

ROMAN CATHOLIC CHURCH RESPONSE TO HIV/AIDS IN ZIMBABWE: A THEOLOGICAL APPROACH

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Abstract

It is more than a quarter of a century since the onset of HIV/AIDS pandemic. Churches, governments and society in general have been grappling with the cure, prevention and care and let alone, the quest for an HIV/AIDS free society. But in accordance with the Church's mission, a time of crises is a kairos moment that challenges believers to seize the opportunity and the burden of responsibility. The Roman Catholic Church in Zimbabwe is seen to be one of the leading members of the ecumenical Church in issues of education, justice and peace, poverty alleviation and also health provision and care. The article explores the interventions and their theological basis of the Roman Catholic Church in Zimbabwe in a situation of HIV/AIDS. A critical evaluation is made on whether the Church is doing enough and what still needs to be done and thus culminates in advocacy.

1. Introduction

More than a quarter of a century since the onset of HIV and AIDS pandemic, countries throughout the world are grappling with finding the cure and with prevention, treatment of opportune diseases and palliative care. While significant strides have been made in these areas, however, total cure of the pandemic has not been discovered and the thought of an HIV and AIDS free world and nation remains a dream. Theology takes central space in that human suffering and humanity's involvement with it raises difficult questions that shake the foundations of faith in God.

These are questions that undergird the problem of theodicy – questioning the existence of an omnipotent, omnipresent, omniscient, *Pantokrator* (who holds all things in being) and all loving God. However, it is true to life that a time of crises like this is a time of opportunity and theologically too, a time of responsibility. In this context, and recognizing that the Church that shares in Christ’s mission is a significant stakeholder in this project, the article explores Roman Catholic (RC) Church initiatives (some done in collaboration with other stakeholders) in the fight against HIV and AIDS in Zimbabwe. Other loci for theological justification of this orientation include the understanding of the Church as the body of Christ (organic mode of being Church) and liberation theology’s tenets of solidarity with and preferential option for the sick, poor and marginalised, Incarnating the gospel in time and place and eschatology (looking into the future with hope). Technical terms concerning the understanding of HIV and AIDS and a brief history of the pandemic in Zimbabwe are unpacked.

Zimbabwe population was estimated in July 2011 at 12,084,304 (www.indexmundi.com/zimbabwe/population.html). The RC Church has about one million followers and this accounts for about 8 % of the population organised into 8 dioceses (Harare, Bulawayo, Chinhoyi, Gokwe, Gweru, Hwange, Masvingo and Mutare) (<http://relzim.org/major-religions-zimbabwe/catholics/>).

2. HIV and AIDS

HIV and AIDS are acronyms for “Human Immunodeficiency Virus” and “Acquired Immune Deficiency Syndrome”, respectively. The Immune system (mainly white blood cells) normally defends the body against pathogens and HIV reverses this process by infecting the cells of living organisms and replicating itself. According to Devine (1996, 2000, 2004:174), HIV is retroviral, that is, it is reverse transcribed into the human DNA (deoxyribonucleic acid of chromosomes) and in that way HIV incorporates itself permanently into the victim’s genetic material. In other words, HIV destroys the very system that is naturally meant to get rid of the virus. On the other hand, AIDS may be referred to as advanced HIV because at a very advanced stage

of HIV infection, a person is diagnosed to suffer from AIDS when the level of immune system cells (CD4 count) in the blood is critically below a certain level. The person therefore suffers from a number of opportunistic diseases (diarrhoea, tuberculosis, herpes, etc.).

Unlike airborne diseases, HIV is transmitted through body fluids such as blood, semen, vaginal lining secretions and breast milk. Consequently, the virus is transmitted in a number of ways in human beings – sexual intercourse (vaginal, anal, oral); blood and blood products, via needles and other skin piercing objects; and from an infected mother during pregnancy, childbirth, or breast milk (Weinreich & Benn 2004:3). Furthermore, in the case of heterosexual transmission, in particular, super-infection may occur, with increasingly devastating effects. It is important to note that because Zimbabwe has not legalised homosexuality, transmission through heterosexual relationships receives centre stage. Similarly, breastfeeding is common practise especially in rural communities and it is advised as healthy in feeding neonates across social strata in Zimbabwe.

Scientific investigations have shown that HIV has various strains – some more lethal than others and showing geographical prevalence preferences (Devine 1996, 2000, 2004:174). HIV strains (sub-types or clades of HIV-1) in Sub-Saharan Africa (except for West Africa) are said to be more aggressive than those in other parts of the world (Weinreich & Benn 2004:1).

3. HIV and AIDS in Zimbabwe

Since the HIV and AIDS pandemic was first identified in the early 1980s, and first reported cases in Zimbabwe were in 1985, epidemiological studies (<http://www.avert.org/aids-zimbabwe.htm>) show that around the end of the 1980s, an estimate of 10 percent of the adult population were said to be infected with HIV. The figure rose dramatically in the first half of the 1990s reaching a peak of 26.5 percent in 1997. Between 2001 and 2009, HIV and AIDS incidence declined by approximately

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25 percent. The adult prevalence was estimated at 23.7 percent in 2001 and fell to 14.3 percent in 2010. In 2006 infant mortality had doubled since 1990 and infant deaths have since fallen from 50 per hundred births in 2006 and to fewer than 30 in 2011. Average life expectancy is just under 52 years for both men and women. Life expectancy rose significantly from as low as 34 years for women (www.sokwanele.com/thisiszimbabwe/archives/6446). By 2009, there were one million orphaned children living in Zimbabwe whose parents died from HIV and AIDS (<http://www.avert.org/aids-zimbabwe.htm>).

However, we are cautioned to interpret survey figures as indicating a fall in Zimbabwe's adult HIV prevalence since a number of factors make a more accurate estimate of HIV prevalence in Zimbabwe almost impossible. These include a significant number of homeless and displaced people in the country who are likely not to have been surveyed. A number of people dying from AIDS and a number of people who migrated to other countries also contribute to the decline in reported cases of HIV infection (<http://www.avert.org/aids-zimbabwe.htm>). In 2008 alone, because of economic meltdown accompanied by political upheaval, there was mass exodus of Zimbabweans as economic refugees to other countries. There was also the cholera outbreak that claimed an estimated 4287 lives.

Graphically, HIV and AIDS epidemiological pattern for Zimbabwe, as for many other countries, shows a rapid increase reaching a peak in the period when people show ignorance and denial about the ins and outs of the pandemic and it starts levelling and significant declining when people show knowledge of the pandemic and take responsibility in promoting awareness, prevention and cure.

It is important to note that in the peak period of rapid HIV infection and death from AIDS related diseases, there were a number of awakenings in the Zimbabwean people. For example, there was a shift in the understanding of HIV and AIDS as a disease of its own kind, different from the known sexually transmitted diseases (STDs) like syphilis, gonorrhoea, etc. or a disease emanating from sorcery like the known *Runyoka* (snake-type wife fencing in order to trap the adulterer – here

nyoka, “snake” would suddenly appear thus preventing the wife from committing adultery) (Chawatama 1993:16-17), or from punishment by angry ancestors or *ngozi* (foreign vengeance spirits implicated in the case of murder) (Chimhanda 2011b: 78,108-110). Consequently, Zimbabweans (especially musicians) coined new names descriptive of how they experienced the ravaging effect of the pandemic. These local names include *mukondombera*, meaning a pandemic that affects all people and thus showing no boundaries of age, sex, social status and creed; *gukurahundi* (cf. the first rains that wipes out chaff) and *shuramatongo* (disease whose first manifestations are a bad omen indicating that the whole family will be exterminated, leaving the home deserted and in ruins) (Chimhanda 2011a:10). However, it is important to note that because of gender, socio-cultural and economic disparities, women, the girl child and the unborn babies were disproportionately vulnerable.

During the peak period of HIV and AIDs infection, morbidity and mortality, women and especially mothers, grandmothers and the girl child were overburdened as caregivers. Rural women were the backbone and main stay of society. This was caused mainly by the fact that even towns people have rural roots and most prefer to die and be buried in rural homes. Consequently rural people were overburdened. The situation was exacerbated by cultural practices that set women as carers of the sick, dying and even the dead (women take centre stage at funerals).

Old women especially experienced the dilemma of having to care for orphaned grandchildren at a stage when they lacked neither the energy nor the skills to engage in paid employment and also the knowledge to protect themselves in the care of HIV positive patients.

Women and the girl-child were at high risk of contracting HIV infection, not only because of their biological make-up, but also because of lack of socio-economic and political power in making decisions in sexual matters affecting their own

bodies. According to Baylies (2000:5), it is this link between powerlessness and the risk to HIV infection that is the key of understanding the sources of women vulnerability. The high HIV and AIDS mortality took toll affecting the age group of high sexuality meant the loss of breadwinners for women who depended economically mainly on men. Similarly, in patriarchal culture, women tended to bear the stigma of prostitute and were silenced by culture to negotiate “where”, “when”, “if” and “how” sex takes place.

Because of a culture that strictly prescribes virginity for girls and not for boys, it means that boys can engage in pre-marital sex or promiscuity. Thus they are more likely to contract HIV and, later, to be the ones who pass it on to a faithful partner in marriage. Furthermore, “the culture of silence” exposes women and the girl child to extensive periods of sexual abuse by male relatives, and consequently to contracting HIV. For example, in the Shona practice of the “conspiracy of silence” (Chimhanda 2011:44, 58, 281), for the sake of protecting family honour, male relatives who sexually abuse minors are not taken to court.

In the event of both parents dying from HIV and AIDS, the girl child was faced with a nightmare in which she became an adult overnight having to care for younger siblings. Cases of child-headed families became increasingly common in Zimbabwe in the HIV and AIDS era (Chimhanda 2011a:12-13). She found she had to resort to sex work and often fell prey to the so-called sugar daddies. Furthermore, HIV positive men who were as alleged ill advised by *n’angas* (witchdoctors) to have sex with virgins and thus there was an upsurge of rape of minors and in some cases there was rape in the cradle. It was at this juncture that Siwela (1997:12-13) urged for a critical examination of culture by asking an incisive question: “Is this the Zimbabwe apocalypse? Before we had infanticide but now we have rampant child abuse. Which is the lesser of the TWO EVILS?”

In the history of HIV and AIDS in Zimbabwe, it came to a period of high mortality rate of babies born of HIV positive parents. In parallel with this, there was also the

phenomenon of baby damping. This is where the PMCT programmes became a very important development in the constant search of the cure of HIV and AIDS.

4. The Church - sharing in the mission of Christ in a time of HIV and AIDS

The acme of Christ's mission to the world is captured in Luke 4:18-19:

The Spirit of the Lord is upon me, because He has anointed me to bring good news to the poor... to proclaim release to the captives and recovery of sight to the blind, to let the oppressed go free, to proclaim the year of the Lord's favour.

The Church as body of Christ is mandated to carry out this mission - *ad gentes* (to the whole world (Vatican II Decree *Ad Gentes* 1965: § 1 [www.vatican.va]), cf. Mark 16:15; Mt 28:19-20). The RCC social teaching affirms human life as a mystery, sacred and social (Pope John Paul II 1995:§ 25, 34, 35, 60, 61). The church thus recognizes the value of preserving human life that rests in the recognition of the highest dignity of humanity of the *imago Dei/Christi*) – that is, humanity as having been created in the image of God and having become son and daughter of God in Christ through baptism (Gen.1:26-27; Gal 3:28). Deducing from the creation category, it is important to note that sacramentally, “all things remember, reveal and reflect the creative presence of God” (Chittister 1998:7).

Human life is social in the sense that it is participated life in sibliingship and *koinonia* (fellowship, togetherness) mutual and reciprocal relationality in which everyone is his/her brother/sister's keeper (Pope John Paul II 1995: §19, cf. Gen.4:9). In other words, believers as responsible and accountable stewards of God's grace are challenged to protect human life and especially when it's most vulnerable - and in this case, from life-threatening effects of HIV and AIDS. Here the RCC is seen to maintain the highly controversial stance of not sanctioning the use of condoms (as in the case of birth control. However, there is slight softening in this area as Sr. Ivy Mudangandi of the Little Company of Mary (LCM) (Personal communication) notes:

We were very much relieved when the Pope agreed to the use of condoms when it is to save lives, in the cases of HIV positive couple and discordant

couples. This was appreciated by the local church as it had in past been one area of criticism as to why the church insists on prohibiting use of condoms when they can be used to save lives.

Pope Benedict XVI softened Rome's blanket ban on contraception, saying: "In certain cases, where the intention is to reduce the risk of infection". But this met with contradiction in conservative circles claiming that the Pope was not speaking *ex cathedra* but as the theologian Joseph Ratzinger and that more specification was needed about the special cases in view. In other words, the Pope "gave no guidance on the long-standing moral and religious question of whether it would be permissible for a married couple, in which one partner is HIV positive, to use condoms in order to prevent the other partner from becoming infected. In this case condom use would be morally justified because it is not used specifically as a contraceptive.

It is known that good nutrition and sanitation improve health status. HIV and AIDS geographical prevalence expose the problem of poverty in that sub-Saharan Africa appears most affected. I would argue that this is not because Africans are more promiscuous than people of other races, but because it is mostly because of the phenomenon of economic poverty and the consequent experience of poor sanitation, malnutrition and difficulties in accessing antiretroviral drugs. Furthermore, situations of poverty and overcrowding make the environment conducive to the rape of the girl child.

4. RCC interventions in a situation of HIV and Aids in Zimbabwe

RCC engagement in the situation of HIV and AIDS in Zimbabwe is indispensable, particularly not only in terms of Christian discipleship, but also in connection with the Synod of African Bishops' (1994) postulate of the Church in Africa as family. For Zimbabwe Bantu culture, model of church as family is a trajectory of communal ontology and epistemology. Theologically, church as family is modelled on the Trinitarian *koinonia* (fellowship of Father, Son and Holy Spirit). The hermeneutic key to affirming full humanity of all people especially in the situation of HIV and AIDS pandemic is both sacramental and organic Christology. Thus in the sick and

suffering we encounter Christ in distressing disguise. It is also important to note that in and through the incarnate Jesus of Nazareth, there is twofold movement – God becomes human and humanity strives to be like God (Christ-like) (divinisation). In organic Christology (model of church as the body of Christ), pertinent to the situation of HIV and AIDS, it can be inferred that, if one part of the body is diseased, then the whole body is affected and also risks being infected (Maluleke, in Musa 2004:59).

Church's response to the *missio Dei* (mission of God) in a situation of HIV and AIDS is undergirded by the Great Commandment to:

Love the Lord your God with all your heart and with all your strength, and with your entire mind; and your neighbour as yourself" (Lk.10:27-28).

Thus, the Christian God is the God of love. In the God-human-cosmos relationality, and facing HIV and AIDS, the Church is challenged to creative agapic love, that is, to Christian and communal love that ultimately orients us to divine love (Pope Benedict XV 2005:6-7). In this context, St Irenaeus (130-200 CE) underscores the urgency of restoring health and wholeness of the human person in his dictum: *Gloria Dei vivens homo* - "The glory of God is humanity fully alive" (*Adversus haereses*, IV, 20, 7, in Pope John Paul II 1995:48).

Love is relational and curbing the harrowing effects of HIV and AIDS is a relational issue. Because of distorted human relationality, it is pertinent to see that in the situation of HIV and AIDS, we are faced with a human tragedy in which human dignity is at stake. According to Schwöbel (2006:57), it is precisely when human dignity is compromised that it becomes imperative for the Church to engage in critical and affirmative public theology. Human beings, and in particular, Christians as moral agents are challenged to make choices that show love, integrity and compassion. They are called both individually and communally to live loving and responsible lives so that others may more fully live. Truthfulness in marriage requires one to disclose one's HIV status to a partner. Compassion spurs us not to

deliberately put others at risk and also to reach out to others in affirming quality life (Chimhanda 2011:16).

In Luke, and, concerning divine call to creative love, neighbour is explained by the ensuing parable of the Good Samaritan. Liberation theologians pick up this understanding of neighbour as the person in need and also the one in whose path we tread” (Assmann 1975:7). Gutiérrez (1992:195, cf. Las Casas) accentuate this when he refers to God’s “memory” - that God has the freshest memory for the smallest and most forgotten. In a situation of the HIV and AIDS pandemic, creative love challenges us further to go searching for the suffering and marginalised – to show conversion towards the “other”. Christian men and women are challenged to make choices that protect and affirm life.

In an Incarnational creative dialogue of culture and the gospel (inculturation), the Church is cautioned to treat culture and the Bible as dual in nature, that is, these historical texts have the potential of affirming and compromising, liberating and oppressing, depending on the lenses used by the reader. Inculturation has two distinct and mutually influencing processes, “enculturation” (learning from one’s culture) and “acculturation” (learning from other cultures) (Luzbetak 1988:65-66). According to Pobebe (1992:34), inculturation is aimed at making believers feel at home in their own faith and culture.

A creative dialogue of African Shona culture and the Gospel lays emphasis on communal ontology and epistemology and this is in mutual agreement with the Christian understanding of Church. Consequently, Bantu essential elements of *unhu* (personhood), *umwe* (togetherness), *ushamwari* (friendship) and hospitality stand in creative dialogue with Christian values of “the dignity of human life, chastity, love, justice, participation, solidarity and stewardship” (Chibika – personal communication) in a situation of HIV and AIDS. For example, in the Bantu principle of *cognatus sum, ergo sum* (I am related, therefore we are, cf. Pobebe 1992:66) – a person is a person through others. In this holistic worldview, every

child is everyone's child. Consequently, and in parallel with the Christian context, fighting the HIV and AIDS pandemic is everyone's business.

From the above cultural, liberation, theological, missiological and Christological premises, the RC Church in Zimbabwe was challenged to prophetic response in curbing HIV and AIDS. According to Tamez (2001:57-58), the prophetic dream is spurred by dissatisfaction with the way things are and thus it is a vision for things desired. Thus the RC Church in Zimbabwe responded, firstly by providing social aid (short-term initiatives) and secondly, by empowerment of people – to participate in order to rise from the ashes of the pandemic scourge (long-term projects). In this effort the RC Church had power houses in its religious communities – approximately 22 religious orders. They did this by living out the evangelical vows (poverty, chastity and obedience) and responding to the founding charism, with apostolates ranging from education (especially primary and secondary), health care provision through hospitals and clinics to social and pastoral care. Furthermore, lay women especially those in RC Church guilds (St Anne, Mary Queen of Heaven, Sacred Heart), were the foot soldiers in ministering to the sick and dying in hospitals and clinics.

4.1 RC Church collaboration in ministry to people infected and affected with HIV and AIDS

It is noteworthy that from the outset, the RC Church collaborated with other stake holders (the state, the ecumenical church, non-governmental organisations). All my informants emphasize that the task of looking after PLHWA was too complex and overwhelming to be handled by a single church, religious congregation or non-governmental organisation. Chibika¹ (personal communication) acknowledges this fact in saying that the Roman, and, in particular, the Jesuits do not have a monopoly in intervening and consequently, of claiming the successes made in fighting the HIV and AIDS pandemic in Zimbabwe.

¹ Susan Chibika is current administrator of the Jesuit HIV/AIDS project

Tim Smith (http://www.co.za/zimbabwe_crisis.htm) notes that the Zimbabwe government has an HIV and AIDS policy. Chibika (Personal communication) acknowledges the collaborative impact of other HIV and AIDS service organizations – faith-based, non governmental, government and businesses.

- a) Ministry of Education, Arts, Sports and Culture: As the custodians to the schools, the Jesuit AIDS Project had to get accreditation to be allowed permission to work with both otherwise. These include: public and private schools. This recognition enabled the setting up of Youth Against AIDS (YAA) clubs in over 40 schools in and around Harare; the training of school Heads and teachers in various programmes in their capacity as club patrons and the distribution of information, educational and communication materials.
- b) Ministry of Health and Child Welfare: A fair component of HIV programming in the country lies under this Ministry and as such, Jesuit AIDS Project is also a recognized partner working with children in and out of school.
- c) National AIDS Council (NAC): an independent government arm, formed by an Act of Parliament, which coordinates all HIV and AIDS Programmes in Zimbabwe. Jesuit AIDS Project is a member to 12 of its wards in the Province of Harare and submits monthly activity reports.
- d) Zimbabwe AIDS Network (ZAN): links up over 75% of all AIDS service organizations in Zimbabwe.
- e) African Jesuit AIDS Network (AJAN): Jesuit AIDS Project belongs to these regional Network of Jesuit initiatives covering most of sub-Saharan African.
- f) Ministry of Youth Development and Economic Empowerment: the Jesuit AIDS Project partners with this particular Ministry in the strengthening of community involvement in issues of youth development

Smith reckoned that in 2009, of the 125 church-affiliated hospitals and clinics (also grouped under the Association of Church-related Hospitals [ZACH]), 51 are of the RC Church. Nearly each of the RC Church dioceses has hospitals and clinics. These are run especially by diocesan sisters in each respective diocese. Religious communities in Zimbabwe, in turn, revised and modified their founding charism in

connection to their respective missionary thrust. Practical examples of RC Church long- and short-term initiatives in combating HIV and AIDS are in order here.

4.2 Practical examples of specific RC Church interventions

Several RCC² men and women, religious of vision, came up with new initiatives to combat HIV and AIDS. Notable here are Sr. Noreen Nolan (Little Company of Mary [LCM]), Rev. Edward Rogers (Society of Jesus [SJ]), Rev Oskar Wermter (SJ) together with Sr. Mercy Mutyambizi, Robert Igo (Benedictine Order), Sr. Ortrudis Maier (Congregatio Jesus [CJ]), Sr. Kathleen Barbee (Maryknoll) together with Brother Benjamin (Redemptorist), Sr. Yulita Chirawu of the Little Children of the Blessed Lady (LCBL), and a lay person Jean Corneck (nicknamed Mama Jean). Existing hospitals, clinics and orphanages were either diocesan (founded by respective bishops of the various dioceses) or belonged to respective religious orders. It can be said that overall, these initiatives were recognized and supported by the RCC in Zimbabwe, the respective orders and were partially state funded. In addition to this, the wider RCC gave significant help through funding of buildings, hospital equipment, food and medicines. The respective congregations discerned, deliberated and gave material, personnel and moral support.

4.2.1 Jesuit AIDS Project

Rev. Edward Rogers of the Society of Jesus (SJ) founded by St Ignatius of Loyola (1491-1556), was a man of great vision. Having founded the School of Social Work in Harare, he now collaborated with a lay Christian, Christine Mtize in founding the Jesuit HIV and AIDS project in 1997, concentrating mainly on peer education. The two projects were mutually influencing in that in the government HIV/AIDS policy, the Social Welfare Department identifies, screens and refers destitute children to orphanages.

² I will only give several detailed examples of the initiatives I have knowledge of as participant observer and I had access to mainly on the websites.

St Ignatius of Loyola founded communities for mission and through the Fourth Vow of obedience to the Pope, Jesuits are committed to go out to places of greatest need and to doing “the more”, (Latin: *magis*). Furthermore, St Ignatius of Loyola, in his *Spiritual Exercises* lays emphasis on “*finding God in all things*” (Puhl 1951: § 98) and at the peak of the spiritual journey, Ignatius, in his *Contemplatio* (Contemplation for attaining love) portrays God as a living dynamic presence who labours with creation in the attainment of knowledge and in giving Glory to God (Puhl 1951:§190-200. The trajectory of all this is the Ignatian motto: “Doing All to the Greater Glory of God” (*Ad Majorem Dei Gratia* [AMDG])).

Chibika explains that the Jesuit AIDS Project targets people of the age-group 12-29 years – the group that is highly sexually active, and consequently at high risk of contracting HIV. The entry point is mainly schools (upper primary, secondary and tertiary education). The aim is to empower the youth to become responsible members of the society and to pursue the vision of an HIV free generation. The objectives are the trajectory of three different departments:

a) Youth Programmes Office

- *Coordinates the Youth Against AIDS Programme*
- *Coordinates Youth Consultative Forums*
- *Manages the Website by directing articles and responding to concerns raised by the youth*
- *Organizes the HIV/AIDS Inter-Schools Competitions run annually*
- *Produces and disseminates information, education and communication (IEC) materials*
- *Coordinates Youth Volunteers (Youth Programme Facilitators) and Interns*

b) Advocacy and Community Mobilization Office

- *Coordinates Community Mobilization through the use of Performance Arts*
- *Organizes and coordinates Exhibitions and Youth Festivals*

- *Organizes and coordinates community participation in National and international commemorations*
- *Responsible for the organization of Community Leaders Participatory Workshops*

c) Training Office

- *Organizes all training programmes namely:*
- *Training in Integral Youth Development (Peer Education Training)*
- *Leadership Training for Youth Groups*
- *Training in Group Facilitation Skills*
- *Training in Peer Counseling*
- *Care and Support for Orphans and Vulnerable Children*
- *Capacity building trainings for Club Patrons (Teachers in Charge)*

Continual reviewing and revision gradually led to Jesuit AIDS Project diversification into various training programmes that include: training in peer education, counselling, group facilitation, performance arts, leadership and youth consultative forums. Sr. Ivy adds that on marking the 10th anniversary of foundation in 2007, the Jesuit AIDS project seized the opportunity to review and evaluate its impact and this culminated in restructuring of the Project in order to meet new challenges and changes.

Significant successes of the Jesuit AIDS Project acknowledged include marked emphasis on:

- a) Youth social responsibility - Issues of youth volunteering for community development*
- b) Human rights, solidarity and youth advocacy work*
- c) The Young People Making a Difference Campaign - an annual initiative meant to mobilize the youth around different developmental campaign themes*

- d) *Positive Living – how infected young people can live with HIV positively and still promote an HIV and AIDS-free generation*
- e) *Edutainment – the use of theatre and arts in the transference of HIV and AIDS information among other related communicable diseases*
- f) *Accompaniment and Peer Counseling*

Landmarks of the Jesuit AIDS Project successes Chibika acknowledges include the following:

- *Over the last three years, 870 young people were trained in life skills and peer education thus becoming confident, assertive and empowered with sound decision making skills.*
- *Over 1,200 young people have shown commitment to social responsibility to care for themselves, others and the environment through various advocacy campaigns such as the Paediatric Anti-retroviral Therapy Campaign that was conducted annually from 2009.*

Show-casing Quality leadership skills, Sr. Ivy claims that several High Schools in Harare select Head Boys/Girls from the *Youth Against AIDS (YAA) club*. Other achievements include:

- *1,800 young people from the 40 project sites have increased information and knowledge on HIV, AIDS and related issues. The young people have acquired life skills and live out healthy relationships and behaviours that reduce the spread of HIV. These young people have shown their commitment to reach out to others.*
- *There have been 9 overt sustainable youth development initiatives with support from the community stakeholders which include Monte Casino High School's continuous moral and financial support for a family living with HIV.*

4.2.2 Sisters of the Little Company of Mary

Sr. Noreen Nolan of the Little Company of Mary [LCM] founded the Mashambanzou Care Trust in Waterfalls in 1989. The main apostolate of the LCM

sisters is mainly nursing. *Mashambanzou* denotes “dawn” – the time of day in which *elephants go to wash themselves*. Dawn, in the context of HIV and AIDS scourge, in turn, refers to giving PLWHA hope at least to die with dignity. Sr. Noleen’s vision was as follows:

Her aim was to offer comfort and reassurance to people living with AIDS and their family members, enhancing the quality of their lives and enabling them to die with dignity and the knowledge that they were loved.

There is echo of the work of Mother Theresa of Kolkata who ministered to the dejected and dying in the streets of Kolkata.

From her vision, the LCM sisters developed the multifaceted *Mashambanzou* as we know it today. The initial HIV and AIDS awareness, prevention and care activities of the Trust included education and awareness-raising in schools and workplaces. An 11-bed Palliative Care Unit was initially set up at the LCM St Anne’s Hospital in Avondale, Harare. *Mashambanzou* later opened its own Care Unit in Waterfalls and currently offers holistic health care through six interlinked community outreach programmes. Sr. Ivy (personal communication) explains:

The LCM sisters are involved in the care for people living with HIV and AIDS through Home based, Orphans and Vulnerable Children [OVC] outreach, Prevention, Palliative care and food distribution care in 13 high density areas of Harare. Mashambanzou project is currently being implemented in collaboration with other religious orders. We have the LCM sisters (management and outreach), Redemptorists brothers (Administration and Outreach), Franciscan Priest from the Waterfalls parish for pastoral care, Jesuits in Mbare...LCBL sisters (Physiotherapy and nursing care).

Sr. Ivy adds:

Also young men and women in formation (Jesuits, LCM, presentation, Redemptorists) come to Mashambanzou for pastoral experience (To this group I add the Congregatio Jesu tertians – sisters preparing for final profession who go for at least a month for mission experience and solidarity

with PLWHA)). Other religious who work with the poor in their various ministries do refer some of their clients when they need services that we offer at Mashambanzou. While we, as religious are sharing the burden of the poor, we also share each other's burden through the referrals we make and receive from one another and from the support we give to each other when we meet and share on the pain and suffering we witness in our ministries.

Sr. Ivy explains that:

While we provide care to the already affected, we do awareness and prevention programs targeting those already living with HIV and those who are not infected so that both parties can play their part in preventing the further spread of HIV.

4.2.3 The Congregatio Jesu

Sr. Ortrudis Maier of the *Congregatio Jesu* (CJ)³ spearheaded the founding of Mary Ward Children's Home in Amaveni, Kwekwe. The original main apostolate of the CJ was education of youth and women. But adopting Ignatian Spirituality, the CJ are open to review and broaden their apostolate in order to do "the *magis* (the more) in their mission and to move to places where there is greatest need.

In 1984 Sr. Ortrudis established a pre-school in the high density suburb of Amaveni Kwekwe. Responding to the needs of the poor, she expressed the need for an orphanage. At that time, when the CJ community deliberated on founding an orphanage, African indigenous members (including myself) argued that this was not necessary, since in Shona culture and extended family setup, orphaned children would always be absorbed and taken care of. However, the orphanage was built in the peak period of HIV and AIDS in the mid-1990s it became full to capacity because of HIV/AIDS orphans and concurrent baby dumping. Mary Ward Children's Home and Pre-School in Amaveni complement each other well in that the orphans get good grounding in early education before starting formal schooling. Sr. Ortrudis later

³ Congregatio Jesu (Congregation of Jesus) is the congregation to which I am a member and so I talk as a participant observer.

started another Pre-school in another high density suburb, Mbizo in Kwekwe. This was close to our Mary Ward Primary School (itself in its early years of foundation). This Pre- school also became a feeder school to the latter.

The set up of Mary Ward Children's home is into four houses each forming a family unit. Two mothers are assigned to each house, each taking a shift. The mothers are chosen from widows (some of them HIV positive) needing a good income to sustain their own families. Ideally each house would take 10 children from babies to 18 years. Care is taken to keep siblings in one house. But, over the years, the numbers swelled up to well above 40 so that today the Children's home cares for about double the original number.

Mary Ward Children's home was built and run from funds raised by CJ sisters in Germany. The government gives per capita grant and this, although important, is not enough to meet the running costs. Significant too, are donations from the local church communities and businesses.

4.2.4 Shungu Dzevana Trust

Sr. Mercy Mutyambizi, as founder of *Shungu Dzevana Trust* (Aspirations of Children) in Hartfield, Harare, took on the idea of fostering children to great heights. She writes:

In 1992, I became concerned with the increasing number of orphaned children as a result of poverty and other social economic problems resulting in babies being abandoned. I formed the Shungu Dzevana Trust caring mainly for children who have been abandoned.

She adds that the plight of orphans in 1992 was exacerbated by the impact of HIV and AIDS – that “had a devastating impact on the lives of Zimbabwe's children”. Celebrating 17 years of foundation in 2007, Shungu Dzevana cared for 496 children. The children range in age from babies to over 16 years old”.

Sr. Mercy lays emphasis on collaboration in this important and yet a task of great magnitude. Pertinent to inculturation, she inculcated the Bantu Shona value of humwe (*nhimbe* in Zezuru Shona dialect - togetherness) that required unity and participation of all stakeholders. She underlines this concept saying:

Despite the serious economic challenges in Zimbabwe, over the years, Shungu Dzevana Trust has continued to help children with support from foster parents, companies, churches and individuals... As the National Director of the Trust and Catholic nun, I am accountable to a strong board of six directors including Fr Oskar from Jesuit communications. As you know, these are difficult times for our children.

She highlights the progress made as follows:

It is most encouraging to see all the children going to school. Three students who have been in my care for a long time are now graduates. In other “professions” (Emphasis is mine) there are 7 nurses, 15 teachers, 1 Policeman and 29 others are already in professional full time employment.

Sr. Mercy is careful to point out that the love of God is the driving force in responding to diverse needs of the children:

Inspired by God’s love and responsibility to serve the poor and vulnerable, our role is to provide security for the children in our care so that they can experience life in all its fullness. We have the will to make this happen, but we cannot do it alone.

4.2.5 The Maryknoll Sisters

In 2002, Maryknoll Sr. Kathleen Barbee and a Redemptorist colleague, Br. Benjamin T Posvo (<http://www.maryknollsisters.org/catholic-mission/index.php/missioners/150-sister-kathleen-barbee>), responded to the profound needs of Zimbabwean children living in poverty and established the Mavambo (“genesis” or new beginnings) Trust. Mavambo programs assist children who live in Zimbabwe’s Mabvuku, Tafara and

Goromonzi districts. Many of the children who receive care are orphans whose parents died from AIDS. Mavambo employs ancillary staff from local residents.

Since most of the children have been unable to attend school due to lack of birth certificates and/or lack of financial resources, among other reasons, Mavambo tries to rehabilitate them into normal school system. It provides them with life skills and psycho-social support. Hundreds of children have been trained in palliative care, since so many of them provide that service in their families. The centre also works with child-led support groups for children living with HIV and AIDS, who continue to suffer discrimination.

Literacy programs and medical assistance are offered as well. Nutrition and health education are also available. The ultimate goal of all the programs is that the children will develop into self-reliant, healthy adults who are able to participate fully as Zimbabwean citizens.

4.2.6 Mother of Peace orphanage

Mother of Peace orphanage is unique for being in Mutoko rural area in Mashonaland East and near the Mutemwa leper Colony (associated with John Bradburn) and in being founded by a lay woman, Jean Cornneck (Mama Jean) in collaboration with Sister Stella in 1993. The two were nurses trained in the United Kingdom (UK). Land was leased by the government for the project and in the early years, with lack of proper medical facilities, treatment and medication for children, Mother of Peace started as a hospice caring for children while they were dying of AIDS or other fatal diseases. Another unique element of Mother of Peace is that its largest donor is the Allen Temple Baptist Church (not RC Church) AIDS Ministry in Oakland CA (since 2000). With the help of U.K. charities, the RC Church and other philanthropists,

Mother of Peace was formally established as a safe refuge for the children of Zimbabwe. The orphanage is comprised of⁴:

- *10 family homes each accommodating up to 16 children.*
- *A Medical Clinic which provides HIV/AIDS prevention education and treatment to children living at the orphanage and also, to adults and children in nearby communities.*
- *A primary and vocational school.*
- *A farming operation.*
- *A bakery.*
- *A Catholic chapel. (<http://www.motherofpeace.co.uk/index.html>)*

Today, given the provision of good medication and living support from The Allen Temple Baptist Church AIDS Ministry and other donors, the mortality rate has significantly reduced. At the Medical Clinic, Dr Scott leads a team of U.S. based and Zimbabwean medical professionals in administering life-saving anti-retroviral medicine therapies and treatment to child patients with HIV and AIDS. Allen Temple AIDS Ministry sources and pays for all HIV/AIDS related medications.

The orphanage now cares for 150 plus children, and more are being referred to the orphanage, mainly by the social welfare in Zimbabwe. Mama Jean has goals set to expand and care for 400 children. Children of all faiths are warmly welcomed. (<http://www.motherofpeace.co.uk/index.html>)

5. RCC treatment and palliative care of HIV and AIDS sufferers in Zimbabwe

The RC Church in collaboration with the state medical providers and other churches (Zimbabwe Association of Church-related Hospitals - ZACH) and overseas donors, has made significant strides in alleviating suffering and improving the quality of life of PLWA. As mentioned above, the RCC has hospitals and clinics in every diocese. All

⁴ I visited Mother of Peace in September 2006 and was impressed by work going on at the place – the level of care and well planned and managed income generating activities

trained medical professionals are on government salaries and there is continual in-service training and medical providers are kept up-to-date with advances in treatment of AIDS related diseases.

5.1 Outreach Programmes

Catholic hospitals and clinics have outreach programmes to cater for people in remote areas. In my own home area, I acknowledge the outreach programme of doctors at Driefontein Mission hospital to Serima rural area and liaising with Serima Mission clinic. Here they do voluntary testing, counselling and administration of anti-retroviral drugs. PLWHA in respective villages know and are very supportive of one another. One notices that the number of people dying from AIDS has come down significantly in the area.

5.2 Voluntary Counselling, testing and treatment

At our (CJ) Clinic (St Josephs' in Chishawasha – Peri-urban area east of Harare), Sr. Rosemary Masvimbo, as nurse (Personal communication), informs that they follow the World Health Organisation (WHO) vision and target of having babies born free from HIV infection by 2015. She explains that:

Mother to Child Transmission of HIV is a high risk factor (a) during pregnancy because of the mother's high viral load, superinfection, early rupture of membranes due to prolonged labour, and unnecessary episiotomy during delivery; and (b) mixed feeding during breast feeding.

Consequently, at ante-natal care (ANC) the following is done:

We do voluntary Prevention of Mother to Child Transmission (PMTCT) testing. The PITCT programme starts during pregnancy to cessation. The Anti-Retroviral Treatment (ART) eligibility assessment criteria used are those of WHO staging and CD4 count. The clients who are eligible for ARV drugs are those with low CD4 count of 350 and below and those with clinical WHO stage 3 and 4. The rule in health practice is for pregnant mothers to be tested

for HIV in early pregnancy so that at 14 weeks they can be commenced on ARV drugs which eliminate the transmission of HIV to the foetus. If the CD4 count is low and clinical staging is 3or4 the client is commenced on ARVs for life. If the pregnant woman's CD4 count is not low the woman will be on prophylaxis during pregnancy and a week after delivery then she is continuously regularly checked for CD4 count every three months.

For post-natal care, Sr. Rosemary explains that:

The child born of HIV positive mother is given extended Nevirapine up to one week after cessation. The Nevirapine will be destroying the HIV attachment to the body cells. During breastfeeding at six weeks the infant is tested for HIV using Dry blood spot [DBS], at one year six months the child is tested using rapid testing with Determine and Bio-Line HIV test kits.

Sr. Rosemary explains that:

There are two methods used in feeding the infant during breastfeeding time which are exclusive breast milk and exclusive formula feeding. The infant and young child feeding recommendation in the context of HIV is that complimentary feeds are introduced at six months of age.

Sr. Rosemary acknowledges the positive effects of the Voluntary PMTCT programme, as follows:

At our clinic the Voluntary PMTCT testing has helped the community to have HIV free children from HIV positive mothers and encouraged those mothers who are not HIV positive to be faithful to one partner and remain negative. At the clinic we are managing very well to eliminate new paediatric HIV infection and keep mothers alive. We are committed to let a mother's fight be our fight. Therefore, during post-natal clinic, the breastfeeding mothers are asked to produce valid results, if not, they are tested again so as to prevent the infant from contracting HIV.

5.3 Herbal treatment and prophylaxis

Sr. Rosemary also introduces another aspect that acknowledges indigenous medicine – exploring local herbs in combating HIV and AIDS. She says she has used the following with significant positive results:

The drug I used to treat Herpes zoster is black jack and Aloe Vera; for High blood pressure I use leaves of peach tree and avocado pear leaves; for oral thrush I use Aloe Vera; for anaemia I use avocado leaves (boil and then drink the water) and for neurosis I use comfrey leaves.

The use of local medicine – in particular, herbs, has been explored significantly as a project of the Chinhoyi diocese that was spearheaded by Sr. Yulita Chirawu culminating in the booklet *Common herbs and their uses manual* (2003). Sr. Yulita, now in the Harare diocese continues to explore this area in the treatment of AIDS opportunistic diseases. There is a lot of wealth in traditional medicine and the RC Church and other health providers in Zimbabwe have realised that exploring this field gives hope in the cure of HIV and AIDS.

5.4 Pastoral Counselling

It is a known factor that PLWHA suffer a lot from emotional stress due to stigmatisation and discrimination, gender vulnerability (biological and from cultural practices) and also from the mere fact that AIDS is a killer. Pastoral care (pastoral theology) plays a significant role here. Fr Robert Igo (of the Benedictine order) in Monte Casino, Macheke, has explored pastoral counselling of and solidarity with PLWHA. People need to be assured that there is life after HIV infection. Faith healing plays an important part here. According to Rev. Robert Igo (2005:56-66) there is need to awaken PLWA to listen with love to God's promptings and to pay careful attention to God's healing presence.

5.6 Reading the Bible with eyes of PLWHA

Reading the Bible with the eyes of PLWHA, shows that Gospels portray who comes to bring life – the compassion and merciful Christ who healed people of all kinds of diseases; who in advocating symmetry of responsibility to relational issues like adultery, never-the-less, does not condemn but unconditionally forgives sinners (Jn. 8:1-11). Christ asks engaging question that elicit conversations and awakenings to new opportunities of self affirmation and fulfilment.

There is also, for example, the classic story of Job in which it is shown that those who suffer are not always guilt of sin. PLWHA can draw from the story of Job that suffering is not always punishment for sin; than often the innocent suffer in and experience solidarity with the suffering. Throughout the book, and in all the misfortunes that befell him, Job maintains that he is “innocent”. However, eventually he learns that he shares the suffering of many innocent people and finally becomes convinced that God is his *goel* (Redeemer, defender) (Job 19:25).

6. Taking stock and strategic planning and implementation

The Joint Conference of Major Religious Superiors observed that while they engaged seriously on prophetic multidimensional interventions to the situation of HIV and AIDS in Zimbabwe, however, in targeting the 12-49 years age group as at high risk to HIV infection, they failed to cater for young men and women in religious formation who were equally at risk. Indeed, the Roman Catholic Church experienced several instances of young clergy dying from HIV and AIDS (cases that were swept under the carpet through the conspiracy of silence). In 2005, I was one of the delegates from the Joint Conference of Major Religious Superiors in Zimbabwe to a “Sister-Sister Solidarity International Conference in Bronkhorstspuit, South Africa. We were made aware of our brothers and sisters in religious communities who were affected (in some cases infected) with HIV and AIDS. These people closer at home were suffering from emotional burden. We were thus challenged to “move forward in hope” by planning and implementing a coordinated plan of action that encompasses all of Roman Catholic responses to the situation of HIV and AIDS in Zimbabwe, Southern Africa and the whole of Africa (2005).

Because HIV infection is associated with heterosexual relationships and PLWA suffered from stigmatisation and discrimination being labelled as, prostitute and promiscuous, and yet as pointed out above, there are other vehicles to HIV infection. Furthermore, more than two decades on of experiencing the HIV and AIDS pandemic, there was now the phenomenon of virgins who were HIV positive. Among key educational issues, the Major Religious Superiors recommended integration of sound spirituality and theology of human sexuality into formation programmes. Furthermore, there was the challenge to go further by analysing and evaluating just:

How focused and coordinated the projects and programmes that different dioceses and Religious congregations sponsored? How good are we at documentation, sharing of information and resources? How clear and unified is the prevention message that people hear from the Catholic Church? What contribution are the theologians of our Church making to a deeper understanding of the complex issues that surround HIV/Aids? How well are we preparing future priests, religious sisters and brothers to make informed contribution to the demanding apostolate of hope in an era of HIV/AIDS? (2005:1-2).

5. Conclusion

It has been shown that HIV and AIDS pose many engaging questions that make fertile ground for the church to engage in public theology of the signs of the times. An important observation explored is that the time of the HIV and AIDS pandemic is a *kairos* moment in which the church is challenged to seize the opportunity to explore all avenues in restoring human dignity and advocating holistic creative love in affirming quality life. As the spotlight light was on RC Church interventions in the situation of HIV and AIDS, it cannot be overemphasized that the Church's response in this context is part of the heart of its mission and existence. It was found that among the stakeholders in combating HIV and AIDS, the RC Church plays a crucial and pivotal role and that it is able to have complex capacity building through its power houses existing in women and men religious orders. Most important of all, it is open

to engage all stake holders in this mammoth task, and, in particular, in empowering PLWHA to be agents of their own history. The importance of continual internal and external critique has been found invaluable in the Church's struggle to be relevant and meaningful. But the struggle to dream dreams of an HIV and AIDS free society continues until the pandemic is eradicated. However, the RC Church continues to forge ahead in hope especial in the sense that it sees light at the end of the tunnel in that the vision to have babies born free from HIV can be realised in not too distant future.

List of References

Assmann, H. 1975. *Practical theology of liberation*. London: Search Press

Chawatama, T. Dec-Jan-1997. "Runyoka: would you fence your wife that way?" *Moto*, No. 131/132, pp.16-17

Baylies, C. 2000. "Perspectives on gender and AIDS in Africa", pp.1-24. In Baylies, C. & Bujra, J. with the Gender and AIDS Group. *AIDS and sexuality in Africa*. London, New York: Routledge

Chimhanda, F.H. 2011a. "Loving well and being whole: a theological response to the impact of

HIV/AIDS on women and the girl child with particular reference to Shona people of Zimbabwe". *Theologia Viatorum – Journal of Theology and Religion in Africa*, 35.1, pp.1-27

Chimhanda, F.H. 2011b. *Christ the ancestor; Shona Christianity and the roots for feminist liberation*

praxis. Saarbrücken, Germany: VDM Verlag Dr Müller

Chimhanda, F.H. 2011c. *An Incarnational narrative Christology of Shona women of Zimbabwe*. Saarbrücken, Germany: LAP Lambert Academic Publishing

Chirawu, Y. 2003. *Common herbs and their uses*. Harare, Zimbabwe: Catholic Health Care Commission – Speciss Print

Chittister, J. "Theology and feminism in Conjunction or Conflict?" 1998, *Trefoil*, pp.7

CONGRESSO INTERNACIONAL DA FACULDADES EST, 1., 2012, São Leopoldo.

Anais do Congresso Internacional da Faculdades EST. São Leopoldo: EST, v. 1, 2012.

| p.823-852

Devine, R.J. 1996, 2000, 2004. *Good care, painful choices*. New York, Mahwah, N.J.: Paulist

Drew, R. 2003. "The current status of the HIV/AIDS crisis", cf. *The hope factor: engaging the church in the HIV/AIDS crisis*. Yamamori, T., Dageforde, D., & Bruner, T. Waynesboro, GA, USA: Authentic Media.

Gutiérrez, G. 1992. *Las Casas: in search of the poor in History*. London: SCM Press

Igo, R. 2005. *Listening with love*. Geneva: WCC

Luzbetak, L.J. 1988. *The church and cultures: new perspectives in missiological anthropology*. Maryknoll, New York: Orbis Books

Maluleke, T.S. 2004. "Towards an HIV/AIDS sensitive curriculum." *HIV/AIDS and the curriculum: methods of integrating HIV/AIDS into theological programme*. Dube, M.W. (ed.). Geneva: WCC

Maryknoll Sisters. <http://www.maryknollsisters.org/catholic-mission/index.php/missioners/150-sister-kathleen-barbee>

McCarty, K.A. 2003. "Home care for AIDS patients in Zimbabwe", in *The hope factor: engaging the church in the HIV/AIDS crisis*. Yamamori, T., Dageforde, D., & Bruner, T. Waynesboro, GA, USA: Authentic Media.

Mother of Peace Orphanage. <http://www.motherofpeace.co.uk/index.html>

Missio Ad Gentes. 1965. www.vatican

Nicolson, R. 1996. *God in AIDS*. London: SCM Press Ltd

Pobee, J.S. 1992. *Skenosis: Christian faith in an African context*. Gweru, Zimbabwe: Mambo Press

Pope Benedict XVI 25 Dec- 2005. *Deus caritas est*. Vatican: Libreria Editrice Vaticana
Pope John Paul II. 1995. *Evangelium Vitae*. Nairobi, Kenya: Pauline Publications

Puhl, L.J. 1951, 1952. *The spiritual exercises of St. Ignatius*. Chicago: Loyola University Press

Church in Zimbabwe Roman Catholic - <http://relzim.org/major-religions-zimbabwe/catholics/>

<http://www.avert.org/aids-zimbabwe.htm>

Schwöbel, C. 2006. “recovering human dignity”, cf. *God and human dignity*. Soulen, R.K. & Woodhead (eds.). Grand Rapids, Michigan: Wim. B. Eerdmans

Siwela, W. 1991. “Is this the Zimbabwe apocalypse? Before we had infanticide but now we have rampant child abuse. Which is the lesser of the TWO EVILS? *Moto*, No.170/171, pp.12-13

Tamez, E. Jan-2001. “An Ecclesial community: women’s visions and voices”. *The Ecumenical review*, 53.1, pp.57-63

The joint Conference of Major Religious Superiors of Zimbabwe. 2005. *Forward in hope: a plan of action for the next twelve months*. Harare, Zimbabwe: Oikumene

WCC Study Document. 1997. *Facing AIDS: the challenge, the Churches’ response*. Geneva: WCC

Weinreich, S. & Benn, C. (eds.). 2004. *AIDS: meeting the challenge – data facts background*.

Geneva: WCC Publications

ZACH & HOCD HIV/AIDS committee manual. 2007. *A guide to HIV and AIDS pastoral care and counseling*. Zimbabwe

Zimbabwe crisis. “Compassionate Health care in the service of Christ” – Church hospitals bearing the brunt in Zimbabwe http://www.co.za/zimbabwe_crisis.htm

Zimbabwe – population – demographics. (www.indexmundi.com/zimbabwe/population.html); www.sokwanele.com/thisiszimbabwe/archives/6446