

**Mission in turbulent waters:
AIDS-related care and mitigation by the Roman Catholic Church in Manicaland, Zimbabwe
(1985-2007).**

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Abstract

The scourge of the HIV and AIDS pandemic in Zimbabwe between 1985 and 2007 was witnessed at a time when the country went through diverse socio-economic challenges. The State reduced budgetary allocation towards the welfare of the citizenry after the introduction of the economic structural adjustment programme in 1991. Further economic decline, witnessed between 1999 and 2007, resulted in the withdrawal of foreign donors. The care of people living with HIV and orphaned and vulnerable children became a burden for non-governmental and faith-based organisations including churches. The leadership of the Roman Catholic Church in Zimbabwe became instrumental in setting up AIDS-related care intervention projects at diocesan level, including Manicaland. The involvement of the Zimbabwe Catholic Bishops' Conference in the national constitutional reform agenda as part of civic organisations led to souring of relations between the church's leadership and the State and thus affected AIDS-related care projects. This article explores the Roman Catholic Church's AIDS-related care mission in Zimbabwe in general and Manicaland in particular within the context of turbulence waters.

Introduction

The introduction of the economic structural adjustment programme in 1991 by the State of Zimbabwe had the effect of cutting fiscal support towards the provision of essential public services including healthcare.² On the one hand, the State's healthcare system appeared to have lacked comprehensive care models for people living with HIV (PLHIV). On the other hand, increased cases of HIV and full-blown AIDS made the need for AIDS-related care more apparent than was the case before. The years between 1996 and 1999 witnessed a steep decline in the public healthcare system amid increased retrenchments, mainly associated with economic reforms.³ Fiscal cuts in public expenditure and the offering of healthcare services at market rates instead, only contributed to the State's neglect of people living with HIV. Between 2000 and 2007 socio-economic decline and political tension in Zimbabwe led to the withdrawal of international donor support to the State. AIDS-related care and mitigation initiatives under the supervision of churches and other non-governmental players filled an important vacuum, but faced repression through laws such as the Non-Governmental Organisation Act of 2004.⁴ Given these circumstances, this article explores the critical role played by the Zimbabwe Catholic Bishops' Conference in advocacy for AIDS-related care and also documents the extent to which the Roman Catholic Church in Manicaland implemented such care programmes.

In 1985 the State officially declared the presence of HIV in Zimbabwe. However, antiretroviral treatment for people living with HIV only became accessible to the general population in 2007, more than two decade later. The church's response to the HIV pandemic had to be streamlined by focusing on "the entire church body, either at the level of a denomination or all denominations taken together; the local congregations or parishes; and AIDS-related organisations directly or indirectly related to a denomination or local congregation".⁵ The findings in this article were attained using the methodology of history in which primary archival sources, mainly from the Roman Catholic Church, formed the backbone of collected data. Interviewees willingly volunteered to participate in this exercise and thus provided consent to do so in accordance with the requirements of the

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² Mirjam van Donk, "Development planning and HIV/AIDS in sub-Saharan Africa," a paper prepared for the United Nations Development Programme Regional project on HIV and Development in sub-Saharan Africa (July 2004), p 138.

³ Lisa Garbus and Getrude Khumalo-Sakutukwa, "HIV and AIDS in Zimbabwe: Country AIDS policy analysis project," AIDS Policy Research Centre, University of California San Francisco (October 2003), p 8.

⁴ Zimbabwe Government, *The non-governmental organisation act of Zimbabwe*, (December 2004). The document was downloaded as pdf. See also Amnesty International, *Zimbabwe: NGO act is an outrageous attack on human rights*, (December 2004). This document was downloaded as pdf.

⁵ Philippe Denis, "The church's impact on HIV prevention and mitigation in South Africa. Reflections of a historian," *Journal of Theology for Southern Africa* 134 (July 2009), p 68.

research instruments used.⁶ All the interviewees agreed to have their names disclosed to the reader and for it to appear in the text. The article starts with a brief discussion about the introduction of AIDS-related care in Zimbabwe, followed by an analysis of AIDS-related care carried out by the Roman Catholic Church nationally and in Manicaland specifically within the early (1985-1995), middle (1996-1999) and later period (2000-2007).

The initiation of AIDS-related care in Zimbabwe

The description of care and support discussed in this article is equivalent to the AIDS-related care described by Jill Oliver and Paula Clifford that includes: activities such as home-based care, palliative care, care of orphans and vulnerable children, care of families and widows, care of people living with HIV and AIDS, treatment support, material support, spiritual support, pastoral education and psychosocial support as well as a wide range of caring and supportive activities.⁷ Similarly, and within the Roman Catholic Church in South Africa, Patricia Fresen presents the argument that AIDS-related care is part and parcel of Christian responsibility and the exercise of a compassionate ministry of presence and accompaniment.⁸ For example, home-based or long-term care provided by formal and informal caregivers⁹ emerged as one of the major forms of AIDS-related care in Zimbabwe. Prior to the AIDS such care mainly applied to the support provided to people who are physically or mentally challenged and the terminally ill.¹⁰ However, in Zimbabwe AIDS-related care emerged as a new phenomenon that was pioneered by the Batsirai Group based in Chinhoyi, in the Mashonaland West province in 1988.¹¹ In Manicaland, the Family AIDS Caring Trust (FACT) established a home-based care programme in 1990¹² and the Roman Catholic Diocese of Mutare launched an AIDS-related care project in 1992.¹³ In that same year the Roman Catholic Archdiocese of Harare established the Dananai Home-based Care project at Murambinda mission hospital, in the Buhera district in Manicaland.¹⁴

Nationally, the majority of the 126 church-related healthcare centres that constitute the Zimbabwe Association of Church-related Hospitals (ZACH) is managed by the Roman Catholic Church.¹⁵ The involvement of churches in the provision of medical care has a long history dating back to the early days of European settlement in Zimbabwe. Consistent with this observation, Michael Gelfand states that Western missionary-initiated churches established medical institutions that have been part of the public healthcare infrastructure since the colonial era.¹⁶ Throughout the colonial era, as well as the years of the liberation war, and now in post-independent Zimbabwe, churches have contributed to the public healthcare system and provided services to all citizens, but they were mainly concerned with the poor. At independence, the new prime minister, Robert Mugabe, extended an invitation to all churches to partner with the state in eradicating disease and underdevelopment.¹⁷ Thus, there is an undisrupted history of church involvement in healthcare in Zimbabwe. However, it is important to note that while churches in Zimbabwe have continued to be key players in the public healthcare system, their involvement in launching HIV and AIDS intervention programmes presented a unique situation. Consistent with this assertion, Ruth Prince, Philippe Denis and Rijk van Dijk have thus stated: "What we see today is a return to non-governmental and faith-based healthcare, not through mission hospitals, but

⁶ The author was given permission to carry out this research under the University of KwaZulu-Natal Research Ethics Protocol Reference Number: HSS/0979/09D. All interviewees signed a consent form and an interview release agreement form.

⁷ Jill Oliver and Paula Clifford, "Religious community care and support in the context of HIV and AIDS: Outlining the contours," in Beverley Haddad (ed), *Religion and HIV and AIDS, Charting the terrain* (Scottsville: UKZN Press, 2011), p 370.

⁸ Patricia Fresen, "Responsibility and caring for one another," in Stewart C. Bate (ed), *Responsibility in a time of AIDS: A pastoral response by Catholic theologians and AIDS activists in southern Africa* (Pietermaritzburg: Cluster Publications, 2003), p 63. See also a discussion on Christians and AIDS-related care by Neville Richardson, "A call for care: HIV/AIDS challenges the church," *Journal of Theology for Southern Africa* 125 (July 2006), pp 38-50.

⁹ WHO Study Group, *Home-based and long term care*, WHO Technical Report Series 898, (Geneva: WHO, 2000), <http://whqlibdoc.who.int/trs/WHO_TRS_898.pdf> [Accessed 10 May 2012].

¹⁰ HDN and SAfAIDS, *Caring from within: Key findings and policy recommendations on home-based care in Zimbabwe*, Harare (2008), p 16.

¹¹ Irish Aid, SAfAIDS and Health and Development Network, *Looking back, mapping forwards: Research findings on home-based care in Zimbabwe*, (November 2007), 1. See also Tafadzwa Mukandi, "Batsirai: An integrated approach to home-based care," in HDN, SAfAIDS and Irish Aid, *Inside stories: Local experiences of home-based care in Zimbabwe*, (2008), p 55.

¹² Tinashe Madava (compiler), *The FACT story, Annual report 2004*, (2005), pp 8-9.

¹³ See Diocese of Mutare Community Care Project, St Joseph's Rusape archives, (DOMCCPR), Everisto Benyera, Tendayi Kureya and George Mutsoka, *Evaluation of CRS Zimbabwe's home-based care programme*, (January 2008), p 18.

¹⁴ Health Development Network, Zimbabwe, "Christ for care: The church's role in home-based care," <<http://healthdev.net/site/post.php?s=1069>> [Accessed 3 May 2009]. See also Irish Aid, *Looking back, mapping forwards*, 16.

¹⁵ Information supplied by Vuyelwa Chitimbire to the author, Harare, October 2010. See also ZACH archives (ZACHA), Zimbabwe Association of Church-Related Hospitals information flyer. See also HOCD, *HIV and AIDS policy* (Harare: HOCD, 2005), 1. See also Auxiliary Bishop Patrick Mutume, information supplied to author, Mutare, 2 September 2010. See also Oliver Mudyarabikwa and Angelbert Mbengwa, *Zimbabwe: A challenge for equity in health*, Equinet Discussion Paper, (April 2006), This was accessed as pdf.

¹⁶ Michael Gelfand, "Medicine and the Christian missions in Rhodesia, 1857-1930," in Anthony J. Dachs (ed), *Christianity south of the Zambezi* (Gweru: Mambo Press, 1973), p 109.

¹⁷ Paul H. Gundani, "The Catholic Church and national development in Zimbabwe," in Carl F. Hallencreutz and Ambrose M. Moyo, (eds), *Church and State in Zimbabwe* (Gweru: Mambo Press, 1988), p 216.

through faith-based organisations (FBOs) and non-governmental organisations (NGOs).¹⁸ Within Zimbabwe though, the Catholic bishops became critical of the State, the same bishops appeared to believe that the church's prophetic role and faithfulness to Jesus Christ entailed that it served the citizens of Zimbabwe freely.¹⁹

Initially, informal AIDS-related care intervention programmes were launched by church women from the Roman Catholic Church and other church denominations in Manicaland.²⁰ This became instrumental in bringing the plight of people infected and affected by HIV and AIDS to the attention of the national clerical leadership, the Zimbabwe Catholic Bishops' Conference.²¹ For example, in 1986, Edward Ted Rogers, a Jesuit priest and founder and former principal of the School of Social Work, Harare, initiated discussions on AIDS awareness and care with the Zimbabwe Catholic Bishops' Conference.²² Three factors appeared to favour the introduction of AIDS-related care intervention projects carried out by the Roman Catholic Church in Zimbabwe. First, the church is not a newcomer in public healthcare and bishops understood AIDS-related care as "part of the church's development agenda".²³ Second, the church has a long history of social development dating back to the colonial era.²⁴ Third, the Roman Catholic Church has human resources or capital equipped with diverse skills and could mobilise funding easily. As an illustration, the Roman Catholic dioceses in Zimbabwe have received AIDS-related care funding support from the US-based Catholic Relief Services (CRS) since 1989.²⁵ It must be noted that globally, few organisations funded HIV and AIDS intervention projects carried out by religious entities until after the year 2000.²⁶

The early years (1985-1995)

Within Manicaland, church hospitals belonging to the Roman Catholic Church took up additional work of providing AIDS-related care. The nuclei included; Triashill, St. Barbra's (Mutasa), Avila, Mt. Mellery and Regina Coeli (Nyanga), St. Michael's and St. Therese (Makoni), St. Peter's (Chipinge), St. Joseph's Sakubva (Mutare), and St. Andrew's (Marange).²⁷ Family members of people living with HIV turned to local healthcare institutions, including those under the Roman Catholic Church, for medical and other forms of care and support.²⁸ Within the first two years, 600 HIV positive people received care and support and 365 children orphaned by AIDS were assisted with school fees.²⁹ AIDS-related care income generating projects were launched at Mt. Mellery, St. Barbra's, St. Peter's and Avila.³⁰ Income generating projects were established with the intention of enhancing the sustainability of AIDS-related care programmes, but existing church structures and human resources became overwhelmed.³¹ The decision by government to charge market rates for medical services at State's healthcare institutions prevented ordinary people, including those who were living with HIV, from accessing healthcare comfortably. Mirjam van Donk observed: "The cost of social services was transferred back into the hands of individuals ... Coupled with the rampant spread of HIV and the emergent consequences of the epidemic, these trends formed the ingredients of a serious humanitarian crisis."³² Thus, the State was publicly perceived as having dumped the citizens and at the same time some church leaders claimed that "the community was at the centre of the church's social development thrust".³³

¹⁸ Ruth Prince, Philippe Denis and Rijk Van Dijk, "Introduction to special issue: Engaging Christianities: Negotiating HIV/AIDS, health, and social relations in east and southern Africa," in Ruth Prince, Philippe Denis and Rijk Van Dijk, R (eds), *Africa Today* 56, 1 (Fall 2009), x.

¹⁹ For this see Gundani, "The Catholic Church and national development in Zimbabwe," p 241.

²⁰ Christinah Mombe, interview by author, St Joseph's mission, Sakubva, Mutare, 19 August 2010. See also Cecilia Mauye, interview by author, Vengere, Rusape, 21 August 2010. See also George Maedze, interview by author, Cathedral of the Holy Trinity, Mutare, 25 August 2010. See also Martin O'Regan, interview by author, St Joseph's mission, Sakubva, Mutare, 25 August 2010. See also Eugenia Tichawangana, interview by author, Triashill mission, 9 September 2010, See also Augustine Dera, interview by author, Triashill mission, 9 September 2010 See also Teresa Nyawera, interview by author, St Paul's Catholic parish, Dangamvura, 5 September 2010. See also Matilda Chitsungo, interview by author, St Paul's Catholic parish, Dangamvura, 5 September 2010.

²¹ Nyawera, same interview. See also Patrick Mutume, interview by author, Mutare, 2 September 2010.

²² Edward T. Rogers, interview by author, ARRUPE College, Harare, 13 April 2011. For a detailed discussion on this see Edward T. Rogers, *Jesuit, social pioneer and AIDS activist: A memoir*, (Pietermaritzburg: Cluster Publications, 2011), *Forthcoming*.

²³ Mutume, same interview.

²⁴ Gundani, "The Catholic Church and national development in Zimbabwe," 216.

²⁵ Catholic Relief Services Zimbabwe, <<http://www.prpzim.info/default/default.cfm?pid=60/>> [Accessed 14 March 2010].

²⁶ Jill Oliver, "Religion and Policy on HIV and AIDS: A rapidly shifting landscape," in Haddad, *Religion and HIV and AIDS in Africa*, 83. See also Kaiser Family Foundation, *The global HIV/AIDS epidemic: A timeline of key milestones*, <<http://www.kff.org/>> [Accessed 10 June 2012]. See also Deborah Dortzbach, and Mederith W. Long, *The AIDS crisis: What we can do*, (Downers Grove: InterVarsity Press, 2006), 25.

²⁷ DOMCCPM, DOMCCP, Evaluation report, January 1993-June 1995.

²⁸ Manyeza, same interview. See also Mutume, same interview. See also Dera, same interview. See also Tichawangana, same interview.

²⁹ DOMCCPM, DOMCCP, First progress report of MCHC CRS project, January 1993 - December 1993, p 1.

³⁰ DOMCCPM, DOMCCP, First progress report of MCHC CRS project, p 3.

³¹ DOMCCPM, DOMCCP, Evaluation report, January 1993-June 1995, p 13.

³² Van Donk, "Development planning and HIV/AIDS in sub-Saharan Africa," p 138.

³³ Mutume, same interview. See also Ambrose Vinyu, information supplied to author in an informal conversation at the Cathedral of the Holy Trinity, Mutare, 10 June 2010.

A study by Sue Parry indicated that AIDS-related care in some countries in sub-Saharan Africa, including Zimbabwe, affected rural mission hospitals which recorded “an increasing burden as patients are discharged from urban healthcare facilities to return to their homes in rural areas”.³⁴ Similarly, and with specific reference to Zimbabwe, Vuyelwa Chitimbire, director of the Zimbabwe Association of Church-Related Hospitals, stated: “The patients who were discharged from public hospitals in towns and cities sought healthcare services from mission hospitals and clinics mainly located in rural areas.”³⁵ Chitimbire’s sentiments were not in isolation of opinions expressed by other informants on this subject.³⁶ Church-related healthcare institutions “still had the advantage of obtaining medical supplies from well wishers mainly in the form of foreign donations directly or and through the Zimbabwe Association of Church-Related Hospitals.”³⁷ In 1993 Richard Hore of the Cimas Medical Aid Society in Zimbabwe stated that the AIDS epidemic became a resource drainer. The cost of AIDS-related treatment drugs at Z\$1 400 per month in 1993 was beyond the reach of Cimas.³⁸ Furthermore, Hore suggested that home-based care remained the only medical costs saving plan for the PLHIV: “It is understood that a similar situation exists with both government and missionary hospitals. The answer lies in having these patients removed from hospital, and nursed at home.”³⁹ HIV and AIDS affected the operations of medical aid societies. The outsourcing of medical drugs by missionaries and expatriate healthcare professionals serving at church-related hospitals in the late 1990s also assisted the PLHIV.⁴⁰ However, none of the Roman Catholic Church’s healthcare centres in Manicaland offered ARVs to the public.

Within the Roman Catholic Church in Zimbabwe, ordinary church members were admonished to serve as carers of fellow community members.⁴¹ This became the backbone of volunteerism among Christians. However, Oliver and Clifford have observed: “Furthermore, volunteerism is an increasingly difficult aspect to access, not least because of the rapidly evolving descriptors of volunteer actors that range from caring community members who provide their time and care for free, to partially subsidised volunteers and fully reimbursed community health workers.”⁴² Within Manicaland, the Family AIDS Caring Trust trained the first ten trainers in 1992.⁴³ At Triashill and Nyahukwe the majority of voluntary caregivers were associated with churches including the Roman Catholic Church.⁴⁴ Volunteerism also opened up prospects of earning money and obtaining household supplies including food.⁴⁵ Chances of abuse of services to AIDS-related care clients by volunteers and donor organisations were not beyond imagination. For example, in 1995 Jane Hatendi, the wife of the then Bishop Peter Hatendi of the Anglican Diocese of Harare observed: “Church and NGO leaders are suspected of giving one donation to the poor and the needy and two donations to themselves thereby forming a company of liars ... It is alleged that church and NGO leaders are enriching themselves at the expense of beneficiaries.”⁴⁶ Supplies of scarce resources such as cash and food given to identified HIV positive people and children orphaned by AIDS became a great source of relief against a backdrop of escalating poverty. While the government of Zimbabwe reduced budgetary support towards the public healthcare system, the Roman Catholic Church’s hospitals in Manicaland became centres of AIDS-related care programming. This improved access to treatment and care for members of the public whereby “clients were never turned away”.⁴⁷

The middle years (1996-1999)

The relations between the Zimbabwe Catholic Bishops’ Conference and the State were further strained in 1997 after the former participated in the formation of the National Constitutional Assembly (NCA). This was

³⁴ Sue Parry, “Responses of the faith-based organisation to HIV/AIDS in sub-Saharan Africa,” (2003), p 8. This paper was downloaded as pdf. See also Health Development Network, Zimbabwe, “Christ for care: The church’s role in home-based care,” <<http://healthdev.net/site/post.php?s=1069/>> [Accessed 3 May 2009].

³⁵ Vuyelwa Chitimbire, interview by author, Zimbabwe Association of Church-Related Hospitals office, Harare, 5 October 2010.

³⁶ Tendai Manyeza, interview by author, Old Mutare mission hospital, 24 August 2010. See also Dunmore Kusano, interview by author, Makuma Medical Centre, Rusape, 21 September 2010. See also Magna Chikukwa, interview by author, St David’s Bonda mission hospital, 22 September 2010. See also Health Development Network, Zimbabwe, “Christ for care.”

³⁷ Chitimbire, same interview. See also Manyeza, same interview. See Chikukwa, same interview. See also Cecilia Mukazi, interview by author, St Joseph’s mission hospital, Mutare, 19 August 2010.

³⁸ Richard Hore, “The medical costs of AIDS in Zimbabwe,” in Sholto Cross and Alan Whiteside (eds), *Facing up to AIDS: The Socio-Economic Impact in Southern Africa* (London: Macmillan Press, 1993), p 241.

³⁹ Hore, “The medical costs of AIDS in Zimbabwe,” p 258.

⁴⁰ Chitimbire, same interview.

⁴¹ Patrick Mutume, “The priorities of the Zimbabwe Catholic Bishops’ Conference since independence,” in Hallencreutz and Moyo, *Church and State in Zimbabwe*, p 470.

⁴² Oliver and Clifford, “Religious community care and support,” p 372.

⁴³ DOMCCPM, DOMCCP, Evaluation report, January 1993-June 1995, p 35.

⁴⁴ Tichawangana, same interview.

⁴⁵ Tichawangana, same interview. See also Dera, same interview.

⁴⁶ Jane Hatendi, “Great Women”, Saleem A. Farag (ed), *Interdenominational AIDS conference for churchwomen leaders in Zimbabwe, A compilation of selected presentations*, 23-27 January 1995, p 14.

⁴⁷ Dera, same interview.

followed by the first post-independence referendum and set the stage for the violent elections of June 2000.⁴⁸ Between 1995 and 2000 national savings were slashed from 18,2% to 9% of the Gross Domestic Product, investment fell by 62% and the spiralling inflation aggravated an economic crisis in Zimbabwe.⁴⁹ The nation of Zimbabwe experienced an increase in the adult population infected with HIV from 10% in the early 1990s to 36% in 1997.⁵⁰ At the national level, the Zimbabwe Catholic Bishops' Conference showed wariness over the State's economic policies that were seen as detrimental to HIV positive people and children orphaned by AIDS.⁵¹ While the State in Zimbabwe invested limited resources in healthcare, churches and NGOs carried the burden of caring for PLHIV and orphaned and vulnerable children (OVC). In January 1996 the Catholic bishops of Zimbabwe attacked the state for what it understood as the withholding of care and support to HIV positive people because of the government's negative stance towards homosexuality.⁵² An appreciation of this dichotomy in the light of President Mugabe's attitude towards gays and lesbians is apparent. In 1995 the State President expressed dismay at public appearances of homosexuals at a book fair in Harare.⁵³ In the United States of America HIV was first recognised almost simultaneously in gay men in Los Angeles, San Francisco and New York City.⁵⁴ However, the relationship between homosexuality and HIV in Zimbabwe has not been established.⁵⁵ The Roman Catholic Church, having a number of missionary clergy and others serving in Zimbabwe, sought to discredit the state for its "blame tactics".

Members of the Zimbabwe Catholic Bishops' Conference appeared to have grown apprehensive and expressed frustration at the "Government's little concern for the welfare of ordinary people".⁵⁶ In a pastoral letter issued in April 1997 the Zimbabwean Catholic bishops called upon the government to show responsibility, honesty and solidarity with people who could not afford payment for basic healthcare services.⁵⁷ Thus, the Catholic clerics warned the government to consider human beings ahead of economic reform policies: "People are the entire purpose of all our economic activity. If they are not served by the economy, then the entire economy does not serve any purpose."⁵⁸ Generally, the governments of developing countries, including Zimbabwe, fail to invest sufficiently in healthcare, AIDS in particular. Consistent with this observation Dean Peacock and Mark Weston assert that even when the HIV prevalence rates had become shockingly high many authorities offered little support to care and treatment.⁵⁹ In appearing to act as the conscience of society, the Roman Catholic bishops stated:

We, the bishops of Zimbabwe, deplore that the health[care] budget has decreased in real terms over the last ten years. We ask the Government to cut drastically any expenditure on unnecessary travel, mere prestige projects, and the army and armaments so as to boost the inadequate health[care] budget.⁶⁰

The downsizing of the public service in Zimbabwe led to job losses and, thus, placed people under pressure and stress, which led to their adoption of risky survival strategies and made them highly vulnerable to HIV.⁶¹ The downturn in the economy witnessed in 1997 made it difficult for the church's Mutare Community Home Care project to financially sustain AIDS-related care interventions because of the collapsing buying power of the Zimbabwean dollar. Sara Dorman observed that the situation was worsened by "a series of public sector strikes

⁴⁸ Sara R. Dorman, "Rocking the Boat? Church-NGOs and Democratisation in Zimbabwe," (circa 2000), 1. This article was accessed on the Internet and downloaded as pdf. See also Sara R. Dorman, "NGOs and the constitutional debate in Zimbabwe: From inclusion to exclusion", *Journal of Southern African Studies* 29, 4, (December 2003), p 845.

⁴⁹ Van Donk, "Development planning and HIV/AIDS in sub-Saharan Africa," p 132.

⁵⁰ USAID, *Zimbabwe: HIV and AIDS health profile*, (September 2008). This article was downloaded as pdf. See also WHO, UNAIDS and UNICEF, *Epidemiological Fact Sheet on HIV and AIDS: Zimbabwe 2008 update*, (October 2008), p 4. See also NAC, MOHCW, *The HIV and AIDS epidemic in Zimbabwe: Where are we now? Where are we going?* Harare, (May 2004), p 10.

⁵¹ ZCBCH, ZCBC, "Responsibility – honesty – solidarity," A joint pastoral statement of the Zimbabwe Catholic Bishops Conference, April 1997. A detailed discussion on this statement will be made below.

⁵² ZCBCH, ZCBC "Male and female He created them," A pastoral statement of Zimbabwe Catholic Bishops Conference, January 1996.

⁵³ LGBT rights in Zimbabwe, <http://en.wikipedia.org/wiki/LGBT_rights_in_Zimbabwe/> [Accessed 13 July 2011].

⁵⁴ See Ronald Bayer and Gerald Oppenheimer, *AIDS doctors: Voices from the epidemic*, (New York: Oxford University Press, 2000), 13.

⁵⁵ Marc Epprecht, *Heterosexual Africa? The history of an idea from the age of exploration to the age of AIDS* (Scottsville: UKZN Press, 2008), 1-34.

⁵⁶ Mutume, same interview.

⁵⁷ ZCBCH, ZCBC, "Responsibility – honesty – solidarity."

⁵⁸ *Ibid.* See also Pope Paul VI, "Pastoral constitution on the Church in the modern world" (*Gaudium et Spes*), (7 December 1965), <http://www.vatican.va/archive/hist_councils/ii_vatican_council/html/> [Accessed 14 July 2011].

⁵⁹ Dean Peacock and Mark Weston, "Men and care in the context of HIV and AIDS: Structure, political will and greater male involvement," (October 2008), 5. This paper was accessed as pdf.

⁶⁰ ZCBCH, ZCBC, "Responsibility – honesty – solidarity." See also the teaching of the Pontifical Council, Pontifical Council, *World hunger, A challenge for all: Development in solidarity*, <http://www.vatican.va/roman_curia/pontifical_councils/> [Accessed 15 July 2011].

⁶¹ Sophie Chirongoma, "Women, poverty, and HIV in Zimbabwe: An exploration of inequalities in health Care," in Isabel Phiri, and Nadar Sarojini (eds), *African women, religion, and health: Essays in honour of Mercy Amba Ewudziwa Oduyoye* (Pietermaritzburg: Cluster Publications, 2006), pp 173-186.

and evidence of a systematic high level corruption, the government's acquiescence to war veterans' demands for substantial pensions led to a rapid devaluation of the Zimbabwe Dollar in November [1997].⁶² The budgets of donor supported HIV and AIDS intervention programmes carried out by churches; FBOs and NGOs were severely affected. The Zimbabwe Catholic Bishops' Conference called on the state to show solidarity "with PLHIV, their families, and those who had been made orphans by the death of their parents, and the promise of care".⁶³

Apparently, the bishops added pressure on the state by declaring that the shortage of funds for AIDS-related care and treatment emanated from corruption within the government.⁶⁴ The same bishops also blamed the government for crafting the new compulsory land acquisition policy.⁶⁵ The Catholic bishops became wary of the dangers of taking over the state's obligations to provide healthcare to all citizens and they argued that such precedence made the government irresponsible. The bishops reasoned "To work in partnership, and with a special concern for the poor, church-related hospitals should, at the very least, be treated no different to government hospitals with respect to finance and personnel administration."⁶⁶

The Catholic bishops of Zimbabwe reiterated that the church's motivation for partnering with the state in healthcare lay in the need to serve the poor, but on condition that "the Government provided support such as finance and personnel resources as at state hospitals".⁶⁷ This position was not new in the history of the church's response to epidemics in Zimbabwe. Jock McCullock noted that between 1900 and 1930 rural mission stations in Southern Rhodesia were involved in the treatment of venereal disease, but asked for state support in the form of medical drugs.⁶⁸ However, churches also had ulterior motives, including the winning of converts. For example, the treatment of syphilis "allowed missions to do good works and thereby attract Africans to their churches".⁶⁹ With the AIDS crisis, the Zimbabwean Catholic bishops appeared to use the HIV and AIDS epidemic as a *kairos* moment to show solidarity with ordinary people. Thus, the church's leadership acted out of an understanding of its prophetic calling by analysing prevailing social contexts and discerned its historical functionality.⁷⁰

For the most part, urban areas did not offer sustainable home-based care and support or organisation compared to rural areas where community ethos was generally quite visible.⁷¹ Thus, the care initiatives in most rural areas became overwhelmed by an influx of HIV positive people moving from urban to rural areas with the intention of receiving care from relatives and families:

The pattern of our clientele in the home-based care indicate that more than half of our clients come from urban areas after being discharged from their employment due to their illness. The widow or orphans in our programme also indicate that either or both parents resided in urban area or other work places. Our STD hospital statistics also confirm that most of the women seen in our mission hospitals presenting signs and symptoms are legitimate wives of men working in town and they usually show up after public holidays when their husbands visit them.⁷²

Whereas the Mutare Community Home Care project mainly focused on the rural poor population groups, the untimely dishonour of medical claims by the Public Service Medical Aids Society at the end of June 1999 increased the demand for healthcare services at church hospitals nationwide, including Manicaland.⁷³ Clientele who previously could afford payment for medical services at private hospitals were now competing with the poor at the church hospitals in rural areas. For example, an increase in public health fees at the state's Mutare provincial hospital and the city clinics, coupled with the general shortage of medicines nationwide, severely

⁶² Dorman, "NGOs and the constitutional debate in Zimbabwe," p 847.

⁶³ ZCBCH, ZCBC, "Working for the common good," A joint pastoral statement of the ZCBC, May 1998.

⁶⁴ *Ibid.*

⁶⁵ ZCBCH, ZCBC, "Statement on land reform," 8 December 1997. For further discussion on this see Tabona Shoko, "Religion, land and HIV/AIDS," Position paper, University of Zimbabwe, (2007).

⁶⁶ ZCBCH, ZCBC, "Working for the common good."

⁶⁷ *Ibid.*

⁶⁸ Jock McCullock, "The management of venereal disease in a settler society: Colonial Zimbabwe, 1900-30," in Philip W. Setel, Milton Lewis, and Maryinez Lyons, (eds), *Histories of sexually transmitted diseases and HIV/AIDS in sub-Saharan Africa*, (Greenwood Press: Westport, 1999), 199. [pp195-216].

⁶⁹ McCullock, "The management of venereal disease in a settler society," 200.

⁷⁰ David Kaulemu, "The Role of the church in society," in Churches in Manicaland, *The truth will set you free: A compendium of Christian social teaching* (Mutare: Churches in Manicaland, 2006), xii.

⁷¹ DOMCCPM, MCHC progress report, 31 December 1996. See also Chitimbire, same interview. See also Tichawangana, same interview. See also Dera, same interview.

⁷² DOMCCPM, MCHC progress report. See also Masimba Biriwasha, "Home based care: struggling to meet overwhelming needs," in HDN, SAfAIDS and Irish Aid, *Inside stories: Local experiences of home based care in Zimbabwe*, (2008), 17. See also Chitimbire, same interview.

⁷³ DOMCCPM, MCHC progress report, 1 March to 30 June 1999.

affected PLHIV.⁷⁴ Healthcare institutions under the Catholic Diocese of Mutare in Manicaland were flooded with patients in need of medical services.

The later years (2000-2007)

The dawn of the new century in Zimbabwe brought limited economic fortunes and affected the nation's capacity to respond positively to HIV and AIDS.⁷⁵ Relations between the church leaders and the state deteriorated when some church leaders, including the Zimbabwe Catholic Bishops' Conference, participated in the formation of the Zimbabwe Election Support Network.⁷⁶ The state became suspicious of the involvement of churches and NGOs in HIV and AIDS intervention programmes and AIDS-related care and, thus, construed that the NGOs and churches, were pursuing an ulterior agenda.⁷⁷ This was despite the formation of the multisectoral National AIDS Council (NAC), in 2000,⁷⁸ in which religious leaders were involved. The government's lack of financial capacity appeared to worsen the situation as Jovonna Rodriguez observed: "The increased number of people in poverty stricken communities has decreased accessibility to healthcare and economic stability, increasing probability for infection."⁷⁹ Without international financial aid the state could hardly fund AIDS-related care intervention programmes adequately as Edwin Kaseke and Jotham Dhemba also confirmed:

Shortages of foreign currency and the international isolation of Zimbabwe have impacted negatively on healthcare delivery in Zimbabwe. Shortages of drugs and the high cost of drugs and medical care now characterise the health delivery system in Zimbabwe. A major challenge of the health delivery system is the HIV and AIDS scourge as this has a negative impact, not only on the health sector but the economy as a whole.⁸⁰

Given the fact that, generally, many African countries denied the existence of HIV and AIDS within their borders, the pandemic did not appear to be a top priority for the state in Zimbabwe. For example, in a study by Masunungure, Ndapwadza, Choguya and Sibanda the authors concluded that ordinary citizens in Zimbabwe held the perception that HIV and AIDS did not deserve to be given priority attention ahead of other matters such as education and employment.⁸¹ However, people infected and affected by the epidemic became critical of the state for its lack of commitment to address the needs of people infected and affected by the epidemic.⁸²

During Easter in 2000 the Zimbabwean Catholic bishops reminded the state of the horrors of political violence and called on the government to join hands with the church to confront the challenges faced by the nation.⁸³ The bishops appeared to believe that the political violence witnessed during the referendum for a new constitution held in February 2000 affected the lives of ordinary citizens including people infected and affected by HIV and AIDS. From 2000 onwards the visibility of the Zimbabwe Catholic Bishops' Conference, as well as the Zimbabwe Council of Churches and the Evangelical Fellowship of Zimbabwe, part of civic organisations intensified.⁸⁴ The state became suspicious of services rendered to PLHIV and OVC by NGOs and religious entities.⁸⁵ Politicians, including those in government, took a partisan approach in the support of people in need. In a study by Sibusisiwe Mpofu, which focused on challenges encountered by NGOs in Zimbabwe in relation to the provision of support services to people in need, it was stated that political parties determined who will be

⁷⁴ *Ibid.*

⁷⁵ Action AID, *HIV and AIDS and violence against women: Priorities for interventions in Zimbabwe, International report*, (2007), iii.

⁷⁶ Elinor Sisulu, Pascal Richard and Steve Kibble, "National unity or national exclusion? Where to for the Zimbabwean churches and civil society?" (2009), 6. See also ⁷⁶ Ezra Chitando, "Down with the devil, Forward with Christ! A study of the interface between religious and political discourses in Zimbabwe," *African Sociological Review* 6, 1 (2002), p 2.

⁷⁷ Sibusisiwe Mpofu, "An investigation into the challenges impeding non-governmental organisations in carrying out supplementary feeding programmes: The case of Care International and Plan International in Zimbabwe," Unpublished Masters in Development Studies thesis, Nelson Mandela Metropolitan University, (April 2011), p 68.

⁷⁸ NAC and MOHCW, *The HIV and AIDS Epidemic in Zimbabwe*, 47. See also, MOHCW, *National HIV/AIDS policy for the Republic of Zimbabwe* (December 1999).

⁷⁹ Jovonna Rodriguez, "AIDS in Zimbabwe: How socio-political issues hinder the fight against HIV/AIDS," *Emory endeavours in world history*, (March 2007), p 10.

⁸⁰ Edwin Kaseke and Jotham Dhemba, "Zimbabwe country report," in Five-country study on service and volunteering in southern Africa, under the Volunteer and service enquiry southern Africa, (July 2006), 11. See also Rodriguez, "AIDS in Zimbabwe: How socio-political issues hinder the fight against HIV/AIDS," *Emory endeavours in world history*. See also Fresen, "Responsibility and caring for one another," p 64.

⁸¹ Eldred Masunungure, *et al.*, "People's development agenda and Government's policy performance in Zimbabwe," *Afrobarometer Briefing Paper*, 28 (March 2006), p 4.

⁸² Van Donk, "Development planning and HIV/AIDS in sub-Saharan Africa," 132.

⁸³ ZCBCH, ZCBC, "Easter message," 17 April 2000. See also ZCBCH, ZCBC, "Working for peace during elections," 2000.

⁸⁴ See Sisulu, "National unity or national exclusion?," p 11.

⁸⁵ ZCBCH, ZCBC, "Use your vote, it is your right," 7 June 2000. See also ZCBCH, ZCBC, "Working for peace during [After] elections." See also a similar message from the ZCBC to the nation before the presidential elections March 2002, ZCBCH, ZCBC, "A call to work for unity, peace and harmony," A pastoral letter, February 2002.

recipients of support services.⁸⁶ The implications were that HIV positive people, and children orphaned by AIDS and their caregivers were denied assistance because of their political affiliation. In response to this situation the Zimbabwe Catholic Bishops' Conference had this to say:

Make your choice in the freedom of your conscience. Do not be afraid. Act as a free citizen. Whatever choice you make, remember to vote for the people who are God-fearing, who will respect human rights and dignity, who will foster the oneness of the Creator, our common Father.⁸⁷

President Mugabe is a known lay Catholic, but relations between him and the Zimbabwean Catholic bishops had taken on a new turn in the early 1980s and throughout the 1990s. The already fragile relations were exacerbated in 2000 and beyond.

In 2001 Zimbabwe had one of the worst HIV and AIDS infections rates in the world with the adult HIV prevalence rate of 25.06%, the number of AIDS-related orphans was at 900 000 and that of AIDS-related deaths was at 160 000. The country was ranked third in the sub-region, after Botswana and Swaziland, with an adult HIV prevalence rate of 35.8% and 25.25% respectively.⁸⁸ The leadership of the Roman Catholic Church in Zimbabwe declared that HIV and AIDS is a national emergency and, therefore, AIDS-related care topped the church's list of priorities. Amid this situation, the Catholic bishops of Zimbabwe stated: "We are aware of the difficult socio-economic conditions our nation is going through. ... There is a spirit of apathy and resignation among our people with an underlying healthy tension that is longing for change in our social system."⁸⁹ Certainly, the members of the Zimbabwe Catholic Bishops' Conference were disappointed that the birth of the new nation, understood to be a blessing from God, turned out to be a curse: "We recall with gratitude the marvellous works that the Lord has wrought among us. We see God at work in our own history, leading us in Christ his Son towards that destiny for which he made us and to which he invites us all."⁹⁰ Meanwhile, the HIV and AIDS intervention programmes carried out by the Roman Catholic Church might have been understood by the state as a means of seeking political expedience.

In May 2001 the Zimbabwe Catholic Bishops' Conference urged the state to consider healthcare as a top national priority:

The poor health delivery system is seriously affecting the majority of our people who are already suffering from the harsh economic environment. Our health institutions cannot even procure some essential drugs. We therefore urge our government to make enough resources available to the health sector.⁹¹

Healthcare, amid an AIDS pandemic, appeared to be a critical issue for the national body of the Roman Catholic bishops. During the severe drought experienced in Zimbabwe in 2002 the bishops demanded that the special needs of people infected and affected by the HIV and AIDS crisis and those affected by famine be met:

Zimbabwe currently has a large number of orphans because of the scourge of HIV and AIDS. A large number are widows and street kids and the sick are affected by the food shortage more severely than those who have someone to provide for them. We, as your spiritual leaders are seriously concerned with the plight of the people and we cannot continue to preach to people with empty stomachs.⁹²

Access to nutrition by people living with HIV, as well as children orphaned by AIDS, is a critical aspect of care. Given the high levels of corruption that filtered through to the grassroots level, it was difficult for people infected and affected by the epidemic to source food. Food donated to disadvantaged members of society was clandestinely sold in shops at the peril of intended beneficiaries.⁹³

The Zimbabwean Catholic bishops used the Lenten pastoral letter for 2003 to castigate those individuals who further marginalised the poor by seizing food for self-enrichment.⁹⁴ These same observations were

⁸⁶ Mpfu, "An investigation into the challenges," 70.

⁸⁷ ZCBCH, ZCBC, "Use your vote, it is your right," 7 June 2000. See also ZCBCH, ZCBC, "Tolerance and hope," May 2001.

⁸⁸ Dan Mullins, "Land reform, poverty reduction and HIV/AIDS," Unpublished paper presented at the Southern Africa Regional Poverty Network (SARPN), Pretoria, 4-5 June 2001.

⁸⁹ ZCBCH, ZCBC, "Jesus Christ the same yesterday, today and forever (Hebrew 13: 8)," A pastoral letter for the new millennium 2000 A.D., December 1999.

⁹⁰ ZCBCH, ZCBC, "Jesus Christ the same yesterday, today and forever (Hebrew 13: 8)."

⁹¹ ZCBCH, ZCBC, "Tolerance and hope."

⁹² ZCBCH, ZCBC, "Appeal for food in Zimbabwe," A pastoral letter, August 2002.

⁹³ ZCBCH, ZCBC, "Appeal for food in Zimbabwe." See also Mutume, same interview.

⁹⁴ ZCBCH, ZCBC, A call to metanoia: Listen to the inner voice," Lenten pastoral letter, March 2003.

highlighted by Hatendi in 1995 who reminded the Christian community in Zimbabwe, as well as church leaders, to be wary of abuse of the poor:

Leaders must listen carefully to the criticism from HIV and AIDS patients and PWA [PLHIV] and respond appropriately to their needs ... The church is the conscience of the larger community, hence the need for a very high level of accountability in all our work.⁹⁵

The Zimbabwe Catholic Bishops' Conference further called on the church's followers to be the "visible sign of Christ today [that] imitating him in showing compassion and concern for the suffering".⁹⁶

Generally, the bishops held the state as accountable for the hardships encountered by Zimbabweans, as well as PLHIV and OVC, as stated by Auxiliary Bishop Mutume: "Where there is political and social strife there is no development and HIV and AIDS is a human development issue."⁹⁷ The Zimbabwe Catholic Bishops' Conference also openly reminded the state that it should make the provision of basic healthcare a top priority for the government:

The situation in hospitals and healthcare centres has deteriorated to shocking levels. Drugs are scarce and if available, the ordinary people are unable to buy them. To make matters worse, the HIV and AIDS pandemic is ravaging in society and Zimbabwe has one of the highest rates of infection in sub-Saharan Africa. We call upon the government, especially the Ministry of Health and Child Welfare, to get priorities right. Caring for the sick is a calling from God of special dignity and importance. It can never be seen as just another job or another way of earning one's living.⁹⁸

The Zimbabwean Catholic clerics focused not just on HIV and AIDS alone, but on the turmoil faced by the entire national healthcare system that became "the victim of a repressive, corrupt and unaccountable Government".⁹⁹ The fact that the bishops maintained that the state had a responsibility of providing affordable healthcare for all citizens also enhanced advocacy for the rights of HIV positive people.

In June 2004 the state ordered the closure of the Roman Catholic Church Archdiocese of Bulawayo's Sibambene AIDS programme, alleging that the project was not registered with the Ministry of Labour and Social Welfare.¹⁰⁰ This was despite the fact that the project had served the communities for ten years. It is important to note that the Catholic Relief Services funded the Sibambene AIDS programme which was similar to the Diocese of Mutare Community Care project in Manicaland.¹⁰¹ The state's Private Voluntary Organisations Act of 1996¹⁰² was replaced by the NGO Act of December 2004. Under the new Act, organisations involved in community development, charity, relief, human rights, gender awareness and environmental protection had to register with the NGO Board.¹⁰³ According to Amnesty international, the state used the Act to eliminate the influence of NGOs and churches on Zimbabwean politics: "The Act also gives the government sweeping powers to interfere with the operations of any NGO in Zimbabwe ... Under the Act, the Zimbabwean NGOs were prohibited from receiving any foreign funding to engage in human rights work."¹⁰⁴

Some church leaders, including the Zimbabwe Catholic Bishops' Conference, opposed the Act because of its impact on HIV and AIDS intervention programmes and in particular claimed that "AIDS-related care was part of the priority for the poor".¹⁰⁵ Apparently, the involvement of the Roman Catholic Church in both the constitutional reform project and public health sector could have been motivated by a political agenda. This observation is confirmed by Erica Bornstein who states in her study on protestant NGOs, morality and economics in Zimbabwe: "These specific local tensions, between NGOs and the state, were a product of transitional context funding in which NGOs operate. This context was highly political."¹⁰⁶

⁹⁵ Hatendi, "Great women," 14.

⁹⁶ ZCBCH, ZCBC, "A call to metanoia."

⁹⁷ Mutume, same interview.

⁹⁸ ZCBCH, ZCBC, "A call to metanoia."

⁹⁹ ZCBCH, ZCBC, "A credible electoral process for a responsible and accountable leadership," A joint pastoral statement, August 2004. See also ZCBCH, ZCBC, "God hears the cry of the oppressed," A pastoral letter on the current crisis in Zimbabwe, Holy Thursday, 5 April 2007.

¹⁰⁰ Church's AIDS programme closed down, <<http://www.kubatana.net/html/archive/hivaid/>> [Accessed 22 June 2011]. See also Sibambene Zimbabwe, <<http://www.volensafrika.org/Sibambene.html?lang=en/>> [Accessed 22 June 2011].

¹⁰¹ DOMCCPR, Benyera, Evaluation of CRS Zimbabwe Home-Based Care Programme, pp 12-17.

¹⁰² Kaseke and Dhemba, "Zimbabwe country report," p 30.

¹⁰³ Zimbabwe Government, *The non-governmental organisation act of Zimbabwe*, 4, 5.

¹⁰⁴ Amnesty International, *Zimbabwe: NGO Act is an outrageous attack on human rights*.

¹⁰⁵ ZCBCH, ZCBC, The cry of the poor, pastoral letter, June 2005.

¹⁰⁶ Erica Bornstein, *The spirit of development: Protestant NGOs, morality and economics in Zimbabwe* (Stanford: Stanford University Press, 2005), 115.

Faced with severe financial challenges the state established the National AIDS Trust Fund (NATF) in 1999 whereby “all employed persons in Zimbabwe were levied an additional 3% tax on their taxable income. The fund was meant to finance the operations of the National AIDS Council and key HIV and AIDS interventions.”¹⁰⁷ Unfortunately, due to a number of limitations and an overwhelming demand the fund failed to cover the intended needs. With minimum support for AIDS-related care programmes, HIV positive people “became increasingly dependent on churches, NGOs and communities with only minimum support from either the Government, through the AIDS levy, or the international donor community”.¹⁰⁸ The state’s introduction of home-based care legislation, including the National Community Home-Based Care Standards in 2004 and the National Home-Based Care Training Manual in 2005¹⁰⁹ came too late. Besides, the two pieces of legislation only served as public policy frameworks and lacked suitable state funding support.

Within Manicaland, the Diocese of Mutare expanded on AIDS-related care activities through the recruitment of an additional 2,000 voluntary caregivers and the distribution of material support to clients.¹¹⁰ Given the fact that over 60% of Zimbabweans were unemployed and the majority of the citizens were living on less than a US\$1 per day,¹¹¹ AIDS-related care became a lifeline for families.¹¹² Meanwhile, in 2002 the number of clients escalated from 5,500 PLHIV to 10,208.¹¹³ While the demand for care services escalated, the flow of donor funding for AIDS-related care intervention programmes by churches was often interrupted by the state. For example, in December 2002 the government delayed the receiving of funds to St Therese, Chiduku, leading to the scaling down of operations.¹¹⁴ However, in Manicaland setbacks encountered by the project were not a deterrent to deliver service to the poor and in 2003 the project expanded from the previous ten sites to nineteen.¹¹⁵

The terminal nature of HIV also resulted in some HIV positive people finding solace in religious. Either clients became Christians or converted to the Roman Catholic Church as confirmed in the following statement:

It was noted that terminally ill clients are eager to turn to God ... a client (name supplied) of B102 Vengere, Rusape, who received the sacrament of baptism and passed away seven days later. One of our volunteers, Flora Marima, helped this client to receive Christ.¹¹⁶

Similarly, children orphaned by AIDS who were supported by diocesan project fell under the influence of religion: “Most orphans who attended our spiritual support sessions have changed their behaviour. They are now regularly attending church services and joining youth groups in churches.”¹¹⁷ The two cases cited resonate in the observation made by Bornstein in relation to Charitable Choice in the US: “Underlying the discourse of choice, responsibility, and liberty are narratives of conversion. That individuals can be transformed and reformed – converted, born again.”¹¹⁸ Therefore, care and support to HIV positive people and children orphaned by AIDS in Manicaland and carried out by the diocesan project had the effect of proselytising some of the beneficiaries. However, in Manicaland, AIDS-related care programmes by the Roman Catholic Church were held in high esteem for what was seen by the provincial National AIDS Council as “transparency and accountability shown by the leadership of the project”.¹¹⁹

The NGO Act led to a drop in AIDS-related care service organisations from 500 in 2001¹²⁰ to only 120 in 2007.¹²¹ However, in Manicaland the diocesan project forged alliances with Plan International, an NGO that worked with underprivileged children. The joint project, established in 2005, supported home-based care in

¹⁰⁷ Nyasha Madzingira, “The Zimbabwe National AIDS Levy Trust (The AIDS levy),” SADC HIV and AIDS best practice series (March 2008), 11,

<http://www.safaidz.net/files/SADC_BestPracticeZimbabwe/> [Accessed 7 May 2012].

¹⁰⁸ HDN and SAFAIDS, *Caring from within*, 20.

¹⁰⁹ Irish Aid, *Looking back, mapping forwards*, 32.

¹¹⁰ DOMCCPM, MCHC project report, March 1999-December 2000, 7.

¹¹¹ Irish Aid, *Looking back, mapping forwards*, 31. See also Mombe, same interview.

¹¹² Tichawangana, same interview.

¹¹³ DOMCCPM, DOMCCP progress report, October 2002.

¹¹⁴ DOMCCPR, St. Therese DOMCCP substations Rusape, Mt. Carmel, Gowakowa and Erra Mine quarterly station report, October to December 2002. See also DOMCCPR, St. Therese DOMCCP substations Rusape, Mt. Carmel, Gowakowa and Erra Mine quarterly station report, January-March 2003.

¹¹⁵ DOMCCPM, DOMCCP annual report, 2003.

¹¹⁶ DOMCCPM, Evelyne Murray, DOMCCP director’s activity report, January to March 2006, 7. See also DOMCCPR, Fanuel Nyatsuro, DOMCCP Makoni district brief annual report to CRS at a core-partners meeting held in Harare, 10-12 December 2007.

¹¹⁷ DOMCCPM, Murray, DOMCCP and PSG quarterly report, p 4.

¹¹⁸ Erica Bornstein, “Faith, liberty and the individual in humanitarian assistance,” in Faith, liberty and the individual in humanitarian assistance,” in Michel Feher, Gaëlle Krikorian and Yates McKee (eds), *Nongovernmental politics*, (New York: Zone Books, 2007), 664. See also Bornstein, *The spirit of development*, pp 170-171.

¹¹⁹ Lovemore Kupara, interview conducted by author, Mutare, 12 January 2011.

¹²⁰ HDN and SAFAIDS, *Caring from within*, 19.

¹²¹ Irish Aid, *Looking back, mapping forwards*, 31.

Mutare and Mutasa.¹²² In 2007 the diocesan project received financial support worth Z\$6 780 000 from Project Support Group (PSG), a University of Zimbabwe NGO working to strengthen organisational capacity of NGOs. This assisted the project in the payment of incentives for voluntary caregivers.¹²³ Intense partnerships with communities could have become a turning point for community perception of AIDS-related care as stated:

In the past communities used to think that the burden of caring for their sick members was the onus of the donors and government. It has been observed that our communities now appreciate that they themselves are responsible for caring for their sick people. We have also noted that communities now frequently mobilise their humble resources to assist their sick members. Increase in community secondary care givers, capacity building in HBC [home-based care] now taken seriously in order to improve the quality of care they render to their ill members. This led to an increase in the demand for standard HBC kits.¹²⁴

The extent to which communities could sustain donor funded AIDS-related care intervention programmes was questionable. Apparently, the future of AIDS-related care in Manicaland became oblique without external funding at a time when Catholic Relief Services was pondering withdrawal of financial support.¹²⁵ It is also important to note that donor funded HIV and AIDS intervention programmes in some parts of Africa have left a bad legacy of weakening the ability of local communities to take responsibility for their welfare.¹²⁶

The access to ARVs in Zimbabwe by members of the general public commenced at very few state healthcare centres in April 2004 and increased to 27 institutions in May 2005.¹²⁷ Bureaucracy limited access to ARVs at the state's healthcare centres which forced the diocesan project in Manicaland to resort to natural medicinal herbs for the treatment of AIDS-related illnesses.¹²⁸ In 2003 Bori Hounnou, a Swiss medical doctor whose husband served at Regina Coeli mission hospital, initiated the propagation of medicinal herbs to treat AIDS-related symptoms.¹²⁹ Subsequently, this project spread to other diocesan stations in Manicaland. Lindsey comments: "They have established a large medicinal garden, and have a solar drier for preparing herbal teas and drying herbs for use in ointments. Now each station is developing a garden of medicinal plants."¹³⁰ In 2004 PLHIV based in Mutare started to receive medicinal herbs from the diocesan herbal garden project situated at St Joseph's Sakubva. Some of the herbal therapies included the use of artemesia annua powder to boost the body's immune system as well as moringa, and aloe vera among others.¹³¹ Herbal therapies could not completely treat all the ailments associated with AIDS, but were seen as having the effect of boosting the body's immune system. This was not new to some people living with HIV in Manicaland. In 1996 Marlou Bijlsma, a Dutch national serving with Mutare City Health Department launched a herbal treatment project for people living with HIV and AIDS.¹³² What appeared unique was that in March 2006 the new initiative could manufacture medicinal herbs into capsules and the viral load of patients that were using medicinal herbal therapies were monitored using a specialised CD4 count machine stationed at St Joseph's, Sakubva.¹³³

The delay in the rolling out of ARVs at the Roman Catholic Church's healthcare centres in Zimbabwe, in general, and Manicaland, in particular, was different from the experience in South Africa. For example, in 2003 in KwaZulu-Natal, South Africa, the Roman Catholic Church became involved in providing access to antiretroviral therapy (ART) to AIDS patients.¹³⁴ Churches in South Africa, including the Anglican Church of Southern Africa, joined the Treatment Action Campaign that successfully denounced companies that "engaged in restrictive practices by refusing licences to other firms making their own low-cost generic versions of AIDS drugs".¹³⁵

It is also worth noting that in Zimbabwe the roll out of ARVs became a politicised issue and therefore non-state players such as churches treaded on this field cautiously. However, on a positive note, the use of herbal therapies gave HIV positive people hope and thus it became a cost effective and convenient therapy for

¹²² DOMCCPM, Joachim Nyamande, DOMCCP Circle of Hope Partnership Project with Plan International for Mutare and Mutasa, 4 April 2006.

¹²³ DOMCCPM, Evelyn Murray, DOMCCP and PSG quarterly report, January to April 2007, 3.

¹²⁴ DOMCCPM, Fanuel Nyatsuro, DOMCCP quarterly report, October to December 2007, 5 January 2008, 15.

¹²⁵ DOMCCPR, Benyera, *Evaluation of CRS Zimbabwe's home-based care*, 20. See also P. Mutume, same interview.

¹²⁶ For a detailed discussion on this see Bornstein, *The spirit of development*.

¹²⁷ HDN, SAfAIDS, *Caring from within*, 20.

¹²⁸ Nyawera, same interview. See also Mombe, same interview. See also Michael Mafulela, interview conducted by author, Mutare, 13 August 2010.

¹²⁹ Information supplied by Joachim Nyamande to the author at the DOMCCP centre, Mutare in 2010.

¹³⁰ DOMCCPM, Keith Lindsey, Seminars on Natural Medicine in Zimbabwe, September-October 2006.

¹³¹ Mombe, same interview.

¹³² Marlou Bijlsma, *Living positively: nutrition guide for people with HIV/AIDS* (Mutare: Mutare City Health Department, 1996).

¹³³ DOMCCPM, DOMCCP-PSG activity report January-March 2006, 8.

¹³⁴ For this see Joshua, "The Catholic response to HIV and AIDS in South Africa," 250.

¹³⁵ Mission and Public Affairs Council, *Telling the story: Being positive about HIV/AIDS*, (April 2004), 12. This was accessed as pdf. See also Elizabeth Thomas et al., "Let us embrace": *Masangane Case Study – A Comprehensive, Integrated faith-based response to HIV and AIDS* (Cape Town: African Religious Health Assets Programme, 2006), p 4.

people living with HIV.¹³⁶ The medicinal herbal therapies also became popular at state hospitals and the government saved money. The government was faced with a crisis because of an inadequate supply of important pharmaceuticals¹³⁷ and had to resort to supplying patients with medicinal herbs. The prevailing economic hardships forced the diocesan project to procure conventional medicinal drugs and sanitary supplies for use at public clinics and hospitals in Mutasa and Mutare.¹³⁸

Conclusion

The fact that AIDS-related care intervention programmes involved the church's top leadership, parishes and a faith-based organisation illustrates that the Roman Catholic Church in Zimbabwe was well organised and committed to AIDS mitigation. This essay has shown that the Roman Catholic Church's extensive network of healthcare centres became an important asset in the provision of AIDS-related care. Within Manicaland, the establishment of the Mutare Community Home Care project in 1992 by the church was one of a number of rare initiatives. The church's long tradition of involvement in social development work and HIV-related funding from Catholic Relief Services presented a unique opportunity. Within the early years (1985-1995), the care of PLHIV became very critical amid the lack of access to ARVs by the general public. In the middle period (1996-1999) AIDS-related care interventions by the Roman Catholic Church were carried out in a context of deteriorating church and State relations. Between 2000 and 2007 the AIDS-related care and treatment intervention programmes carried out by the diocesan project contributed significantly to public welfare amid a declining state social support system.¹³⁹ While ordinary people could have benefited from the initiative, this article has indicated that the involvement of the leadership of the Roman Catholic Church in civic matters became a matter of concern to the state. Given the unfolding and evolving socio-economic crisis faced by ordinary Zimbabweans, the church emerged with innovative AIDS-related care intervention programmes carried out as a part of a mission within turbulent waters.

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¹³⁶ Irish Aid, *Looking back, mapping forwards*, p 31.

¹³⁷ *Ibid*, p 8.

¹³⁸ DOMCCPM, DOMCCP-PSG activity report, January-March 2006, 8. See also DOMCCPM, Joachim Nyamande, "Summative progress report of the Circle of Hope Project, 4 April 2006, p 9.

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