore the necessity to seek help and change behaviour" (Paterson 2011:350). Stigma is caused by many reasons and among them is ignorance about the epidemic and this always results in impeding one from getting the necessary support and care (Nduku 2008:51). "The fear of stigma and condemnation often translates into a reluctance to use various means of protection available to them (women)" (Ayanga 2008:42). All efforts and resources meant to be accessed by people living with HIV become inaccessible due to fear of being discriminated against (Machyo 2012:64).

In Zimbabwe women are blamed for diseases such as AIDS like any other sexually transmitted diseases. HIV and other sexual transmitted infections are labelled "women's diseases" (Chitando 2008:182). Stigmatization of women living with HIV is fuelled by the perceptions that women are carriers of HIV. This perception is shaped and promoted by the situation of some musicians and the great number of female sex workers (Chitando 2008:182). "Fear of rejection has also prevented some individuals from using condoms in sexual encounters with their partners" (Chitando 2008:183). The problem does not end with women but goes further to affect their babies. "Treatment may be available to prevent mother-to-child transmission, but pregnant women may not come forward to ask for it" (Paterson 2005:32). Some women living with HIV are forced to breastfeed their babies to avoid suspicion and questions that may be raised if they seem not to do so (Chitando 2008:183). "Stigma, we are told, is the most powerful obstacle to the prevention of HIV transmission and to the implementation of effective care for people living with HIV or AIDS" (Paterson 2005:32). Due to internalization of stigma, people living with HIV are prevented from seeking care, support and treatment or disclosing their HIV-positive status (Chitando 2008:283; Machyo: 2012:64).

Stigma and discrimination is also directed against people of same sex orientation. In many African countries, including Zimbabwe, homosexuality is criminalized and those who practice it are threatened with arrests and imprisonment (Ngure 2007:119). "Some

governments seek not only to exclude lesbian and gay people from local culture, but also to deny that they are members of the human race. For example in 1995 President Robert Mugabe of Zimbabwe branded gays as 'less than human'" (Amnesty International 2001:4). NAC rightly indicates that "Sex work and homosexuality is illegal in Zimbabwe, as a consequence, sex workers and men who have sex with men lack legal status and protection" (2011:xvii). Failure to have legal protection for same sex oriented people leaves them vulnerable as they are open to stigmatization which leads to abuse and violation of their rights including open expression of their sexuality and access to treatment and care. In Zimbabwe homosexuality has become a source of stigma and on the other hand it may also facilitate the spread of HIV since people of same sex are stigmatized and lack the access to treatment.

2.4 Conclusion

Although statistics show a significant decline in HIV prevalence in Zimbabwe, it has been noted that due to the socio-political and economic climate this need to be accepted with caution. This chapter has discussed the issue of HIV decline in Zimbabwe and also highlights the factors that fuel the spread of the epidemic. While HIV is both a medical and justice issue, it also poses a theological challenge to the church. In the next chapter, some of these theological challenges will be addressed; including both negative and positive theologies in the context of HIV and AIDS.

<center>**Chapter Three**</center>

<center>**Theological discourse in a time of HIV and AIDS**</center>

3.1 Introduction

Chapter two discussed the various factors that fuel the spread of HIV and the impact of these factors in Zimbabwe. It discussed the economic and political factors that have created disparities among the population and have increased their vulnerability to the epidemic. The socio-cultural factors relegate women to a subordinate position and hence undermine their human rights and dignity as created in the image of God. This has contributed to the high HIV prevalence amongst women. Stigma and discrimination has played a large role in further spreading the epidemic. In addition the church has also contributed to stigma and discrimination through its theological discourse. This chapter focuses on theological discourse in a time of HIV. It discusses how the church has shifted from a theological discourse of retribution to a theological discourse of liberation and life. Life affirming theologies in the era of HIV influence the church's positive responses to this epidemic.

3.2 Theologies of retribution

Initially the response of the church to the HIV epidemic was marked by theological paralysis, leaving those in the medical profession to respond. At that time when HIV was spoken about, the theological discourse was filled with retribution linked to sexual immorality. On the whole, HIV has been related to issues of morality and also aligned to sexual sins and hence led to stigma and discrimination (Chitando and Gunda 2007:189). "Our narrow theological formations lead people to believe that HIV is result of immoral and sinful activities, and therefore, is sin, unclean, a punishment from God" (Longchar 2011:408). According to Longchar, a theology of retribution creates attitudes that lead to stigma and discrimination and bring about guilt and shame among people living with HIV (2011:408). In the context of Zimbabwe, the nexus between culture and the use of biblical texts has promoted stigma and discrimination against the people living with HIV and their families.

Biblical texts shape the theology of the church, and the Shona and Ndebele culture in Zimbabwe have together fuelled stigma as both emphasize reward and punishment from God and/or ancestors. Retribution has to do with the understanding that every action leads to either reward or punishment. God will reward the righteous or punish the sinner as reflected

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in the biblical text Deuteronomy 28. "This theology stresses that God is completely in control. Applied to human life, it teaches that 'whatever you sow, you will reap' (Job 4:7-8; 5:6)" (Munyika 2005:78). In the Zimbabwean context retribution is part of traditional religion whereby whenever one has suffered a setback in life he or she is believed to have angered the ancestors. From a Christian perspective the person is said to have angered God. All good omens and successes are viewed as a reward from the divine for obedience and a good relationship with the divine and the ancestors.

This type of theology is carried through into the HIV context. "Whatever the religion, there is some form of theology of retribution: what you sow you will reap. If you are HIV positive you must have done something to deserve it" (West 2011:135). In Zimbabwe, the euphemistic names given to HIV and AIDS such as "the divine rod" would imply that God is punishing people living with HIV for their sin (Chitando 2004:17). People living with HIV are believed to have done something wrong that provoked God's anger hence their suffering is God's punishment. This connection of sin and punishment and belief that any suffering is as a result of sin that provokes God's punishment has formed the dominant discourse of the church in the HIV context.

In Christian circles the initial discourse is associated with the statement "HIV and AIDS are signs of divine punishment" (Munyika 2005:78). "This belief is based on teachings in the Hebrew Bible that link sin and punishment, disease and punishment, obedience to the law and health and prosperity, and social justice and healing" (Hadebe 2007:72). Whenever one justifies HIV and AIDS as divine punishment he or she turns to some specific common biblical texts that link sin and suffering (Haddad 2005:32). "Many Christians turned to passages like 'For the wages of sin is death' (Romans 6:23) to account for the suffering and death of people with AIDS" (Chitando 2007:8). Retribution is life denying as it fuels discrimination of people living with HIV. It would seem as if those who are not yet HIV positive are living a righteous life while those who are HIV positive are sinners receiving what they deserve for their sinful behaviour. This legitimation of stigma and discrimination against people living with HIV has continued in the church through the use of the Hebrew biblical texts (Chitando and Gunda 2007:189). "This type of theology continues to have devastating effects on the lives of people today, including those people living with HIV and AIDS" (Munyika 2005:80). What is significant for the discussion is that the retribution is linked to negative views of human sexuality.

3.2.1 Human sexuality and retribution

One of the issues that fuels stigma is the church's negative understanding of human sexuality. "Human sexuality refers to the quality or state of being sexually, that is, the human capacity to express sexual feelings or to engage in sexual activity" (Ngure 2007:7). Very often the church has turned to associate sex and sexuality with sin. "Theologically, we affirm God's gift of sex, but simultaneously we have been embarrassed and fearful of the practices and pleasures accompanying sexual relationships" (Messer 2004:34). Through Christian tradition and the Hebrew bible, the church inherited a negative view of sexuality (Longchar 2011:413). "Negative attitudes towards sex as being sinful have persisted throughout history. Some basis for this attitude is evident in the book of Leviticus. Men and women who engaged in sex were also regarded as unclean (Lev. 12 and 15)" (Ngure 2007:33). Chitando also asserts that "As products of their own time, the missionaries who carried the gospel to African shores had a negative attitude towards human sexuality" (2007:31). The good gift from God has been turned into evil and sin hence the negative view on sex and any issues around it including HIV.

Both Christianity and African culture have become barriers to discussions about sex. Due to Christianity and cultural influence, in Zimbabwe issues around sex are discussed in euphemistic language that contributes to secrecy that hinders sex education in the context of HIV (Amaze 2010:87). "We often find that when we talk about sex in public, we are faced with comments like, "Don't talk about sex, we are Christians" or "Don't talk about sex, we are Africans." (Khathide 2003:1). This has drawn Christians into silence on sexuality even in the context of HIV epidemic. "Christians have no problems talking about blood transfusion, organ transplants, cancer, or even war, but typically are tongue-tied and hesitant to talk about condoms, 'safer sex' or oral and anal sex" (Messer 2004:35). The negative view around human sexuality has made it difficult for the church to respond positively to HIV. "Since HIV/AIDS is linked to social taboos, such as sex and sexuality, drug use and death, there are enormous levels of ignorance, denial, fear and intolerance in most communities" (Semple 2003: 62). According to Messer "Christian missionaries were not always very effective in spreading the good news of the gospel, but the bad news of sexuality somehow reinforced previously existing taboos or was successfully implanted in churches and cultures" (2004:34).

The integration of missionary views about sex as sin together with taboos in African culture has made it difficult for the church to address issues of sexuality in the context of HIV.

Sex is classified together with sin hence it is not openly discussed or it is discussed in relation to acts of sin and condemnation. "One of the major hurdles in facing HIV and AIDS is this theological-moral association of sexual sinfulness with HIV infection, which has been deeply entrenched in the minds of many believers (Longchar 2011:413). These attitudes and views have contributed to silence and relegation of sexuality in the public realm, hence affecting the way the church and family can discuss HIV as it is closely linked to sex. Avoiding discussions on human sexuality and sex or demonizing and use of euphemisms have served to fuel the spread of the HIV epidemic.

The church has only accepted sex within prescribed boundaries such as heterosexual marriage relationships (Hallonsten 2012:117, Ngure 2007:121). Most churches teach that "Marriage has been provided by God as a place where love and sex can be expressed as means of fulfilment for a couple" (Ngure 2007:43). Sex outside marriage is unacceptable and prohibited as it is perceived as sin that provokes God's anger (Ngure 2007:121). Within this relationship, faithfulness has been emphasized. Those married people who have found themselves having contracted HIV tend to remain silent for fear of stigma (Clifford 2004:9). This is because HIV is associated with sex work and sexual promiscuity – consequently, the church's rejection of people living with HIV (Clifford 2004:9).

The emphasis of sex in marriage has led to the relegation of other sexual orientations, relationships and activities to sinful acts (Longchar 2011:413). The church has failed to accept same sex as a gift from God. Some biblical texts are used as a valid reason for rejecting same sex people. "Homosexuality is one of the reasons given for the destruction of Sodom (Gen.19: 1–29). Homosexuality is specifically forbidden in three instances in Romans1:24-27" (Ngure 2007:121-122). This has only led to silence and an increase in HIV prevalence as people would not express their sexual orientation for fear of stigma and discrimination - moreso if they are living with HIV (Ngure 2007:119). The church's negative view of human sexuality, its emphasis on the heterosexual marriage relationship, and the rejection of homosexuality and other sexual orientations has contributed to the spread of HIV through stigma and the discrimination against people living with HIV. There is the need for

the church to have a paradigm shift to more life-affirming theologies that promote compassion and human dignity.[2]

3.3 Liberation theologies that are life-giving

The HIV epidemic challenges the church to move from retribution to life giving theologies. Theologies of retribution coupled with negative theologies of human sexuality have created negative attitudes that compromise and undermine human life and dignity. "Negative attitudes stigmatize, exclude and discriminate against people with HIV and create feelings of guilt among many people" (Longchar 2011:408). Munyika argues that "The theology of retribution is not the final word; there are other more compassionate theologies, struggling to be articulated, which embrace the real pain of those who suffer with illness and stigmatization, of being HIV positive" (2005:83). To counter unhelpful responses there is a need for theologies of liberation that are life giving. "Liberation theology presupposes an energetic protest at such a situation, for that situation means - collective oppression, exclusion and marginalization, injustice and denial of human rights and social sinfulness" (Boff and Boff 1987:3). The context of HIV undermines human rights and dignity, and for this reason there is the need to confront it with such life-giving theologies of liberation. "Underlying liberation theology is a prophetic and comradely commitment to the life cause and struggle of those millions of debased and marginalized human beings; a commitment to end this historical iniquity" (Boff and Boff 1987:3). Concerning the marginalization of people living with HIV through stigma and discrimination, the church needs to be prophetic.

3.3.1 The need for a prophetic word

One of the liberation and life giving theologies is prophetic theology. Many factors that contribute to the spread of HIV in Zimbabwe have to do with issues of injustice and marginalization of other members of society, as discussed in chapter two. The era of the HIV epidemic in Zimbabwe requires a prophetic theological discourse. According to Gustafson, prophetic discourse includes indictment which critiques the sinful and corrupt nature of the society, and a utopian form which spells out "an ideal future" (1988:269). "Prophetic indictment usually addresses the roots of moral and social waywardness, not specific instances in which particular policies are judged to be inadequate or wrong" (Gustafson

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[2] The ELCZ has not taken a clear public stance on homosexuality .For detailed discussion see Moyo 2012. The contentious doctrinal issues surrounding homosexuality and the church are compounded in the Zimbabwe context because it has been criminalized as discussed in section 2.3.3 of this study.

1988:269). As discussed in chapter two, the HIV epidemic is not only a health issue but it is fuelled by socio-economic and political issues which further results in poverty – and this calls for prophetic indictment. While indictment spells out waywardness, the utopian discourse would enable people to envision a better future where there is care and compassion and hope in an HIV troubled context (Gustafson 1988:269).

The starting point is acknowledging that HIV is a justice issue and that the church with its theology of retribution has perpetuated the injustice experienced by people living with HIV in their communities. "To a large extent injustice toward those who suffer from HIV has been fuelled by ignorance, fear and judgmental attitudes" (Longchar 2011:409). The people living with HIV have been discriminated against in the community and some have been denied access to treatment and care due to their sexual orientation (Ngure 2007:120). A prophetic word is needed to challenge the injustices against people living with HIV and promote positive attitudes that promote dignity and life for all.

The focus of prophetic theological discourse should be on ways in which the structural causes of HIV may be identified and curbed. "Indeed, the effectiveness of prophetic discourse today, especially in the context of HIV prevention, may well depend on its respect for and inclusion of other modes of discourse for example, social analysis, empirical evidence and practical reasoning (Farley 2009:62). Prophecy in the context of the HIV epidemic should investigate the social injustices that undermine human dignity and expose particularly women to high risk. According to Farley, prophetic discourse needs to lament the socio-economic contexts through the real stories of people infected and affected by HIV and critique the conditions that increase its prevalence (2009:64). "Therefore prophetic discourse may include in its task the bridging of what have been insurmountable divides - cultural, racial, gender, geographic, religious, class" (Farley 2009:65). A prophetic theology in the context of HIV challenges "injustices and inequalities at the local, social, political and international level and lack of respect for human rights" (Parry 2008:18). It calls for socio-economic justice, gender equality and equal educational and economic opportunities for all.

Furthermore, prophetic theologies need to deal with issues of human sexuality in order to adequately speak to the HIV epidemic. "A prophetic discourse regarding HIV/AIDS prevention must incorporate new understandings of human sexuality and requirements of justice" (Farley 2009:67). It should enable the church to declare that "God's gift of life includes the gift of sex and sexuality. Sex is not only for procreation but also to celebrate and

mutually affirm God's gift of human body, with respect and responsibility" (Longchar 2011:413). It should guide the church into acknowledging other forms of sexual orientation besides heterosexuality. Failure to understand and accept some people's sexual orientation leads to denial of their human rights and dignity. "Norms for sexual relationships and activities must take into account the concrete realities of human persons, particularly their capacity for freedom and relationality" (Farley 2009:67). Prophetic discourse challenges our sexual preference and calls us to unconditional love for all humanity and this requires that the Christian community engage in advocacy. "A prophetic discourse should focus on advocacy for HIV prevention especially issues of sexuality. It must address ways of dealing with stigma and discrimination" (Farley 2009:65-6).

What is important in the prophetic word is that it professes hope in the midst of despair caused by the ubiquitous presence of HIV in our communities. It is through strong family, gender and community partnerships that stigma and discrimination can be fought against. All relationships that put others at risk are critiqued and positive relationships that promote life and human flourishing are encouraged. "Prophets of prevention must tell the stories that articulate and bring into being the hopes of peoples, the possibilities of their coming together to weep over similarly recognized incongruities, to stand in awe of one another, and to labour for common goals" (Farley 2009:65). Hope is restored if the church acts in line with Jesus' prophetic action when he restored hope to those who were outcasts and marginalized. According to Dube, Jesus "not only healed lepers, who were feared and isolated, but also touched them and restored them back to society; this should help us to confront the stigma of HIV/AIDS and to minister to the sick" (2003:55). It is a prophetic word that is needed in order to restore hope to the affected and infected through the solidarity of the church.

3.3.2 Theologies that affirm human sexuality

In order for our theological discourse to be life affirming, it must address issues of human sexuality positively. For a long time the church has lived with negative views of sexuality, as noted earlier in this chapter. "This negative view of sex and sexuality has led to seeing sexuality as dirty and sexual desires as evil" (Longchar 2011:413). This has negated the fact that sexuality is a good gift of God (Ngure 2007:21). This leads to the church and Christians' failure to address human sexuality in a way that liberates people as they struggle with the HIV epidemic (Chitando 2007:31). A positive view and perception about human sexuality may lead to an appreciation of human sexuality and its celebration.

Positive theological discourse on sexuality acknowledges that "Sexuality is an integral part of human identity" (WCC 1997:30). Since it concerns relationship it has "physical, emotional, intellectual, spiritual and social dimensions" (WCC 1997:30). Sexuality has to do with creation and the image of God because it originates from God's identity. "We understand sexuality in a profound sense when we see it as part of who we are in God's image" (Bongmba 2007:50). Thus because it marks who we are, "Christians should celebrate God's gift of sex and praise God for it" (Ngure 2007:24). Since sex is a gift of God, it is a good gift worth celebrating and should not be demonized and pushed out of the public domain. "A Christian theological view of sexuality has no place for the sex is dirty syndrome" (Nussbaum 2007:54). "Thus theology that takes human sexuality seriously pays attention to the nature of the human being as created by God, and the nature of our relationships with one another as expressions of our humanity in its fullness" (Ackermann 2007:118). This is a theological discourse that acknowledges sexuality as an irremovable central part of all humanity (Bongmba 2007:50). Such theologies would equip the church to openly talk about sex, sexuality and issues of HIV, leading to more effective prevention.

3.3.3 Theologies that focus on human dignity

As discussed in chapter one and earlier in this chapter, stigma and discrimination have greatly contributed to the spread of HIV. By being judgmental to people living with HIV the church has promoted stigma (Messer 2004:31). Due to HIV stigma and discrimination, the church needs theologies of human dignity employing the notions of the *imago dei* - created in the image of God. A theology of human dignity is more liberating and life giving in the context of HIV. The notion of the *imago dei* affirms dignity for all irrespective of their sexuality, gender, race and HIV status.

The image of God in humanity is revealed in Genesis where human beings are said to be created in God's image. "Then God said, "Let us make man in our image, after our likeness. So God created man in his own image, in the image of God he created him; male and female he created them" (Genesis 1:26a and 27). "The image of God places on each person a special and immeasurable worth" (Bongmba 2007:49). This reflects the inherent dignity in all human beings despite their socio-economic status, body or health condition. Longchar holds that "Every person reflects the mystery and glory of God. To treat any person as less than valuable is contrary to Christian faith; it is to deny the special sacredness of every human life" (2004:23).

In the context of HIV and AIDS, human dignity is compromised in several ways. The rights of women, children and people of same sex orientation as well as the people living with HIV are violated. As has already been discussed earlier, there is marginalization, stigmatization and discrimination of people living with HIV which is part of the brokenness of relationships and undermining of rights and dignity. Such violation of human rights is dehumanizing hence compromises our being created in the image of God. "Stigmatization and discrimination are blasphemous actions against God as well as individual persons. God is incognito in every person" (Messer 2004:98). Bongmba (2007:46) also maintains that "Each person who carries the *imago dei* is special and all people ought to follow God's example and treat others with special dignity because they too bear the image of God". The inherent dignity in every human being does not permit others to discriminate against him or her for any reason or inflict any form of violence against women which puts them at risk. Being created in the image of God means we are also made to be in relationship.

In addition, God created male and female, marking the beginning of human community just like God is a triune God, the Father, Son and the Holy Spirit. "The image of God is not restricted to the Godhead but extends to humanity. The image of God, therefore, establishes a vertical and horizontal communion" (Bongmba 2007:46). This divine and human relationship helps in promoting life together especially in cultures that make distinctions between male and female, rich and poor as well as between those who are healthy and sick. Since we have the inherent image of God it means we are related to God and to our brothers and sisters. The *imago dei* is "a love relationship, expressed in the vision of the Trinity as a model of intimate interaction, of mutual respect and sharing without domination" (WCC 1997:100). We are created to be a community in relationship despite our sexuality, gender differences and health conditions.

This relationship must drive us into acts of compassion. "Jesus crushed the bias of his time as he reached out both in compassion and companionship to lepers of his time" (Messer 2004:63). Thus we must challenge the norms and values of the society in order to save life and restore human dignity due to the power of *imago dei*. The promotion of human dignity is critical especially in Zimbabwe where people living with HIV are stigmatised and especially women who are being assumed to be carriers of the virus (Chitando 2008:182) "Because humanity is created in God's image, all human beings are beloved by God and all are held within the scope of God's concern and faithful care" (WCC 1997:100). Cultures that

undermine women and devalue people living with HIV are working against the notion of the *imago dei* which is inherent in every human being.

Imago dei points to responsibility in love and unity of all people. "The notion of *imago dei* calls for a responsible relationship that cares for one another as humanity is created in God's image" (Chinemelu 2006:43). The *imago dei* should be understood in terms of relationship which "should be marked not just by mutual respect but by active concern for the other" (WCC 1997:102). It provokes solidarity and vocation of care in the HIV era like the triune God who is in loving communion. The life and action of the triune God is being in solidarity with the poor. "Christians understand God as standing in loving solidarity, especially with those who suffer or who are abandoned (e.g., orphans, widows) or mistreated" (Messer 2004:63). This is part of being responsible, being able to work in solidarity and speaking for and with those who are suffering and marginalised in the context of HIV.

Accepting that we are in the image of God drives us into actions that resist any form of structural injustices that make people vulnerable to HIV. "Actions taken deliberately which harm oneself, others or the creation are sinful; and indeed we are challenged by the persistence of sin, which is the distortion of this right relationship with God, other persons, or natural order" (WCC 1997:102). That means these actions which are promoted by sin need counter actions that challenge sin. The prophetic voice of the church should condemn "all stigmatization, discrimination, reckless behaviour, and political and economic injustice that keep people in poverty and create a climate for risky behaviour" (Bongmba 2007:53). The notion of the *imago dei* does not allow any form of discrimination and actions which bring harm to life hence it promotes human dignity, relationships and responsibility which are key issues in the era of HIV and AIDS.

3.3.4 Compassion as a critical response

Given the factors that fuel HIV and the effects discussed in chapter two, the church needs to become a compassionate church. "The word compassion is derived from Latin words *pati* and *cum*, which together mean; to suffer with. Compassion asks us to go where it hurts, to enter into places of pain, to share in brokenness, fear, confusion, and anguish" (Nouwen *et al* 1982:4). Compassion means entering into the other's sphere of struggle and joining him or her in the journey with a view to transform the situation of struggle and suffering. It is leaving one's world behind and enter into another person's world especially that of suffering.

"Compassion, in other words, begins with the capacity to identify with the other, to be in solidarity with the suffering and to work with them for change" (Dube 2007:20). This is a character of God and Christ which Christians would need to imitate in the era of the HIV epidemic.

One of the outstanding characteristics of God is that of being a compassionate God and Jesus reminds his disciples to take up this character. "Jesus commands us, 'Be compassionate as your father is compassionate' is a command to participate in compassion of God himself" (Nouwen *et al* 1982:20). Throughout the Old Testament and the New Testament, God deals with humanity compassionately. Dube (2007:30) traces the compassion of God right from the beginning of all creation and emphasises the compassion of God through the Exodus story. "The Exodus story emphatically demonstrated to us that God is compassionate towards the suffering. It thus follows that we should be compassionate just as our Creator is compassionate" (Dube 2007:33). A compassionate creator God takes initiative to be part of the human struggle for their liberation. God does not become a spectator or the one who puts blame on those who suffer but becomes part of the struggle in order to transform their situation. Dube (2007:33) argues that, the context of HIV requires those created in the image of the compassionate God to respond with compassion.

According to Nouwen *et al* "God's compassion is not something abstract or indefinite but a concrete, specific gesture in which God reaches out to us. In Jesus Christ we see the fullness of God's compassion" (1982:24). In Jesus, God is seen in action among his people and with his people. The compassionate God in Christ journeyed with the sick, suffering and marginalised to restore them to wholeness and dignity (Longchar 2011:414). The compassion that God shows through Christ is the same as what we should also show to our brothers and sisters in the context of HIV and AIDS. The church's compassionate response to the people living with HIV reveals the character of God as expressed in Jesus' ministry.

The HIV world that we live in which is characterised by injustice, stigma and discrimination is similar to the world in which Jesus lived. In his first century world, there were many structures of society that were oppressive and impoverished and that marginalized others. It was a society where people such as lepers were also ostracised, and discriminated against due to their sickness. It was in this context that Jesus lived compassionately. "Thus motivated by compassion, Jesus acted with justice on people's behalf; he liberated them from many of their forms and experiences of oppression, whether be it sin, or suffering or guilt, or infirmity"

(Dempsey 2008:96). Chitando (2007:9) claims that before the time of the HIV epidemic, especially the missionary era, the church in Africa lived this character of Jesus as its mission was characterised by its accommodating and assisting the most vulnerable in the African communities. The current context of HIV requires a church that seeks justice and supports those who are stigmatised.

According to Dube (2007:19), compassion is an active word that presents the drive for engagement and involvement rather than being passive and inactive. Munyika also asserts that "A compassionate person cannot stand aloof, disinterested, disengaged or be neutral about issues of stigma and discrimination" (2005:96). The church that is made of followers of a compassionate saviour and God also becomes a compassionate community. Therefore, this compassionate community is challenged into action that portrays its character and identity (Chitando 2007:10). Munyika advances that "The church community needs to be an inclusive, healing and accompanying community, engaged in efforts of caring for the sick, the orphans, the widows and the dying" (2005:114). In order to bring about healing in an HIV context, the church should be critically engaged though social analysis and be involved in activities that bring about the restoration of human dignity.

Furthermore, compassion leads to protests for justice. "It is not surprising that compassion, understood as suffering with, often evokes in us a deep resistance and even protest" (Nouwen *et al* 1982:4). The HIV epidemic is as a result of injustices against the poor, women and children. It results in stigma and discrimination of people living with HIV and their families and friends and even orphans whose parents died from AIDS-related illnesses. "Compassion, in other words, should always involve activism and liberation from all forms of oppression" (Dube 2007:20) Compassion calls for an action of protest against the dehumanization of other sectors of society. Dube argues that "Compassion, in other words, begins with the capacity to identify with the other, to be in solidarity with the suffering and to work with them for change" (2007:20). To be compassionate in the era of HIV and AIDS, the church should reflect the character of God and Christ and become actively involved in HIV prevention and actively care and support widows, orphans, people living with HIV and other vulnerable groups.

3.3.5 The Church is the body of Christ

A further theological motif that is life affirming is the understanding that the church is the body of Christ. In the context where many members are living and struggling with HIV, the church as one body is affected in many ways. This theological motif is a call for unity and solidarity with each other in responding to the HIV epidemic.

In the context of HIV, in order for the church to act in solidarity as the body of Christ it begins with the admission that it is affected and infected due to its many members who are ill and others who are dying from AIDS-related illnesses. "They include those amongst us who have the HIV virus in their physical bodies, those who are affected either through caring for the orphaned, the sick, and the widowed, and through grief in the loss of relatives, friends and loss of hope for the future" (Dube 2009:9). With such a crisis it has been argued that "the body of Christ has AIDS" (Rappmann 2009:24). Dube asserts that "And indeed, as a church, we are also infected by HIV and AIDS; for if one member is infected, we are all infected (1 Cor 12:26a)" (2009:7). The fact that the church acknowledges the impact of HIV amongst its members means it is difficult to deny the presence of HIV and AIDS in the church (Dube 2009:6). The church is a community of people including those who struggle with HIV and AIDS; hence the body of Christ has HIV and AIDS. There is therefore, no way can it marginalise the people living with HIV as it would be marginalising itself.

The church as the body of Christ should act compassionately and in solidarity with people living with HIV and those affected by its consequences. "As the body of Christ the church is bound to enter into the suffering of others, to stand with them against rejection and despair" (WCC 1997:102). It is there to bring healing to the sick and the broken hearted. "We affirm that the church as the body of Christ is to be the place where God's healing love is experienced and shown forth" (WCC 1997:102). As the body of Christ the church should be actively responding to the HIV epidemic. The body of Christ is seen through its active participation in journeying with the people living with HIV and those affected by it. "As the church enters solidarity with those affected by HIV/AIDS, our hope in God's promise comes alive and becomes visible to the world" (WCC 1997:102). The work of solidarity proves that it acknowledges its vulnerability to the epidemic and its HIV positive status. The motif of the church as the body of Christ provokes the spirit of love and solidarity which enables the church to be actively involved in advocacy for prevention, treatment and protection of widows and orphans in the context of HIV.

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3.4 Conclusion

This chapter explored the church's shift from retribution and a negative view of sexuality to liberating and life-affirming theologies in the context of HIV. It has discussed the impact of theologies of retribution and negative views of human sexuality. In dealing with life-affirming theologies, it stressed the importance of a prophetic word, and theologies that affirm human sexuality, human dignity, and compassion as critical responses. It stressed the church as the body of Christ.

This chapter argues that life affirming theological discourse enables the church to engage the HIV epidemic and resist forces that promote stigma and discrimination. Theological discourse is important for the church as it enables the church to respond to the HIV epidemic in helpful ways. However, the church does not only need theology, it needs other practical skills and approaches in order to respond to the epidemic effectively. The next chapter explores how the church may become more competent in its response to HIV.

<center>**Chapter Four**</center>

<center>**Becoming an HIV competent church**</center>

4.1 Introduction

Chapter two outlined the complex context of HIV in Zimbabwe and chapter three discussed the church's need to shift from retribution to more liberating and life-giving theology. Given the complexity of the causes and effects of the HIV epidemic as discussed in chapter two, there is a need for greater competence by the church in its response to the epidemic. Therefore this chapter focuses on "HIV competence" (Parry 2008:13).

4.2 HIV competency

Despite a concerted response by various players such as governments, non-governmental organizations (NGOs) and faith-based organizations (FBOs), the epidemic remains a global challenge. As organizations and theologians attempted to deal with the HIV epidemic, Parry (2008), Chitando (2007), and organizations such as the World Council of Churches (WCC) (2007) and the Churches United Against HIV and AIDS (CUAHA) (2010) began to talk of "HIV competency" in the church.

Competence is having the capacity to do something through the availability of one's relevant knowledge and skills to carry out a particular task (Brown 1993:459). In order for the church to effectively respond to the HIV epidemic it needs the relevant knowledge about the HIV context and skills handle to the situation of HIV, and consequently it becomes an "HIV competent church" (Parry 2008:20). Chitando (2007:10-11) rightly notes that an HIV competent church reviews its theology, teachings, and should defend human rights and especially women's rights, advocating for their freedom from subordination and abuse that makes them vulnerable to HIV. This means that the church fully understands the context and the factors that fuel the spread of HIV and is making a positive response. "CUAHA suggests that an HIV and AIDS competent church understands the HIV and AIDS challenge at hand; has the ability and corresponding skills related to HIV and AIDS; and is able to respond to the epidemic" (Happonen et al n.d:16). In other words, competency has to do with building capacities to respond to HIV. The World Council of Churches defines an HIV competent church as "A church that recognizes and accepts the imperatives of HIV to itself and

communities; has the knowledge, willingness and experience to respond in an inclusive, effective and prophetic manner that reflects the fruits of a spirit filled congregation" (WCC team 2007, cited in Parry 2008:88). Although the church has responded to HIV since the early stages of the epidemic, it has contributed to stigma by reinforcing some negative attitudes in the communities (WCC 1997:5). Second, the complexity and impact of HIV calls for church competence as it has remained one of the role players responding to the epidemic. Becoming an HIV competent church involves getting to grips with the scope of the epidemic in the given context, accepting limitations and challenges within the church and seeking to reinforce resources and skills from within and outside the church.

Parry (2008:20) has further defined and developed the HIV competent framework in a more comprehensive way. She has suggested that an HIV competent church should engage three areas in their work with HIV, namely, "inner competences" and "outer competences" which are linked together by a bridge of "leadership, knowledge and resources" (Parry 2008:20).

4.3 Inner competence

Inner competence begins with where the church stands with its theology, values and attitudes. The church begins by accepting its vulnerability, assessing its successes, failures and limitations in its response to the HIV epidemic. This also involves recognition of its role in fuelling the spread of HIV due to its judgmental attitudes based on a theology of retribution as discussed in chapter three.

Inner competence involves four components. The first one is personalisation and internalisation of the challenge of HIV (Parry 2008:20). This is whereby the church acknowledges its vulnerability and fully owns the challenge of HIV. This begins by questioning the church's teachings and value systems in the context of HIV. This critical evaluation of the church's theology, such as retribution and negative attitudes on issues of sex and sexuality as discussed in chapter three, is very important in building inner competence. "Churches must be ready to challenge their own way of thinking, listen to experts, and learn from people living with HIV" (Happonen *et al* n.d:17). Until the church becomes self-critical and realizes its vulnerability and the mindset that has contributed to its failures to give helpful responses, it would not be able to transform and develop inner competence. Internalisation has to do with change in attitudes towards HIV issues. It is only if the church is fully aware

and has acknowledged the presence of the problem that it can deliberately engage with it in an effective way.

Second, inner competence involves recognizing the short and long-term impact of the epidemic (Parry 2008:24). HIV has proved to cut across all sections of society and has affected the socio-economic sectors of the community. In Zimbabwe, in as far as it is spread by the socio-economic and political factors; it also has socio-economic impact on families, churches and the country at large (Parry 2008:24). "Men, women, young people and children are dying; families and communities are severely affected socially and economically, particularly in less affluent countries" (WCC 1997:1). Families and companies experience loss of membership, labour and financial gains due to the HIV epidemic. Different sectors of society, including the church, are facing disruption due to sickness and death among their members (Parry 2008:24). The church's competence to respond to the epidemic should be guided by its understanding of the impact of the HIV epidemic in the context which it should respond.

Third, inner competence calls for a holistic approach to the assessment of the factors that fuel the spread of HIV epidemic. "Discrimination, inequalities, lower educational status, economic dependence on men, and the formidably defended cultural and social norms make it difficult for disempowered women to refuse sex, or negotiate for safer sex" (Parry 2008:25). These socio-structural risk factors have been extensively discussed in chapter two as part of socio-economic factors that fuel the spread of HIV in Zimbabwe. It is within this environment of gender imbalance and gender violence that women are put at risk to contract HIV. Chapter two of this study has also pointed to some of the marriage practices that put those involved in these relationships at risk, especially women when it comes to levirate marriages and polygamy. These marriage practices have been generally identified as contributors to the spread of HIV (Parry 2008:26).

In chapter two, I have discussed the role of the economic and political landscape in promoting the spread of HIV. The economic situation plays an important part when it comes to the spread of HIV. Just as indicated in the chapter, in Zimbabwe, poverty and economic insecurity has contributed to mobility and migration of people for employment and economic survival (Parry 2008:27). As these people are usually separated from their families, some would end up engaging in multiple sexual contacts and extra-marital relationships which put them at high risk for contracting HIV. On the other hand, "Poverty influences choices people

make, particularly in the case of women resorting to survival transactional sex-work, where HIV risks are manifest" (Parry 2008:27). Bad governance and political violence undermine human rights and compromise service delivery in such a way that people do not have access to health care services. In Zimbabwe there was forced internal and external migration by political decisions policies such as the Fast Track Land Reform programme, (FTLRP), Operation Murambatsvina (OM) and political violence during election times (Bird and Busse 2007; Tibaijuka 2005). Due to these displacements people lost their family ties and access to health care facilities (Parry 2008:27). A thorough assessment of all these factors needs to be done in order to have an understanding of the context of HIV in which the church needs to respond.

Fourth, "Inner competence faces the reality of issues of stigma, discrimination and denial. HIV stigma reflects human values, heart issues, and stems from fear, ignorance, anxieties, prejudices and rigid attitudes" (Parry 2008:28). In the last section of chapter two, I argued that stigma and discrimination form part of major factors which fuel the spread of HIV epidemic. In chapter three, I have also argued that the church has contributed to stigma and discrimination due to its theology of retribution and its negative attitudes towards issues of sex and sexuality. According to Semple, stigma and discrimination "hamper prevention efforts, prevent people from being tested early, prevent people from looking for medical care, treatment, and support, and thus sustain the silence and denial around HIV/AIDS" (2003:61). As pointed out by Semple, stigma and discrimination have multiple negative effects on HIV prevention and hence create a favourable environment for its spread. Chitando (2007:8) argues that "One key area where AIDS competent churches must make a difference relates to HIV and AIDS stigma and discrimination". This can only happen if the church has accepted its role in the propagation of stigma and seeks transformation through the change of attitudes and belief systems. Stigma and discrimination need to be assessed and addressed together with the socio-economic and political factors that make people vulnerable.

Having understood the inner issues, the church then needs to give a compassionate response to the epidemic (Parry 2008:29). The response would cut across all aspects reviewed above such as prevention, maintaining justice that aims at improving and confronting stigma and discrimination, mitigating the impact of HIV in the communities and striving for the restoration of human dignity that has been compromised due to the impact of the epidemic (Parry 2008:29). While the church's response is guided by the HIV context, the church has to

have the necessary tools, techniques and skills to address the epidemic. This leads us to the church's need for outer competence.

4.4 Outer competence

The complexity of the factors that fuel the spread of HIV and its impact require the church to have the basic and relevant skills in order to respond in helpful ways. These practical, technical skills and resources mark the church's outer competency. According to Parry (2008:44), outer competence has seven components. These include theological competence, technical competence, being inclusive, socially relevant, networking and collaboration, engaging in advocacy and lastly dealing with restoration of dignity and hope in a compassionate manner (Parry 2008:44).

First, the church needs to be theologically competent in order to be able to offer a unique and meaningful response to the HIV epidemic. The church is a faith community hence it depends on its theological and faith resources when faced with challenges of life such as the HIV epidemic. As already pointed out in chapter three, the church initially responded with a theological discourse of retribution that shaped the "negative and judgmental" attitudes towards people living with HIV (Longchar 2011:408). However, in the past decade the church began shifting away from retribution to life giving theologies. In other words, churches in the current moment are moving towards being theologically competent in responding to HIV. The church's roots are in theological discourse drawn from biblical texts and hence its engagement with the HIV epidemic needs theological competence. "The church believes that the Bible is the authoritative source in matters of faith and conduct. Therefore, it needs to develop abilities and skills that enable it to apply biblical teachings and principles in the context of HIV and AIDS" (Happonen *et al* n.d:17). The HIV epidemic challenges the church to revisit and think about its biblical and theological base. Parry rightly notes that "HIV provides an opportunity for the whole Christian family to rediscover its roots and to re-focus on the divine commission to become living centres of love, recalling human beings to their true destinies and dignity" (2008:45). People living with HIV and the church are faced with crucial questions that challenge their faith and theology. That calls for critical thinking about Christian theological discourse especially on people's relationship with God and the work of Christ and to explore how these theological insights affect our involvement in prevention and care in the context of HIV (Parry 2008:46).

Theological competence is generated by critically examining our understanding of God, creation in relation to gender issues, the concept of sin and the Good News of Christ, forgiveness, healing, prayer and worship, human sexuality, the use of scripture in relation to justice and Christian life choices (Parry 2008:49). Being theologically sound in these aspects will give competence that is needed as the basis for our response to the epidemic. The church needs to acknowledge that God created, cares and is a liberating God of love (Longchar 2011:412). By realising that God is a God of love and compassion as argued in chapter three, the church would strive to respond to people living with HIV through love and compassion (Nouwen et al 1982:17). Our theological discourse in the context of HIV should emphasise that male and female are created in the image of God and hence challenge any forms of subordination, injustice and violence against women (Chitando 2007:21). Because God cares and desires human flourishing, the church of God would be concerned with justice that promotes human life, especially concerning women, people living with HIV and other vulnerable groups.

The church's theological discourse should not emphasise sin but promote life by bringing the Good News of Christ that comes with forgiveness and restoration of life into the HIV context. Retribution as discussed in chapter three has shown that God is concerned with punishing sinners rather than forgiving them. But our theological discourse should uphold the gospel of God's forgiveness through Christ that accepts everybody irrespective of their infirmity. Instead of labelling and discriminating against people living with HIV as sinners, the church needs to acknowledge that stigmatization and discrimination is sinful (Messer 2004:62). In the HIV era, sin is also characterised by socio-economic injustices that are created by social structures of society. In chapter two I have argued that the socio-economic injustices have created poverty and caused people to migrate looking for employment and economic survival elsewhere. This situation of poverty causes separation of families and causes people to indulge in extra-marital relationships that lead to the spread of HIV. In such situations the church should provide a prophetic word denouncing the structural sin as indicated in chapter three of this study. On the other hand I have argued in chapter three that the church has contributed to stigma through its negative attitude towards issues of sex and sexuality. This has led people living with HIV to avoid disclosing their status and seeking care and treatment, hence it has contributed to the spread of HIV (Ngure 2007:52). The church needs to develop a more liberating and life giving theological discourse on human sexuality. Chitando suggests that "By overcoming an impoverished gospel that demonizes sexuality and

the cultural conservatism surrounding it, the church in Africa can become more effective in meeting the challenge of HIV" (2007:33). A liberating theological discourse of sexuality would challenge the inherited traditional Christian and cultural negative views on sexuality that hinder sexual education in the context of HIV. A theologically competent church would "challenge Christians to live faith, not simply talk about it" (Parry 2008:49). Theological competence seeks to engage our faith and theology in the lived experiences of our communities that struggle with the HIV epidemic.

The church's theological competence needs to be combined with technical competence. This involves skills in planning, implementation, coordination, monitoring and evaluation of HIV programmes (Parry 2008:50). For the church to have technical competence it must engage in developing skills in capacity building. Capacity building is the one that would enable the church to have a systematic and well-structured response to the complex causes and effects of HIV. The starting point of the church's structured response should be marked by developing an HIV policy document. This should be formulated taking into account the legal implications of the context of its implementation in order to avoid legal pitfalls later. A policy document is an operational base which can be used to justify the church's programmes and projects. As indicated in chapter two, in Zimbabwe there is political instability especially during election and this affects the operation of churches and NGOs. The church therefore needs to have a policy document to justify its work. It is also the basis for its engagement with HIV, spelling out the ways of responding to the epidemic. However, given that there are others in the same field, the policy document should also be developed in consultation with those other partners in order for it to be comprehensive and avoid unnecessary pitfalls (Parry 2008:52). A policy to be easily implemented needs a strategic plan that breaks down the major themes of the policy into smaller components and defines who does what, when and how, and the aims and goals to be achieved within a certain time frame. Since this HIV and AIDS policy document belongs to the church, its strategic plan should have six basic components. It should have respect for human rights, be grounded in one's faith, apply evidence based-decision making, demonstrate openness to the stated objectives, be participatory and maintain accountability (Parry 2008:53).

The strategic plan needs to take into consideration the issue of human rights because HIV is easily stigmatised and hence the policy itself may become a tool of stigma if not carefully thought through and drawn up (Parry 2008:54). Language used in the strategic planning

should be inclusive and promote human dignity. Human rights and dignity are also central in the church's teachings. Strategic planning should be grounded in the character of God and Christ. These are love, justice and compassion. In Christian community these are used to promote human rights and dignity. These would promote helpful responses to the epidemic based on principles of faith that challenge any forms of injustice and dehumanisation of people living with HIV. In order for the church to effectively respond to HIV it needs to have a strategic plan which contains "evidence-based decision making" (Parry 2008:54). This is gained through critical analysis of the context, research and the personal contact with experiences on the ground. The strategic plan should include responses to the actual information and experiences in a given context. In order to get the necessary support from the community, the plan should have clear objectives directed to the above discussed contextual experiences. All these linked to community participation and accountability would make an ideal strategic plan that facilitates policy implementation.

According to Parry, "The third component of outer competence is to ensure social relevance, inclusivity and to seek to build social cohesion" (2008:69). Chapter two discusses the socio-economic and political factors that fuel the spread of HIV and these are structural causes other than individual causes. However, Parry rightly argues that the church sometimes misses the point by blaming people living with HIV for individual bad morality and personal sin, leaving out the structural sin that makes them vulnerable (2008:70). In order for the church's response to be socially relevant, it must address the actual drivers of the epidemic and advocate for treatment and protection of vulnerable groups. "It is important that the churches continue to put pressure on the government to make available the best possible treatment to all people in efforts to reduce the impact of the epidemic on people's lives" (Gennrich 2004:58). Even though the church may concentrate on home-based care, counselling and treatment and orphan care, it must also deliberately address issues of inequalities and justice that increase people's vulnerability to HIV. "HIV is an issue of justice and as such demands a response that is more than just charity" (Parry 2008:70). To prevent further spread of HIV the church must defend the rights of people living with HIV, widows, orphans and all those who are more vulnerable. By advocating for justice and denouncing stigma the church builds social cohesion that is necessary where the society is faced with challenges of HIV that bring social disintegration. A socially relevant response to HIV is the one that is holistic in attending to the actual issues and aimed at the restoration of human dignity and hope in our communities threatened by this epidemic.

Inclusiveness is one of the key aspects of a church's outer competence. "Churches can play an unrecognized preventative role by being a home, an anchor, a place where there is a reinforcement of positive value systems and loving, compassionate peer support" (Parry 2008:75). Such compassionate responses have great impact in breaking silence and scaling up prevention efforts. But this response must include those living with HIV and not ignore their experience. "Open and meaningful involvement of people living with HIV in programmes can also encourage others in similar situations, or suspecting that they might be, to break their silence and seek out testing, support and care" (Parry 2008:75). Parry highlights that "Their participation in policy, programme design and implementation has been instrumental in reorienting priorities, ensuring relevance and effectiveness, and increasing accountability" (2008:76). Participation and involvement of the people living with HIV in various church programmes and policies affirms their dignity. Their involvement promotes ownership of the programme and hence increases the chances of its successful implementation. Often people living with HIV lose their agency as the church and other organization treat them as "projects". Programmes aimed at assisting them are drawn and implemented without their involvement and hence sometimes those programs do not make the desired impact because of lack of support and ownership from the concerned people.

The other component of outer competence is networking. HIV is neither concentrated in one area nor requires one simple response from a single entity that can easily tackle it. HIV poses multiple challenges such as the need for support and treatment of people living with HIV as well widows and orphans who need support. This raises the question of resource mobilisation and distribution which also calls for skilled management of these financial and human resources. It is a fallacy to assume that the church can have sufficient resources to respond to the HIV epidemic. Due to these challenges, the HIV epidemic calls for united efforts, and therefore the need for networking for resource mobilization and to meet the needs of those infected and affected in various corners of Zimbabwe. "Networking implies collaboration with other key players in the response to HIV and AIDS" (Parry 2008:76). In order for the church to effectively respond to the epidemic, it needs to collaborate with government departments, non-governmental organisations (NGOs), Faith-Based Organizations (FBOs) and activist groups that are addressing issues of HIV (Parry 2008:76). Partnership and collaboration contribute to sharing of human, financial and material resources thereby improving service delivery (Parry 2008:76). Such "sharing of experiences, what works and what does not, exposure of gaps and challenges, is all essential, relevant and can help to

formulate responses that are more strategic and thus more likely to have a better impact" (Parry 2008:76). As noted above, networking is a powerful tool in responding to the HIV epidemic as it enables stakeholders to share experiences, skills and other resources needed to address HIV issues. It may also enable organisations to avoid duplication and repetition of programmes in the same community.

Advocacy is another component of the outer competence needed by the church. In the context of HIV, being involved in advocacy is being prophetic. Advocacy should entail social analysis of the HIV context in order to adequately speak for and with those who suffer. "Advocacy is based on the comprehensive understanding of the living conditions of people living with HIV. Poverty, the state of women, attitudes towards the children, and harmful cultural practices should be considered while the church addresses HIV and AIDS" (Virtanen n.d:43). As discussed earlier in chapter two, factors that fuel the spread of HIV are linked to structural sins of the society. These are socio-cultural causes that create inequalities between male and female, and make women more vulnerable. Parry highlights that "Advocacy is particularly needed against those determinants that are driving the epidemic such as: gender disparities, sexual abuse, domestic and gender-based violence and negative cultural practices" (2008:78). In chapter two again I have pointed to economic and political decisions and policies that have caused displacement of people thereby facilitating the spread of HIV. In chapter three I identified the role played by negative views on human sexuality and the theology of retribution in promoting the spread of HIV in Zimbabwe. It is through the understanding of such context that the church may be focused on specific issues that need advocacy. Some of these situations require confrontation through the prophetic word, as I pointed out in chapter three of this study. "Advocacy is needed against discriminating laws, policies and practices, particularly those against marginalized groups of people. Orphans have a right to identification documents and a right to protection, education, shelter, food, health care and psychosocial support" (Parry 2008:78). The church that is involved in advocacy is the church that is more prophetic - and the complexity of the HIV context in Zimbabwe needs such a church.

The centre of advocacy is promotion of human dignity and this is achieved through solidarity with the vulnerable groups in community. Virtanen argues that "The plight of women, widows, orphans, children, prisoners, and refugees and other vulnerable groups should be at the top of the church's advocacy agenda" (n.d:43). Solidarity seeks to restore the dignity of

the vulnerable groups that are continually compromised by the many issues surrounding HIV spread and prevention. A prophetic church involved in advocacy would speak out and seek to defend the rights of the vulnerable groups thereby giving hope of survival in the context of HIV. Through advocacy, the church engages with authorities to make sure the necessary steps are taken to provide the desired services to the vulnerable groups as well as condemning policies and practices that put people at risk in the context of HIV.

According to Parry (2008:79), the last and most important component of outer competence is compassion. Compassion draws us to actions of solidarity as we journey with those who suffer. "Compassion challenges us to cry with those in misery, to mourn with those who are lonely, to weep with those in tears" (Nouwen *et al* 1982:4). HIV is always associated with stigma and discrimination as discussed in chapter two of this study. This brings about marginalisation and loneliness for people living with HIV. On the other hand, widows and orphans also suffer forms of discrimination as their spouses or parents are assumed to have died from AIDS-related illnesses. These need a compassionate church that acts in solidarity with them in their struggle to cope with life challenges. "We need to be compassionate in what we do and to accompany, in solidarity, those amongst us who suffer from the effects of HIV" (Parry 2008:79). The only way the church may offer a compassionate response to people living with HIV is by being in solidarity, sharing their pain and suffering. Being in solidarity includes speaking out for and with the people living with HIV so that they get the necessary support from their families, church and government. They need protection from all forms of injustices including stigma and discrimination. "What we seek to do in our response, more than just bringing care, support, treatment and advocacy, is the restoration of hope" (Parry 2008:80). Solidarity would bring hope as it shows that the church is prepared to walk side by side with those who suffer and desire to bring a change in their lives. The other components of the outer competence can be made more effective by solidarity that marks a compassionate response to the HIV epidemic. The outer competence and the inner competence discussed in this chapter are linked by leadership, knowledge and resources.

4.5 Linking inner and outer competencies

In order for inner competency to move to outer competencies, there is a need for leadership, knowledge and resources (Parry 2008:32). The HIV competent church needs to have leadership that is prepared to respond to the epidemic. Leadership plays a key role in promoting meaningful response to the HIV epidemic. It is the church leadership that takes

decisions, draw and implement policies and speak out on issues such as the HIV epidemic. Responding to HIV should be systematic in order to produce results. This can only be achieved through the establishment and implementation of HIV and AIDS policy (Happonen *et al* n.d:17). It is the leadership that ensures the policies are implemented and periodically evaluated to measure their impact. This is only done by the leadership that is positive and keen to respond to the epidemic.

Usually the church's attitude and response is shaped by leadership. "They are expected to provide vision and inspiration to the church so that it will not remain indifferent to HIV and AIDS, but will take appropriate action" (Ramashapa n.d:53). If the leadership is not actively and positively responding to the epidemic or has a negative attitude then the church follows the same. "Any dramatic reduction or increase in HIV and AIDS cases is mostly the result of the environment of church communities created by leadership" (Byamugisha 2010:40). Leadership should influence the positive responses to HIV in order to make an impact on the reduction of its prevalence and peoples' vulnerability. Ramashapa argues that

> An HIV and AIDS competent church has focused leadership that unconditionally reaches out to people living with HIV and AIDS. A competent leader listens to people, accepts them unconditionally, and does not turn his/her back on the challenges he/she faces in the present. Competent church leaders associate with and support people living with HIV and AIDS (n.d:52).

Competent leadership is determined by awareness and striving to make a change. The capacity to counter stigma by unconditional love and to journey with people living with HIV requires skilled, knowledgeable and committed leadership.

The kind of leadership needed in the context of HIV is a leadership willing and committed to make a change and meaningful impact on reducing the effects of the epidemic. It is a leadership that is open and accepts the limitations and is prepared to learn so that they become well informed about the epidemic and its context. It is through education that the leadership gets accurate information about the epidemic and become equipped to respond in various ways that promote prevention, support and treatment (Parry 2008:34). Through learning and experiences, the leadership becomes aware of the various factors that fuel the spread of HIV such as those discussed in chapter two of this study. Church leadership also needs education so that they are well informed about the negative and positive discourses that shape the church's response to the HIV epidemic.

In the context of HIV, good leadership should be guided by the commitment to make an impact, be accountable and create an environment of participation and involvement (Parry 2008:34). "Increased technical skills, advances in medication, effective as they are, will fail without committed leadership and improved human resources and infrastructure" (Igo 2009:15). Commitment is shown by the leadership when it deliberately and actively engages in HIV issues. "Church leaders speak out openly and emphatically about HIV and AIDS" (Happonen and Virtanen n.d:97). Since HIV programmes may involve mobilisation of resources from various sources, accountability becomes imperative. Church leadership should remain transparent and accountable when it comes to resources and especially those that come from partners and other stakeholders so that their work and programmes gain credibility (Parry 2008:34). Leadership needs also to give space to and promote the engagement and participation of all people irrespective of their HIV status. For the leadership to be able to shape the church's helpful responses to the HIV epidemic, it needs to have relevant knowledge about issues around HIV.

Due to the complexity involved in HIV issues, knowledge becomes a key component. There is the need for "acquisition of and provision of accurate up-to-date and relevant information concerning the virus and its: transmission, detection, effects and management" (Parry 2008:36). Knowledge would also involve accurate statistics about the people living with HIV, and vulnerable groups such as widows and orphans (Parry 2008:36). Leaders should have knowledge on the "accessibility of services that provide information, communications on behaviour change for risk reduction and prevention, testing centres, counselling centres, prevention of mother to child transmission programmes and anti-retroviral therapy (ART), nutritional support and referral systems" (Parry 2008:36). Such relevant and up-to-date knowledge is needed for educational and referral purposes since the church may not have specific skills and equipment needed for handling some HIV cases.

The other component of "the bridge between inner and outer competences is resources" (Parry 2008:37). According to Parry (2008), resources include financial, structural, human, spiritual, material and partnership resources. Funding is one of the key aspects of resources needed for HIV programmes - hence the need for leadership to budget and allocate financial resources to these programmes. Transparency and accountability are highly required for all financial resources through accurate financial records and reporting (Mogdani 2003:149). Therefore, competence in handling and implementing programmes is proved by transparency and accountability to mobilized funding for HIV programmes.

Facilities form part of resources that are needed to respond to HIV. Churches may make available their institutions such as educational and health facilities as well as their chapels for training and other HIV activities (Parry 2008:38). Besides physical infrastructural resources, the church is well equipped with members who have skills in all fields such as health, education, social work and law. The task of the church may be the identification and putting into proper use of these readily available resources within its structures.

The church also has valuable spiritual resources. These include aspects such as pastoral care and counselling. "Christian counselling draws on spiritual resources such as biblical texts, prayer, songs, liturgical material, and the sacrament of Holy Communion for freeing, empowering and nurturing wholeness within the church as the body of Christ" (LWF 2007:47). In the context of HIV, pastoral care and counselling brings comfort, encouragement and hope to desperate and devastated people living with HIV and their families. "AIDS-related counselling also means home and hospital visitation, funeral, memorial services and bereavement support" (Cherry and Mitulski 1990:159). Widows, orphans and the relatives who lose their loved ones through AIDS-related deaths would need services of pastoral care and counselling, and the church provides these services. Parry further argues that "The value of prayer and intercession for those who are suffering, and for those who suffer with them, cannot be underestimated" (2008:40). These spiritual assets are valuable as they help in sustaining and giving hope to the suffering and the bereaved.

The spiritual resources are always accompanied by theological resources which is their base. Parry notes the shortage of theological material resources on HIV and AIDS and acknowledges the work of World Council of Churches which has provided a number of resources that can be of greater use to churches (2008:41). She also laments that the material is mostly available in languages foreign to the local people which makes it inaccessible. (2008:41). On the other hand she advocates that material resources can be enriched by using volunteers and youth in the processes of data and information collection as they are the people on the ground (Parry 2008:41). These are the people who are directly involved in communities, working with the people living with HIV and their families. "It transforms them from passive receivers of HIV messages to active participants in the fight" (Parry 2008:41).

The church needs to improve in the way it gathers and distributes material resources. It is through international and local links that the church can access and share resources such that

the links form part of resources that the church has (Parry 2008:41). "Churches have relational links that stretch from the grass-roots to the international community. These are channels for solidarity between churches of the North and South, as well as conduits for resources, both financial and human" (Parry 2008:41). Through these links the church's response to the HIV epidemic is strengthened.

4.6 Conclusion

This chapter has discussed the importance of HIV competence in responding to the epidemic. We have noted that the church needs to have four inner competencies, seven outer competencies, and the link between the inner and outer competencies is formed through leadership, knowledge and resources. The inner competencies have to do with understanding and internalisation of the HIV context that would lead to compassionate responses. The outer competencies form the methodology or the theological, ethical and practical ways of responding to the epidemic. The bridge is a focus on the structures and resources that can bring together the above aspects and enable a meaningful church response to the HIV epidemic. In the next chapter, the HIV competence framework is going to be used to analyse the ELCZ HIV and AIDS policy document.

<center>**Chapter Five**</center>

<center>**The Evangelical Lutheran Church in Zimbabwe HIV and AIDS policy document**</center>

5.1 Introduction

Chapter two is a description of the context of HIV in Zimbabwe. It discussed the economic, political and socio-cultural drivers of HIV in Zimbabwe. Chapter three is a discussion on theological discourse in the context of HIV showing how the church has contributed to the spread of HIV through retribution and negative views on human sexuality. It further points to the shift from retribution to theologies of liberation and life such as the prophetic word, positive discourse on human sexuality, human dignity, compassion and solidarity and the body of Christ. Chapter four is a summary of the HIV competence framework which is used going to be used to analyse the ELCZ HIV and AIDS policy (ELCZHAP) document in the current chapter.

This chapter provides an analysis of the ELCZ HIV and AIDS policy document. It begins with a brief introduction of the ELCZ and a discussion of the formulation of the ELCZ HIV and AIDS policy document. It examines the strengths and weaknesses of the document in accordance with the HIV competence framework and its relevance to the Zimbabwean context.

5.2 A brief background of the Evangelical Lutheran Church in Zimbabwe (ELCZ)

The Evangelical Lutheran Church in Zimbabwe (ELCZ) was formed in 1903 through the work of the Church of Sweden Mission (CSM) (ELCZ 2007). Its work was focused on preaching the Gospel through evangelism, education of people through the establishment of mission schools, as well as healing through building hospitals (ELCZHAP 2011). This work was realised through the establishment of the first mission centre at Mnene which had all the components - the chapel, hospital, primary and secondary schools - to holistically cater to various aspects of human life. This was followed by the establishment of other mission centres in the Mberengwa district in the Midlands and in the Southern part of Matabeleland South province (ELCZ 2007). However, the work of the ELCZ eventually spread into all ten provinces of Zimbabwe.

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Currently, the ELCZ has five primary schools, two secondary schools and six high schools in the Eastern, Central and Western dioceses of the church. It also has four hospitals namely Mnene, Masase, Musume and Manama in the Midlands and Matabeleland South provinces respectively (ELCZ 2007). The ELCZ has made efforts to respond to the HIV epidemic through its development wing, Lutheran Development Service (LDS) and two home-based care (HBC) centres, namely, Betseranai in Mberengwa district in the Midlands province and Thusanang in Gwanda district in Matabeleland South province, to address the HIV epidemic (ELCZ 2009).

The ELCZ mission statement shows that the church aims to preach the gospel holistically. This is done through evangelism and the provision of education and health care to the community (ELCZ 2009:6). The mission statement itself is central to the work and mission of the ELCZ. It does not only focus on spiritual nourishment but also on socio-economic needs which is crucial in the context of the HIV epidemic as has been discussed earlier. For that reason the ELCZ finds if imperative to respond to the HIV epidemic in Zimbabwe.

5.3 The ELCZ response to the HIV epidemic

Although the ELCZ has been impacted by the epidemic since the first HIV positive diagnosis in 1985, it only began to respond in the early 1990s. As indicated in chapter one of this study, the ELCZ, like most churches in Zimbabwe, did not immediately respond to the epidemic. As HIV was regarded as any other health problem, the ELCZ left it to be attended to by its mission hospitals. These were seen at the time to be the most relevant institutions to address the problem. Due to the growing impact of the epidemic in most of the communities, the church then began to use its development wing. "The pandemic is a key development issue and Lutheran Development Service (LDS) will prioritize orphan care and awareness building where it has demonstrated its capacity" (LDS 2006:8). LDS's work was concentrated in Beitbridge, Chivi, Gwanda, Mberengwa, Mwenezi and Zvishavane, mainly attending to poverty, food security and HIV and AIDS (LDS 2006:8). These are mostly rural areas where the ELCZ is predominantly located. Its HIV and AIDS programmes include education, orphan care and support through provision of food and school fees (LDS 2006:27-28). These efforts were boosted by the inception of Thusanang and Betseranai Home Based Care programmes specifically for HIV and AIDS which were launched in 1993 and 2001 respectively (ELCZ 2009:6).

Through financial aid from the Church of Sweden, the ELCZ managed to start the Thusanang HIV and AIDS project in the Western Diocese of the ELCZ (ELCZ 2009:6). Its work covers areas of Gwanda and Beitbridge in Matabeleland South province. Thusanang is part of the ELCZ Diaconal Ministry and exercises a holistic approach in all aspects of service delivered (ELCZ 2010:1). It should be noted that since 1993 its work was based on responding to community requests for support in areas of home based care and orphan care (ELCZ 2010:1). "Thusanang activities are focused on the following areas; Home Based Care (HBC), Care for orphans and vulnerable children (OVC) and Information, Education and Communication (IEC) on HIV/AIDS issues" (ELCZ 2009:1).

On the other hand the HIV work was carried by Betseranai in the Midlands province and in the Eastern deanery of the ELCZ central diocese (ELCZ 2009:6). Betseranai Home Based Care (BHBC) project started in 2001 funded by the Lutheran World Federation (LWF) (ELCZ 2007). Its work covers all parishes in the central Diocese of the ELCZ from Mwenezi to Lower Gweru (ELCZ 2010:4). The programmes of BHBC include prevention, care and support, Treatment and Safe environment creation in the context of HIV and AIDS (ELCZ 2006:14).

The church saw the need to centralise the coordination of Betseranai and Thusanang projects in early 2000. "In 2002, the projects were integrated into one program and the HIV and AIDS programme is considered as an integral part of the ELCZ holistic mission strategy of the church, in order to assist the church fulfil its Diaconic work in the communities" (ELCZ 2009:6). Still the integrated projects continued with programmes of prevention, care and support, treatment and education (ELCZ 2009:6).

The work of the ELCZ remained concentrated in rural areas. The home-based care programme depends a great deal on trained volunteers (ELCZ 2010:11). The work of the volunteers includes both HBC and care for orphans and vulnerable children (OVC). Care for orphans and vulnerable children involves provision of food, clothing and educational support, such as fees, uniforms and stationary (ELCZ 2010:11). This work has been so limited in terms of areas of coverage (rural areas), and activities involved as discussed earlier. The other challenge is that the scope of the epidemic in Zimbabwe became so overwhelming such that the church saw the need to have a well-coordinated effort through the introduction of an HIV

and AIDS policy document.[3] The policy document would guide the church's response. The church also found the policy document necessary due to the political challenges that had seen the co-ordinator of Betseranai being arrested and the church found it difficult to justify the HIV work they were doing in the communities.[4] These reasons prompted the church to issue the first ELCZ HIV and AIDS policy document in 2005.

5.4 Formulation of the ELCZ HIV and AIDS policy document

Until 2005 the ELCZ was responding to the HIV epidemic without a policy document, as highlighted earlier in this chapter. In early 2002 Bishop Ambrose Moyo met with the ministerial board[5] and discussed the challenge of HIV, the political climate and the need for an HIV and AIDS policy document (ELCZ 2009:46). Besides the political climate, pastors' daily experiences of funerals and loss of church membership, and growing numbers of widows and orphans in the communities they serve became an eye opener to the scale of the epidemic (ELCZ 2009:47). On the other hand, the work of Betseranai and Thusanang provided the church with statistical information, success and challenges which also pointed to the scale of the epidemic (ELCZ 2010:8-10). It was after consultations with other pastors in different parishes that the church agreed to the proposed idea of a policy document. The ELCZ HIV and AIDS policy document was written by members of the ministerial body, medical board (doctors and nurses), and the two coordinators from Betseranai and Thusanang Home Based Care projects.[6] It was ratified by the ELCZ church council and issued in 2005.[7] This policy document was reviewed in 2011 and has become a very important document for the ELCZ as it forms the basis of the ELCZ response and HIV and AIDS programmes (ELCZHAP 2011). Basically, one may argue that the formulation of the ELCZ HIV and AIDS policy document seems to have been informed by the work of the two projects discussed above. Through the work of Betseranai and Thusanang, the church has been brought to the realities of the HIV epidemic in Zimbabwe and the need for a systematic response to this epidemic.

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[3] Personal conversation with Dr Herbert Moyo, a minister in the Evangelical Lutheran Church of Zimbabwe and who was one of the members who drafted the first ELCZ HIV and AIDS policy document of 2005, 5 July 2013.
[4] Personal conversation with Dr Herbert Moyo, 5 July 2013.
[5] Ministerial board is an ELCZ organ composed of three diocesan bishops two deans, one pastor and one lecturer from the United Theological College (seminary).
[6] Personal conversation with Dr Herbert Moyo, 5 July 2013.
[7] Personal conversation with Dr Herbert Moyo, 5 July 2005.

5.5 Summary of the ELCZ HIV and AIDS policy document

The ELCZHAP document indicates the church's commitment to respond to the HIV epidemic in Zimbabwe. It is also in line with the national and global goal of addressing the HIV epidemic. "The ELCZ will complement the national response to HIV and AIDS pandemic by contributing to the national goal of zero new HIV infections, zero HIV related deaths and zero stigma and discrimination through holistic care" (ELCZHAP 2011:4). The key aspects of the ELCZHAP document are the theological principles, four thematic areas and the six related issues in addressing HIV and AIDS pandemic.

5.5.1 Theological principles

Theological principles on which the policy is based are highlighted in three statements with some texts in brackets. These theological themes are stated but not eleaborated upon. The first one is on *imago dei*. This principle presupposes that humanity created in the image of God (Gen. 1:27) is failing to adore God due to the impact of HIV (ELCHAP 2011:3). The HIV epidemic affects humanity and God's purpose for human beings. "God is not happy with that which disturbs the purpose of His creation. Man was created to live for God and to die for Him (Rom. 14:7-9)" (ELCZHAP 2011:3). In other words, the church is there to restore and maintain human dignity that is compromised by the epidemic.

The second theological principle is based on Jesus' mission. The church engages with HIV and AIDS as a way of continuing and fulfilling the mission of Christ who healed and reconciled people to people and God to people relationships. All this is based on John 3:16, Matt. 9:35 and Matt. 10:1 (ELCZHAP 2011:3).

The third and last theological principle is based on John 9:2-3. This has to do with issues of stigma and discrimination in the context of HIV and AIDS. The ELCZ is prepared to fight against stigma and discrimination by avoiding condemnation of people due to any form of illness, including people living with HIV (ELCZHAP 2011:3). There is no room for retribution, rather it promotes solidarity. Based on these theological principles, the policy document spells out key objectives.

5.5.2 Objectives

There are seven objectives set. These objectives include the aim to facilitate testing for HIV, and treatment, care and support for the people living with HIV, and reduction of stigma and discrimination against people living with HIV and their families (ELCZHAP 2011:4). The church also aims at empowering vulnerable people, including people living with HIV, widows and orphans through involvement and participation in all church programmes (ELCZHAP 2011:4). The ELCZ also strives for the "mainstreaming of HIV and AIDS, TB, Gender and Development principles and ensuring gender-based budgeting principles in all planning and budgeting processes" (ELCZHAP 2011:5). The other objective is an emphasis on collaboration as a way of making meaningful contributions (ELCZHAP 2011:4). Furthermore, the ELCZ put a great deal of emphasis on the need for further and new research on the HIV epidemic and other current challenges such as TB and gender (ELCZHAP 2011:5). These objectives points to important issues when it comes to practical responses to HIV. They focus on prevention, care and stigma which are key when addressing HIV issues. In order to achieve these objectives the policy document has several themes and programme areas.

5.5.3 Thematic areas and related programmes of HIV and AIDS

The policy document has four thematic areas and other themes related to programmes of HIV and AIDS. This section highlights the thematic areas in the ELCZ HIV and AIDS policy document.

Theme one deals with "prevention and control of transmission" (ELCZHAP 2011:5). This theme is concerned with education and awareness programmes especially on the HIV epidemic and TB, and also addresses gender and development issues. This theme also focuses on prevention methods such as abstinence and faithfulness, male circumcision and voluntary counselling and testing (VCT) (ELCZHAP 2011:5). Education will also take into account issues of masculinity, sex and sexuality. As a way of prevention of the spread of the HIV epidemic, the ELCZ will also "engage in poverty alleviation programmes" (ELCZHAP 2011:5).

Treatment, care and support are under thematic area two. Basically the policy shows that the church would need to create space and enable people to get the necessary information about treatment of HIV and AIDS and TB (ELCZHAP 2011:6). The church seeks to promote care

and support of those who are sick and suffering with the epidemic including orphans and vulnerable groups (ELCZHAP 2011:6). Support is done through collaboration with local authorities and the community in general (ELCZHAP 2011:6).

Thematic area three is about mainstreaming the HIV epidemic, TB, gender, and development (ELCZHAP 2011:6). That will be done through internal and external forms of mainstreaming. The ELCZ will use deployment and transfer strategies as a way of reducing risk of HIV. Externally, "the ELCZ shall involve both men and women in challenging unequal gender relationships and promoting more protective environment for girls and women" (ELCZHAP 2011:7).

The fourth and final thematic area focuses on a supportive environment. The church targets leadership support - from the local congregation to national level - with a view to promote review and policy implementation (ELCZHAP 2011:7). The policy document also suggests that the church steps up lobbying and advocacy in the areas of treatment and care, reduce stigma and discrimination and promote gender justice and equality (ELCZHAP 2011:7).

Besides the above themes labelled one to four, the policy document has other themes relating to dealing with the HIV epidemic. One of the themes is respect of disclosure and confidentiality of one's HIV status which is guaranteed by the disciplinary measures taken against any disclosure of one's status by any church member without written consent (ELCZHAP 2011:8). Confidentiality is not only encouraged among the church members but also in all marriage relationships (ELCZHAP 2011:8).

Clearly, as stated in the document, ELCZ does not intend to work alone in the HIV and AIDS programmes, but seeks to have partnership with others doing similar programmes. "The ELCZ shall collaborate with government, CBOs, NGOs, FBOs, AIDS service organizations and other institutions and partners locally, nationally, regionally, and internationally in all issues related to HIV and AIDS" (ELCZHAP 2011:8). Partnership helps in sharing, knowledge, skills and resources in order to make a greater impact in responding to the HIV epidemic in Zimbabwe.

The ELCZ seems to recognise the importance of gender issues in the context of HIV and AIDS. The policy highlights the church's concern for gender by having a theme on gender. In this theme, the church will promote equality between men and women, empowerment of women and other vulnerable people and defend the rights of women in marriage especially on

sexual matters (ELCZHAP 2011:8). "The ELCZ affirm the rights of women and men to an equal say when it comes to sexual matters" (ELCZHAP 2011:8).

One of the themes is sustainability. HIV and AIDS programmes sometimes suffer because they are not sustainable. The ELCZ puts forward a plan for creating sustainability of these programmes. Amongst other issues are the leading roles of ELCZ leaders in these programmes, stakeholder involvement, and participation and encouragement of self-reliance projects among members of the local communities (ELCZHAP 2011:9). In addition to that the church will "mobilize local, national, regional and international resources for sustainability of the programmes / projects and all ELCZ activities" (ELCZHAP 2011:9). Sustainability is also attained through governance and accountability.

Through its finance and medical boards the ELCZ intends to ensure accountability of resources meant for HIV and AIDS programmes. The church will strive to "ensure proper use of all resources (human, material, financial, assets) earmarked for the HIV and AIDS programmes" (ELCZHAP 2011:9). On the other hand the church shall engage in effective communication and monitoring and evaluation. On the aspect of communication, "The ELCZ shall ensure effective accountability and transparency for effective documentation and communication of HIV and AIDS, TB, Gender and Development programmes at all levels" (ELCZHAP 2011:9). Finally, the "ELCZ shall have monitoring and evaluation framework for managing results on HIV and AIDS, TB, Gender and Development programmes at all levels. The ELCZ shall promote participatory Monitoring and Evaluation" (ELCZHAP 2011:9). These are some of the programmes in the ELCZHAP meant to strengthen its response to the HIV epidemic. Having summarized the details of the ELCZHAP, the following section critically analyses the ELCZ HIV and AIDS document using the HIV competence framework discussed in chapter four.

5.6 A critical analysis of ELCZ HIV and AIDS document

In chapter two, I have argued that the spread of HIV is fuelled by political and economic factors such as the Economic Structural Adjustment Programme (ESAP), Fast Track Land Reform Programme (FLRP), Operation Murambatsvina (OM) and political violence. These factors are dealt with extensively, showing how they contributed to the unemployment, poverty and displacement of people which lead to sexual relations that may leave people at risk of contracting HIV. In addition, I discussed the socio-cultural factors that fuel the spread

of HIV such as marriage practices and stigma and discrimination. It is in light of the HIV context that I give the evaluation of HIV competence reflected in the ELCZHAP. In the first place the document does present the church's acknowledgement that the HIV epidemic is a major problem in Zimbabwe. The extent is not given but a statement of acknowledgement shows that the church is aware of the problem at hand. The HIV epidemic is regarded as one of the greatest challenges which the country is facing and its effects are felt in the socio-economic spheres (ELCZHAP 2011:2). The ELCZ accepts the responsibility and imperative to respond to the epidemic as its call and mandate as a way of showing God's love (ELCZHAP 2011:2).

The objectives and themes of the ELCZHAP reflect inner competence, as discussed in chapter four, in a variety of ways. There is an emphasis on the need for prevention and care, reduction of stigma and empowerment of vulnerable groups (ELCZHAP 2011:4). In prevention, many aspects are brought to the fore. Among other issues are HIV education, dissemination of information on prevention and treatment, and promoting access to relevant information. It is lack of education and access to information that may lead to the spread of HIV in Zimbabwe, hence the church seeks to promote these aspects as it responds to the epidemic. The church "can sensitize people to the existence of HIV and the risks it presents, and it can share with them its educational messages" (Okaalet 2009:83). The objectives and themes show that the church has assessed some of the factors that increase vulnerability, such as lack of knowledge about the epidemic in Zimbabwe (ELCHAP 2011:4).

Furthermore, the policy document shows that to some extent, the ELCZ has personalised the risk as it reveals some of the factors that fuel the HIV epidemic such as poverty, gender inequality and sexuality (ELCZHAP 2011:5). These form part of the risk factors. In chapter two it has been discussed that poverty drives women and girls into risky behaviour that increases their vulnerability (Gennrich 2004:13). On the other hand I have argued that gender inequalities also put women at risk of contracting HIV as men assume authority over women in sexual relations thereby denying women their rights to advocate for safer sex practices.

The policy documents also indicate that the ELCZ is committed to address issues of sexuality (ELCZHAP 2011:5). I have argued in chapter three that the negative views on human sexuality perpetuated both by the church and Shona culture have hindered disclosure and prevention efforts. The focus on sexuality shows that the church has become aware of the role of silence and secrecy in spreading HIV and the need to develop a comprehensive

theological discourse on human sexuality. This helps to talk about sex and sexuality in an open and honest way. "Since HIV is transmitted mainly through sexual intercourse, preventing its spread naturally demands a focus on sex and sexuality. But the silence that engulfs sexual issues seems all-pervasive" (Clifford 2004:13). Introducing a positive theology of human sexuality can lead the church to handle issues of sex, sexuality and HIV, as these are connected. In the ELCZHAP document it is clearly stated that the ELCZ believe "Sex is a gift from God not only for procreation but also to be enjoyed by both husband and wife. The ELCZ affirm the rights of women and men to an equal say when it comes to sexual matters" (ELCZHAP 2011:8). This is to acknowledge that sex is "something not to be deplored but to be the subject of rejoicing and thanksgiving" (Clifford 2004:14). This is a revolutionary and prophetic move by the church to bring liberation to both men and women and even the youth. The church is prepared to "educate congregants and communities on matters of sex and sexuality including positive masculinity among other things across all ages" (ELCZHAP 2011:5). It is critical to deal with issues of sexuality as that would enable people to openly share their sexual experiences including sexual abuse and sexual orientations. This also reduces stigma and discrimination.

On the other hand, ELCZ is also prepared to confront stigma and discrimination which are some of the key factors that fuel the spread of HIV in Zimbabwe as discussed in chapter two. One of the key objectives in the ELCZHAP is "To encourage communities to care and support people infected and affected by HIV and AIDS and their families in order to reduce stigma and discrimination" (ELCZHAP 2011:4). The ELCZ makes a deliberate move to deal with stigma in the context of HIV as it is also one of the major factors which fuels the epidemic in Zimbabwe. The church has developed some inner competence by owning the problem and being prepared to address it.

The church's HIV competence involves "leadership, knowledge and resources" (Parry 2008:32). The ELCZHP seems to show that the church is well informed about the key role of leadership, knowledge and resources in addressing the HIV epidemic. The production of a policy document is in itself a sign that the church leadership is taking the epidemic serious and desires to guide the church in responding. In the context of HIV, leadership is there to draw policies and direct the implementation (Ramashapa n.d:51). As clearly indicated in the policy document, leadership from congregational and national levels is meant to create a "supportive environment" for the people living with HIV, and other vulnerable groups (ELCZHAP 2011:7). This environment helps in preventing the spread of HIV and promotes

care and support of the people living with HIV. "Any dramatic reduction or increase in HIV & AIDS cases is mostly the result of the environment of church communities created by leaders" (Byamugisha 2010:40). Church leadership is important as it shapes the attitude and behaviour of people in the local congregation and at other church levels. For a church to be HIV competent, it needs to have competent leadership. Nurnberger argues that the "positive and active stance of the church leader is decisive for changing the mood of the diocese or church" in addressing the HIV epidemic (2005:300). In addition, church leadership is responsible for resource mobilisation and distribution in the context of HIV. As stewards of resources therefore, the church needs a responsible leadership. "All leaders must be fully accountable for the funding received from resource partners. For credibility, and sheer responsibility to those whom we are representing, there must be complete transparency and accountability" (Parry 2008:34). The policy clearly states that through the relevant boards it will ensure sustainability as well as transparency and accountability even with the use of resources meant for HIV programmes (ELCZHAP 2011:9).

Knowledge is gained through research and the ELCZ has a commitment to research current HIV information and disseminate that information to the people (ELCZHAP 2011:5). "Research is needed to provide sound, scientific and reliable information that will influence and guide policy practice and interventions in response to HIV/AIDS" (NHAPZ 1999:35). However, knowledge does not only mean the technical and scientific knowledge about the HIV epidemic and its prevention. It also has to do with the circumstance and conditions that put people at risk in the context of HIV. "In order to achieve some level of such understanding, it requires acquiring appropriate knowledge of the people concerned, their circumstances, the context in which they live and what contributes to their vulnerability to HIV infection" (Parry 2008:35). The policy document shows that the church endeavours to help find more knowledge and disseminate it to its membership (ELCZHAP 2011:5).

The policy shows the church's desire to promote the availability of resources and their appropriate use. Through its programme of lobbying and advocacy the church intends to make the availability of medication and treatment for the people living with HIV easier (ELCZHAP 2011:8). "The ELCZ National Finance board and three Diocesan Medical boards shall ensure proper use of all resources (human, material, financial, assets) earmarked for the HIV and AIDS programmes" (ELCZHAP 2011:9). It is one thing to mobilize resources but it is another thing to put them into proper use. The fact that the church has a system which it is

going to use in ensuring proper use and accountability of resources is the strength of the church and its policy on HIV and AIDS.

The other strength closely linked with the church's outer competence is its theological principles. Although it has not given detailed theological statements, the ELCZ has outlined three theological themes which form the basis of its response to HIV. These are highlighted earlier in chapter three - the *imago dei, missio dei* and challenging stigma basing on John 9:2-3. These are critical theological principles on which any response to HIV should be based, yet the ELCZ has not fully engaged these principles nor outlined their practical implications. In chapter three of this study I have argued that the notion of *imago dei* is utilised to affirm human dignity and it promotes relationship, responsibility and care as discussed in chapter three of this study. It is a theological principle that makes male and female respect one another as created in the image of God despite being infected or affected by HIV. This is an important theological insight as it enables the church and community to fight against stigma and discrimination in the context of HIV and AIDS.

It is also important for the church to view itself fulfilling the mission of God and Jesus. According to ELCZAP the ELCZ's involvement in HIV and AIDS issues is because it "stands in the continuity of this mission (God and Jesus' mission)" (2011:3). It is important for the church to view its engagement on issues of HIV and AIDS as part of its mission. "Blessed would be the Christian church and believer who understood and took up the mission of Jesus to serve people and save lives" (Dube 2002:543). The mission of Jesus is a life-giving one; hence the ELCZ hopes to make a difference in the area of promoting life in the community threatened by the HIV epidemic. It is through its theological understanding of the mission of Christ that the church would respond with compassion to the HIV epidemic in Zimbabwe. This is closely related to the third theological principle which does not promote condemnation of the people living with HIV and AIDS. "Through teaching, preaching and healing, the ELCZ will not condemn any kind of disease or illness (John 9:2 and 3)" (ELCZHAP 2011:3). By so doing, the ELCZ embraces those who are affected and infected and fights against stigma and discrimination. In other words these theological underpinnings enable the ELCZ to respond to the epidemic in helpful ways as it embraces people living with HIV and their families. But the ELCZ is aware that it cannot work alone and therefore acknowledges the role of other stakeholders in responding to the HIV epidemic in Zimbabwe.

The ELCZ is committed to working together with a variety of partners in responding to HIV. "The ELCZ shall collaborate with government, CBOs, NGOs, FBOs, AIDS service organizations and other institutions and partners locally, nationally, regionally, and internationally in all issues related to HIV and AIDS" (ELCZHAP 2011:8). The document shows that the church is aware of other stakeholders which can enable the church to make greater impact in addressing HIV issues. "The many governmental and nongovernmental agencies working on HIV/AIDS in Zimbabwe need to collaborate to avoid the many gaps and prevent duplication as well as to share in evidence based best practices" (Duff 2005:29). It is through partnership with others that the church may be challenged on its attitude and gain new information through meetings and workshops (Byamugisha 2010:64). Furthermore, partnership enables pooling of resources and exchange of information, knowledge and skills that would equip the church to effectively respond to the epidemic. "Sharing of experiences, what works, and what does not, exposure of gaps and challenges, is all essential, relevant and can help to formulate responses that are more strategic and thus more likely to have a better impact" (Parry 2008:76). This aspect of outer competence strengthens the ELCZ response to the HIV epidemic in Zimbabwe.

The ELCZ aims to engage in advocacy programmes. "Lobbying and advocating for the infected and affected. For instance access and availability of medication, equal opportunities and elimination of stigma and discrimination among others" (ELCHAP 2011:7). This is taking a stand to defend the rights of the people living with HIV. Advocacy challenges the systems that promote discrimination of people living with HIV, discriminate against women and children and put other sections of society at risk in the context of the HIV epidemic. In advocacy the church "speak[s] out about HIV: confront[s] stigma, denial and discrimination" (Parry 2008:78). I have argued in chapter three that in the context of HIV the church that engages in advocacy is a prophetic church. Parry (2008:20) also asserts that advocacy is a way of reclaiming the church's prophetic voice. The ELCZ intends to compassionately respond to HIV as it journeys with those affected and infected and through being their voice. This is one of the strengths of the ELCZHAP that constitutes part of HIV competence.

Another key aspect of being HIV competent is inclusiveness (Parry 2008:75). The ELCZ is committed to being more inclusive in dealing with HIV issues in Zimbabwe. To be inclusive would mean taking the people living with HIV onboard when it comes to decision making processes, programmes and projects, showing non-discriminatory behaviour (Parry 2008:75). It is clearly stated in one of its objectives that the ELCZ would like to empower all people

and especially the vulnerable, such as people living with HIV, by involving them in leadership and church programmes and activities (ELZHAP 2011:4). The document also states that for sustainability of the projects, the church will create opportunity for participation and "meaningful involvement of all stakeholders and beneficiaries" (ELCZHAP 2011:8). This is important for the people living with HIV as it would affirm their dignity. "Open and meaningful involvement of people living with HIV in programmes can also encourage others in similar situations, or suspecting that they might, to break the silence and seek out testing, support and care" (Parry 2008:75). That means inclusiveness can also be used as an HIV prevention strategy.

Lastly, the ELCZ engages in the mainstreaming of HIV and other diseases as well as gender and development. The ELCZ is committed to the mainstreaming of HIV and other related issues as a way of mitigating against the epidemic. "The ELCZ shall mainstream HIV and AIDS, TB, Gender and Developmental issues in all her church activities, pastoral formation and communities (internal and external)" (ELCZHAP 2011:6).

"Internal mainstreaming of HIV and AIDS is about changing organizational policy and practice, to reduce an organization's susceptibility to HIV and its vulnerability to the impacts of AIDS" (Holden 2003:127). With internal mainstreaming, the ELCZ intends to "modify ways the church functions in the context of HIV and AIDS, TB and Gender and developmental principles to reduce risks and vulnerability e.g. planning of meetings, meals and accompaniment" (ELCZHAP 2011:6). It would also promote access to HIV information as well as access to treatment and care and prevention of stigma and discrimination (ELCZHAP 2011:6). By mainstreaming HIV, it means the ELCZ would make sure HIV issues are addressed in the church, in meetings, conferences and even behind the pulpit.

Through external mainstreaming the ELCZ would like to create environments that protect vulnerable groups such as women and the people living with HIV (ELCZHAP 2011:7). External mainstreaming has to do with "modifying existing development work, or designing new development work, so as to enhance the way in which it indirectly address HIV and AIDS" (Holden 2003:246). Mainstreaming of HIV is important as it would to lead to empowerment of all sections of society through access to information on HIV and prevention of stigma and discrimination associated with HIV epidemic. Mainstreaming does not only prevent stigma by openly talking about it but through people participation in workshops, discussions, Bible studies and sermons, HIV would become part of people's normal talk. This

would displace secrecy and use of euphemism. "Euphemisms that are used to refer to HIV/AIDS, such as 'the divine rod', 'sign of the end of time' and others are not at all empowering" (Chitando 2004:17). This enables the church and members of society to openly talk about HIV issues without any fear of being stigmatised. These strengths form part of the ELCZ's competence in addressing HIV issues in Zimbabwe as it responds to its HIV context.

Despite the strengths discussed above, the document has a number of weaknesses to be discussed in this section which forms the lack of competence in responding to HIV in Zimbabwe. The document seem to be more skeletal and not user friendly. One can imagine how the congregations and ministers might be able to follow such summarised statements without substantial details.

To begin with, the policy shows lack of theological competence. The church's theological principles are critical but they are not discussed in detail. They are skeleton statements which imply the church's shift from retribution to a form of life giving response. Basically the theological statements affirm humanity as created in the image of God, the church's response as part of God or Jesus' mission and the need to discourage retribution, stigma and discrimination (ELCZHAP 2011:3). The theological presuppositions of *imago dei* and *missio dei* are believed to help the church to be actively involved in HIV issues and fight stigma and discrimination. "Through preaching, teaching and healing, the ELCZ will not condemn any kind of disease or illness (John 9: 2 and 3)" (ELCZHAP 2011:3). This challenges the previous retribution whereby the church was associated with promoting retribution. "Due to the emphasis on personal morality, the preaching in the various churches tended to condemn people living with HIV/AIDS. The popular refrain was, 'for the wages of sin are death' (Romans 6: 23), thereby fuelling stigma and discrimination" (Chitando 2004:14).

The skeletal form of the ELCZ's theological principles makes it difficult for one to think that those who are responsible for policy implementation and the general membership in the church may learn and hold them as their basis for being involved in HIV programmes. "There is no clear theology of the church on HIV/AIDS and its impact on the church" (ELCZ 2009:21). The fact that the church does not have a comprehensive theological exploration means the church has some "theological paralysis" (Chitando 2004:16). Like any other church involved in HIV programmes, the ELCZ needs to "formulate the theological principles that determine their response to the epidemic if this is to be seen to be well-founded" (Clifford 2004:1). The church needs to have a clear, comprehensive and robust

theology of HIV in order to equip its membership with theological underpinning for a Christian response to the epidemic. "HIV/AIDS is now forcing the church to develop a comprehensive theology that addresses all areas of human suffering with the aim of bringing hope in the midst of suffering" (Phiri 2004:430). A comprehensive and robust theology of HIV asks some critical questions about the context in order to equip the church to give a helpful response to the epidemic.

Theological reflection is needed on essential questions around sin and illness; life and death; fatalism and self-responsibility; and charity and neglect. There is a special role for the churches in strengthening the spiritual dimension in delivering care, in bringing about attitudinal change, combating stigma and discrimination and bringing about a holistic approach to HIV in the community (Shishova 2004:28).

The church's theological reflection needs to bring the issues of compassion and justice to the fore. "Theological strategies of confronting structural sin is therefore vital, for HIV/AIDS is not just about individual lack of morality, but also an individual's lack of social justice" (Dube 2002:542). This is lacking in the ELCZHAP hence its weakness to aid the ELCZ to be theologically competent in the HIV context. Besides its failure to have clear theological underpinning, the ELCZ does not give any form of background to the HIV epidemic in Zimbabwe.

Another weakness of the ELCHAP is its failure to fully describe the context in which it operates. The policy gives the background of the ELCZ as a church but does not spell out the context of the HIV epidemic to justify its commitment to deal with the epidemic. The only statement that seems to explain the crisis is that of acknowledging that the epidemic affects the socio-economic development of the country (ELCZHAP 2011:2). The policy does not spell out the causes and impact of the HIV epidemic in the family and national economic sectors. It does not set out the socio-political and economic context of Zimbabwe in which it is implemented to show that the church has fully "assessed the risk factors and personalised the risk" at hand (Parry 2008:25).

Failure to spell out the factors that fuel the epidemic would lead one to doubt that any research has been done and it is also doubtful if the document would reflect or lead the church to have inner competence. "Inner competence also requires identification of the risk factors facilitating the spread of HIV within our communities and within society as a whole" (Parry 2008:25). It is in the background that the policy document should have described the

"structural and social risks, cultural practices, economic risks, political challenges" that fuel the HIV epidemic in Zimbabwe (Parry 2008:25-27). In chapter two, I have argued that cultural practices such as polygamy, levirate marriages, gender imbalances, gender violence and silence and taboo contribute to the spread of the HIV epidemic in Zimbabwe. In the same chapter I have discussed the impact of political violence, FTLRP, ESAP and Operation Murambatsvina on the spread of the HIV epidemic. It is amazing that the ELCZHAP does not highlight such important issues that have led to unemployment, displacement and poverty. In passing, the document just stated the church's desire to address gender inequality, gender based violence and poverty as part of the objectives and approaches to dealing with socio-economic factors that fuel the spread of HIV in Zimbabwe. This is however, too little to paint the whole story of HIV in Zimbabwe. "HIV/AIDS research shows that gender-based inequalities overlap with other social-cultural and political inequalities to leave women wallowing in social apathy, abject poverty and in a state of powerlessness" (Gichaara 2008:193). The ELCZHAP was supposed to appraise these problems which are dominant in the Zimbabwean context. This weakness marks the deficiency of the ELCZ's inner competence to face the epidemic in Zimbabwe.

In its prevention strategies the document has emphasized the use of "scientifically proven methods such as VCT, PMTCT, PEP, Treatment, and Male Circumcision" (ELCZHAP 2011:5). Such commitment needs to be commended because the church is responding to the epidemic. However, what is worrying is that there is no mention of condoms as one of the scientifically proven prevention methods that the church can use. Probably the church is still struggling with the condom issue as it again picks up on abstinence and faithfulness as part of its key teachings. Phiri argues that the protection of life also involves the "responsible use of condoms" (2004:428). The church needs to admit the fact that, "while condoms are not a solution, they can help to contain the spread of the disease where sexual discipline has broken" (Nurnberger 2005:297). If the church intends to have a holistic approach to the prevention of the HIV epidemic it should seriously consider promoting the use of condoms. Surprisingly the Lutheran church does not to object the use of condoms for family planning and protection of other forms of infection but when it comes to HIV it is uncomfortable (Nurnberger 2005:306). This is the time and moment the church needs to show its compassion and desire to save life.

On the other hand the ELCZ puts abstinence and be faithful at the fore with utter silence on condom use. "The majority of the churches in Africa have stuck with the message of

abstinence and faithfulness and fought vigorously against the use of condoms on the understanding that condoms promote promiscuous behaviour" (Phiri 2004:428). The ELCZ is aimed at "promoting behaviour change including abstinence before marriage and faithfulness in marriage as our basic teaching" (ELCZHAP 2011:5). This is not helpful considering economic and cultural barriers that undermine these principles. Earlier in chapter two I have pointed out that in Zimbabwe men are free to have multiple partners while women are forced to be faithful to their partners. I have also pointed out that women are subordinate to men as well as subjected to gender-based violence that increases their vulnerability in the context of HIV. "These golden values of many faiths, cultures and religions do not work because of violence against women at home, at work, and in the streets, where many women are raped" (Dube 2002:541). Gender inequality, poverty, peer and media pressure are part of major factors that make abstinence ineffective (Dube 2002:541).

On the other hand the displacement of people due to unemployment, poverty and political violence also renders faithfulness and abstinence ineffective if not merged with other prevention methods such as condom use. "Also, because globalization increases job insecurity and mobility, and separates families for long periods of time, the values of abstinence and faithfulness, though excellent, are often ineffective" (Dube 2002:541). It is these forces of structural sin that render faithfulness and abstinence ineffective. Unless these principles are coupled with condom use the church is fighting a losing battle with HIV in Zimbabwe. This shows that the church has not fully internalized the problem. It is failing to consider condom use as an important preventative measure in the context of HIV.

The policy has shown the church's commitment to advocacy but its advocacy seems to be narrow as it is focused on resource mobilisation, access to medication and equal opportunities, and advocacy against stigma (ELCZHAP 2011:7). It leaves out issues of social justice and the prophetic voice that challenges the structural sin. "Structural sins are those social evils which constrain the choices that individuals are able to make and which render them so vulnerable to this epidemic" (Parry 2008:70). These include the socio-economic and political systems and environment that fuel the spread of the HIV epidemic which are discussed in chapter two of this study. I have argued that the government policies such as the Fast Track Land Reform Programme (FTLRP) and Operation Murambatsvina (OM) among others have contributed in spreading HIV. If the government makes decisions and implements policies that subject people to poverty, such the FLRP and OM which displaced many people, the church needs to be prophetic by confronting and challenging such policies.

It is the duty of the church to speak against political violence that leads to loss of life and displacement of people that as a consequence leads to the spread of the HIV epidemic. The ELCZ advocacy should go beyond "resource mobilization, access to medication and elimination of stigma and discrimination" (ELCZHAP 2011:7). There is a need to engage with structural issues in the society which include the actual cultural practices, and economic and political policies implemented by the government. "The repressive political environment has also prevented activism and debate about HIV/AIDS and human rights in civil society. HIV prevention and care services were among the health programmes disrupted by government actions" (Amon and Kasambala 2009:533-534). Given the situation whereby the government deliberately disrupts HIV programmes by displacing the people living with HIV and their families, the church needs to be prophetic as it confronts the government on such political programmes. In other words, advocacy should be all encompassing and should engage on policy issues in as much as it focuses on the variety of factors that fuel the spread of the HIV epidemic. By being actively involved in the issues that make other people vulnerable, the church will be socially relevant and compassionate, hence becoming more HIV competent.

Advocacy is part of being prophetic as it exposes and condemns structural sin of society. By addressing these issues, the church would be acknowledging that "HIV is an issue of justice and as such demands a response that is more than just charity" (Parry 2008:70). This would call "us to attack harmful cultural traditions, for instance, those connected to male virility, female subjugation, secrecy and taboos regarding sex education" (Nurnberger 2005:299). The church's prophetic voice should also include being "confrontational on gender discrimination and campaigning for justice" (Clifford 2004:19). "HIV competent churches in Africa must help build communities characterised by gender justice and mutuality" (Chitando 2007:8). This is not reflected in the ELCZHAP as it is silent on polygamy, widow inheritance and gender violence. Neither does the church policy document bring to the fore advocacy on policies nor government laws that criminalize homosexuality and sex work. If it really wants to seriously engage with human sexuality as argued earlier on in this chapter, the ELCZ needs to advocate for people of same sex orientation and fight for justice.

5.7 Conclusion

By drafting an HIV and AIDS document, the ELCZ has shown some commitment and competence in the context of the HIV epidemic in Zimbabwe. In this chapter, the background

of the ELCZ, its response to the HIV epidemic and the formulation of the ELCZ HIV and AIDS policy document has been discussed. This policy document was then analysed according to the HIV competence framework and its relevance to its Zimbabwean HIV context. Various strengths were outlined and the weaknesses of the document were also assessed. This was an attempt to show how the ELCZ may become a more HIV competent church.

In the next and final chapter, the study will be summarised, way forward will be suggested and recommendations for further research will be made.

Chapter Six

Conclusion and Recommendations

6.1 Summary of the study

This study was motivated by personal experience of the effects of the HIV epidemic in Zimbabwe. My participation in the diaconal work in the ELCZ motivated me to critically analyse the ELCZ HIV and AIDS policy document that guides the church's response to the epidemic. The focus of this study has been to critically analyse this document and understand how it may or may not lead the ELCZ to HIV competency in the complexity of the Zimbabwean context.

The first chapter introduced the study by outlining the crisis of HIV globally, and in Zimbabwe in particular. It also highlighted the general church response that initially began with retribution and shifted to some positive responses through its participation in care giving of people living with HIV. This chapter outlined the research questions and objectives, research methods and limitations, theoretical framework and the structure of the study.

Chapter two discussed the context of HIV in Zimbabwe. The chapter presented the rise and fall of HIV prevalence. The rise was attributed to a lack of political will by the government through its denial of the HIV reality. Later, the government, churches, NGOs and Faith-Based Organisations came on board providing care and prevention measures and rolling out ART. Although these intervention programs may have facilitated the decline of HIV prevalence, it was shown that the political and economic environment coupled with the socio-cultural situation in Zimbabwe contributed to the persistence of the epidemic. This chapter also discussed the impact of the political decisions and political violence, government policies such as the ESAP, FTLRP and OM on the spread of HIV in Zimbabwe. It further explored the role of the different marriage practices, gender inequalities, gender violence and stigma and discrimination in spreading HIV in Zimbabwe.

Chapter three discussed the church's shift from theologies of retribution to a liberating and life-affirming theological discourse in the context of HIV. This study has argued that the church would only respond to the HIV epidemic through change in its theological discourse. It should have a prophetic theological discourse that is critical of any of the conditions that contribute to the spread of HIV, and thus promote a compassionate response. A life-affirming

theological discourse should take into account human dignity that is presupposed by humanity being created in the image of God. It should also affirm a positive theology of sexuality that sees human sexuality as God's creation. Furthermore, the chapter also explored the theological discourse of compassion and what it means for the church to be the body of Christ in the HIV context. These two aspects give impetus to the acknowledgement of the church's vulnerability to the epidemic as well as the need for solidarity with people living with HIV.

Chapter four outlines the HIV church competent framework. This framework is characterised by practical steps that the church needs to adopt in responding to the HIV epidemic. These are classified as inner competencies, outer competencies and the bridge of leadership, knowledge and resources (Parry 2008:32).

Chapter five discussed the ELCZ's response to the epidemic. The chapter highlighted the fact that the ELCZ's response was marked by the establishment of two Home Based Care programmes namely Thusanang and Betseranai (ELCZ 2009:6). These focus on prevention, care and support, treatment and creating a safe environment in the context of HIV and AIDS (ELCZ 2006:14). In addition, the chapter discussed the formulation and introduction of the ELCZ HIV and AIDS document. The objectives and the themes of the document are outlined. Finally, the chapter analysed the ELCZ HIV and AIDS policy document in light of the HIV competence framework. While the document seems to show that the ELCZ has most components of being HIV competent, the document's major weaknesses are its failure to address cultural issues such as marriage practices and engagement with political challenges in the context of Zimbabwe. The other weakness discussed is the lack of a robust theological discourse. The document has just three theological statements that lack detail.

6.2 Key findings of the study

The objectives of this study were**;** to explore the shifting landscape of the HIV pandemic in Zimbabwe; to investigate the ELCZ response to the HIV pandemic in Zimbabwe;to evaluate the strengths and weaknesses of the ELCZ policy on the HIV and AIDS and to explore the ways in which the ELCZ HIV and AIDS policy document may be strengthened enabling it to become a more HIV competent church.

Following the above objectives, the key findings showed that while the statistics have shown a significant decline in HIV prevalence, there are still some socio-political and economic

conditions which increase people's vulnerability to the epidemic. On the other hand one would also argue that the statistics do not reflect on these socio-political and economic challenges that play a significant role in spreading HIV in Zimbabwe.

This study has also found that the ELCZ like other churches in Zimbabwe has shifted to some extent from retribution to life-affirming theological discourse on HIV hence has positively engaged with HIV issues as shown by its policy document which is central to this study. On evaluating the ELCZ HIV and AIDS policy document, one of the key findings of this study is that the ELCZ has taken a major step in responding to the HIV epidemic in Zimbabwe through acknowledging its vulnerability and the vulnerability of the community. In many ways the HIV policy document shows that the church is addressing some of the factors that fuel the spread of HIV such as poverty, gender inequality, stigma and discrimination. However, in order to become more HIV competent, there are some key issues which still need to be dealt with.

Issues such as theological competence are important for the church. While the ELCZ has alluded to some theological themes as its principles in responding to HIV, it however did not explore in detail how these would influence the implimentation of their programmes. In addition the policy document does not explicitly show how the church deals with some culural practices and political situtions that put people at risk in the context of HIV in Zimbabwe. Given these findings, in the next sections I make some recommendations forfurther research and suggest ways forward for the ELCZ.

6.3 Recommendations for further research

As indicated in chapter one, this study has been limited and, therefore, it is important to note areas needing further research.

First, there is a need for an evaluation of the impact of the ELCZ HIV and AIDS policy in local congreations since it was introduced in 2005 and updated in 2011.

Second, there is a need to understand the reception and implementation of the ELCZ HIV and AIDS policy by different structures of the church such as dioceses, parishes and congregations.

Third, it is noted that the ELCZ HIV and AIDS policy suggests partnership with the government in addressing HIV issues, but the exact nature of this partnership between the church and government should be further investigated.

Finally, there is a need for further research on the prophetic role of the church in the politically polarised society of Zimbabwe in order to prevent the spread of HIV.

6.4 Steps to be taken by ELCZ

First, the HIV and AIDS policy document needs a more solid theological foundation. The theological themes need to be expounded in more detail in order to enable those who implement the policy (pastors, deacons and church elders) to be more theologically competent as they respond to HIV in their communities. In addition, a well-grounded theological discourse would be a contribution the church could make to other organizations in the overall response to the epidemic.

Second, the ELCZ needs to note particular spiritual resources that can contribute to an effective response to HIV. It would seem that the HIV and AIDS policy document recognises the importance of human, material and financial resources and other assets but does not consider its spiritual resources as important (ELCZHAP 2011:9). In order to strengthen the policy document, resources such as prayer, counselling and faith leading to resilience should be addressed.

Third, the ELCZ needs to give a comprehensive assessment of the cultural and political factors that fuel HIV. The HIV and AIDS policy document should include the ways in which the church must engage with government on political and economic policies that put people at risk in the context of HIV. Cultural marriage practices such as widow inheritance also need to be critiqued. The policy document should be explicit about the way the church needs to address cultural issues that put women at risk of contracting HIV. Furthermore, the policy document shows that the church needs to address poverty through self-help projects but does not deal with the root causes of poverty in the current Zimbabwean context.

Finally, the policy document couldbe strengthened by expanding the notion of advocacy to include issues of the rights of women who are put at risk due to cultural practices that give men power over women. Advocacy needs to address and challenge all forms of socio-cultural and economic injustice.

6.5 Conclusion

The HIV epidemic has remained a major challenge that requires the government, the church and other organisations to work together. This challenge has awakened the church to rethink its mission and evaluate its theological discourse in order to respond to the HIV epidemic. The ELCZ has taken a helpful stance on HIV by producing the policy document despite its shortcomings. The ELCZ however, needs to be more deliberate in developing theological principles within the socio-political and economic issues that increase people's vulnerability.

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